

What is Culture?

Our February newsletter (<http://www.cchap.org/nl15/#two>) addressed the importance of strong cross-cultural communications skills in healthcare settings. April's topic coincides with the beginning of spring, a time to start digging deeper in our understanding what culture is and why it is critical to understand one's own culture before learning about others. We are preparing the ground to plant seeds of real cultural awareness so we can foster better relationships with culturally diverse patients and ease the challenges of providing medical care for them.

The meaning of "culture" has been widely debated and it can be defined in many ways. For our purposes in the medical field the following definition is useful:

Culture can be seen as an integrated pattern of learned beliefs and behaviors that can be shared among groups and includes thoughts, styles of communicating, ways of interacting, views on roles and relationships, values, practices, and customs. (Robins et al., 1998b)... Culture should not be considered "exotic" or about "others." We all are influenced by and belong to multiple cultures that include, but go beyond, race and ethnicity. (IOM)

The culture a person *learns* early in life becomes a set of hard-wired mental and emotional "operating instructions" for how to go about getting basic needs met.

As humans, we develop our self-esteem and identity within a particular cultural context. Without a clear cultural identity, we would experience confusion and isolation. Our resistance to cultural difference is natural. It is important to recognize the resistance we feel, to see it as part of being human and avoid turning it into something negative. Resistance to cultural difference is a phase we pass through on the way to becoming more cross-culturally aware and skillful.

To begin moving beyond resistance, we first have to ask some basic questions. Do we see our own culture as the "one" that is central to reality? Do we assume our way of operating in the world is better, thereby trivializing difference automatically? In the field of intercultural communications, the terms ethnocentric and ethnorelative are often used. Ethnocentric means that we view our own culture as being central to reality. Ethnorelative means we can indeed experience our own culture within the context of other cultures. Moving through resistance means moving towards a place of comfort in the ethnorelative stage.

You might be thinking at this point, "OK, I understand the concepts here, but what can I DO to become more cross-culturally skillful. The answer may surprise you. The first step is learning more about your own culture – American culture. Are you thinking, "We Americans don't really have a culture because we are a melting pot of other cultures." If so, you are in good company; many of your fellow Americans feel the same way. But you *do* have a culture, and it is a very specific one. Your culture is something people around the world are keenly aware of, so it's a good idea to learn how others see you. Further, as a healthcare provider to increasingly multi-cultural populations right here in Colorado, it is vital that you understand your culture as a baseline for comparing other cultures. Hopefully this feels like good news because an imbalance has been addressed. Instead of feeling charged with responsibility for learning about everyone else, you realize that you too are part of the culture game. You have something to learn about yourself first, and then, hopefully, learning about others will be more meaningful and more pleasurable. You'll be able to replace the paralysis of political correctness with an intercultural playfulness. One day, you'll even be able to laugh at yourself for behaving so darned *American* in a situation.

It's worth addressing what we mean by "American" before we start exploring specific cultural dimensions in other cultures, like time and its control, individualism and language use. Just what constitutes being an American? It's a tricky question. There are Asian Americans, African Americans, Native Americans, etc. All of these "groups" are *absolutely* Americans. But for our purposes here, being very specific, we are addressing the styles of communicating, ways of interacting, values and beliefs that are rooted in what interculturalists often refer to as Americans of Northern European descent. In other words, historically speaking, white middle and upper class citizens of the US.

Based on the definition we are using here, if you think of yourself as an "American," ponder the following questions. Go beyond a quick "yes, no" response – feel your answers as they arise in you. This is very important.

- Do you feel as if there's enough time in your life to do all the things you want and need to do?
Americans think of time as a very important commodity. For many, time dictates much of their day. Much more than other cultures.
- When you ask someone a question, do you expect a straight answer? If she gives a long story as an answer or "beats around the bush," does it frustrate you?
Americans are very linear thinkers who value efficiency in most things, including conversation. "Get to the point."
- How important is a person's being direct? Do you depend on others to "say what they mean, and mean what they say"?
Americans are direct in their style of communication. They depend on the words they speak to convey the message they intend. Non-verbal cues are given less emphasis than in other cultures.
- Do you believe that hard work and determination will enable you to achieve your goals?
Americans believe in their ability to create the future they want for themselves. Americans place far less emphasis on the role of fate in life.
- Do you respect a person who knows his own mind and can think for himself and doesn't need several other people to help?
Americans value the individual over the group and this is very evident in decision making.
- Do you believe in the ideal that everyone should be treated equally?
Americans tend to be very informal and believe everyone should be treated the same. In many other cultures, status plays a greater role in social interactions.
- Do you believe that technology and science should be trusted to provide new solutions to replace the old solutions to common problems?
Americans (especially medical people) believe in science providing new solutions that are better than old solutions. Most other cultures do not believe this as strongly as we do.

In the next issue of the CCHAP newsletter, we will be looking at specific dimensions of American culture that relate directly to these questions, and how our culture differs from other cultures. It might be useful to review the March newsletter on stereotypes and generalizations (www.cchap.org/nl16/#one). As I visit CCHAP participating practices to do cross-cultural trainings, I find these newsletter topics are helping prepare staff and providers for the trainings. To return to the springtime analogy I started with, preparing the ground for planting rewards us with more abundant growth.

Advice for Your Practices From Parents of Medicaid, CHP+ and Minority Children

CCHAP conducted a **parent advisory meeting**, in which parents from CCHAP-affiliated pediatric practices discussed their perceptions and ideas about their experiences with the children's pediatric office. We had a variety of minority and ethnic groups represented, including recent immigrants and an undocumented parent with one US citizen child and one undocumented child; and nearly all had children with Medicaid or CHP+. During a two hour discussion they described their experiences in private pediatric practices. They provided us with many wonderful ideas that Marcia Carteret will incorporate into the cross-cultural training sessions she offers private practices. Please contact her to learn more about the private practice cross-cultural communication training programs (Carteret.Marcia@tchden.org).

In this article, we will share the three ideas that parents shared with us that will most dramatically help your practice better serve minority and low-income families.

The importance of the reception staff

As you know the reception staff in a practice is the face and the voice at the front door. And, since families with Medicaid and CHP+ often experience “glitches in the system,” the front desk staff are usually the people in the practice who are most affected by the problems that arise with Medicaid and CHP+ patients. And the front desk folks are usually the people in the practice who are most affected when confusion or problems surface with families from other cultures. The reception and scheduling staff are the ones who must serve as first responders when parents are upset.

The parents in our advisory group recognized how important their interactions with the reception, scheduling and business office staff are. They thought that it would be helpful for office staff to learn a little more about the trials and tribulations of low-income families and families from other cultures, and to learn about ways to help parents deal with frustrations.

And there is another phenomenon that we learned about from the parent advisory group. Since families receiving Medicaid and CHP+, or minority or immigrant families, often experience prejudice associated with “being poor” or “being different” elsewhere in their lives, they may expect it when they arrive in your practice. They might be inclined to misperceive the front desk staff attitude (perhaps due to a very hectic day) as another instance of prejudice. Therefore, the reception staff has to be especially aware to extend themselves to these parents and especially knowledgeable about the problems faced by minorities and by families with Medicaid and CHP+ children. As the families going to private practices become more diverse, the reception, scheduling and business staff will be called upon to handle increasingly difficult and complex problems. So, they will need to develop a high level of sophistication and skill at cross-cultural communication.

The importance of a patient advocate in private practice

Private practices frequently receive recommendations on additional services they should provide, but without the funding to support it. Well, here is another idea that seems very important for the care of special needs children, low-income families and families from other cultures. Although this idea is not currently funded, CCHAP is making the commitment to work with you to figure out how practices can afford it.

It was quite clear in our parent advisory group that the help parents get with paperwork, referrals, socio-economic issues, and coordinating care or resources are things they highly value. For example, they love Erlinda Diaz and Lorena Reyes and the people in your practice who do similar things to help parents. These patients and families with special health care or socio-economic needs require more time than your staff can routinely provide. They need more help in coordinating care, or in understanding the treatment plan, or in understanding complicated health

issues, or in completing paperwork or in arranging various services or appointments. Only it is not just children with special health care needs; it is also children in families with special socio-economic needs, parents who have limited English proficiency, families with Medicaid or CHP+ glitches, families with limited literacy / or ability to understand, or families with complicated treatment plans or complicated paperwork. To maintain the efficiency of the office, a person is needed who can help families with this higher level of need: A PATIENT / FAMILY HELPER to serve as an advocate and navigator/resource coordinator.

But, how is a practice going to afford to add another person, when practice margins are already so narrow? That is something we at CCHAP want to help practices with: how to afford patient advocates (what some people call “navigators”) in their practices. These could be volunteers, whom CCHAP could help train; or they could be paid individuals, whose time could be paid for by better compensation for care coordination.

We will be asking for practice managers and providers to advise us on creating positions like this to help special needs children: children with multiple, complex conditions, families with difficult socio-economic conditions, or families in need of help in understanding or navigating the complexities of health care.

At the end of the visit – two questions that will improve the outcome for the child

There are two things that parents felt that health care providers can do that will dramatically improve parent understanding, compliance and satisfaction, and as a result improve outcomes for the child. Minority and low-income parents told us that they often feel reluctant to ask questions or to admit that they don’t really understand the recommendations they receive. This could be due to limited English proficiency or limited understanding of terminology or complicated instructions. They said that providers often seem to be in a hurry and the parents feel reluctant to interfere by asking questions. They said it might take a little extra encouragement to enable them to admit that they have questions or do not understand. Their request was for providers at the end of the visit to ask, “Have I explained everything well enough? (Do you feel you understand this well enough?)” Or, “Do you have any questions?”

How are EPSDT (Medicaid) Preventive Care Requirements Different from American Academy of Pediatrics Recommendations?

The new AAP Periodicity Schedule, published in December of 2007, has some changes compared to the previous schedule. In the past there have been a few minor differences between the AAP recommendations for preventive care and the EPSDT requirements for Medicaid children's preventive visits. Some of those differences are now resolved, but there are still some differences. The 2008 AAP periodicity schedule recommends a preventive visit for every year from 3 years on. In the past, the 7 and 9 year preventive visits could be skipped. This brings the AAP periodicity schedule in line with the EPSDT requirements. The AAP periodicity schedule recommends visits at 3-5 days, 1 month, 2 mos, 4 mos, 6 mos, 9 mos, 12 mos, 15 mos, 18 mos, and 24 mos. This is consistent with the EPSDT requirements for 10 preventive visits in the first 2 years. There is now a recommended preventive visit at 30 months in the AAP schedule; but this is not reimbursed by Medicaid.

Referral to a "dental home" appears in the AAP periodicity schedule to be optional based on availability of pediatric dental homes and the degree of risk in children under 3 years of age. EPSDT requires referral at one year of age to a dental home. This makes sense, since Medicaid children are at significantly increased risk for dental caries.

Lead screening is another area of significant difference. On the AAP schedule it appears that lead screening should be performed based on risk factors. If you read the reference material in small print at the bottom of the page, though, it recommends that you follow state or Federal law (which trumps the AAP recommendations). Since all Medicaid children are considered to be at-risk, State and Federal law for Medicaid children require lead screening on all Medicaid children at 12 and 24 months. If a child is seen at an older age and has not been screened, lead screening should be done.

Hematocrit is recommended by the AAP at 12 months. The EPSDT recommendation is either 9 or 12 months, though EPSDT prefers 9 months.

Please note also that the AAP recommends developmental screening with a standardized screening tool. This is also an expectation of EPSDT. We are very fortunate in Colorado that EPSDT administrators are very enlightened and supportive of primary care providers providing developmental screening. Colorado EPSDT reimburses for standardized developmental screening as well or better than any other state and at a much higher rate than commercial health insurance. Please read the article in this newsletter about how your office can receive free training on developmental screening and can receive this high rate of reimbursement for developmental screening of Medicaid children.

There are other minor differences. **To do your own comparison of the AAP periodicity schedule and the EPSDT schedule, go to:**

AAP - <http://pediatrics.aappublications.org/cgi/content/full/120/6/1376/DC1>

EPSDT - http://www.chcpf.state.co.us/HCPF/EPSDT/EPSDT_Final_page2.asp

Also, all practices to provide care for Medicaid children should become familiar with the Colorado EPSDT web site. It has a wealth of helpful information for providers and staff. The web site has information on referrals and has sample encounter forms, parent handout and a variety of other helpful tools.

http://www.chcpf.state.co.us/HCPF/EPSDT/EPSDT_Final_page2.asp

Practice Manager's Corner

By Christina Ells

There have been a number of questions among CCHAP-affiliated practices regarding developmental screenings and the use of codes 96110 and 96111. The article listed below was developed by the American Academy of Pediatrics for the purpose of training primary care Pediatricians about the use of both codes and provides recommendations about standardized, validated testing. It is one of the best written articles I have seen on this topic to date.

In summary, the only code appropriate for a PCP's office is the 96110, which covers developmental screening. The 96111 is for specialists who do actual developmental testing with test never used by the PCP.

Please be sure to share this article with your physicians, mid levels, billing team and support staff. As always, please let me know if you have further questions or concerns about developmental screening.

<http://lnk.nu/cdc.gov/jc9.pdf>

Is Your Medicaid Patient Eligible for Home Health Care? ULTC 100.2.

By Christy Blakely, Family Voices

As any parent knows, navigating the service delivery systems can be quite confusing. In fact, at times, down right intimidating! It is with this notion that I hope through this article to breath some clarity into one such process, that of the ULTC 100.2. Just the name causes families hearts to stop!

The ULTC stands for **U**tilization **L**ong **T**erm **C**are. The 100.2 stands for the document number which is in rules for **H**ealth **C**are **P**olicy and **F**inancing (HCPF is Colorado Medicaid's administrative agency). This tool is Colorado Medicaid's evaluation tool to assess the need for a baby, child, youth, adult or elder, in for long term care (think home healthcare) services. This tool assesses the ability or inability of this individual to accomplish the 6 ADL's (**A**ids of **D**aily **L**iving) which are: feeding, bathing, dressing, mobility, transfers, toileting PLUS supervision (think safety). Scores are given based on the individual's ability to perform these tasks by themselves or with the assistance of others. The state's contractor which is the agency contracted to assess this eligibility is called the SEP or **S**ingle **E**ntry **P**oint (SEP). The SEP for Arapahoe and Douglas counties is Long Term Care Options, for a list of counties and the SEP go to <http://www.chcpf.state.co.us/HCPF/LTC/Single%20Entry%20Points%20list.htm>

The evaluation is to assess the patient's ability *as compared to another person at the same age and stage of development*. This gets tricky to score for a small child., The small (0-3) child, who is not potty trained yet, would typically have the parent do the care of diapering or dressing, so no points are given. For a seven year old, who is still unable to manage without diapers, then points would be given, since a typical seven year old would be potty trained during the day. See how it works? The tool is then tallied with an eligibility score for how much care this child will need *long term*.

Using the same tool for children and elders causes some confusion. It is every parent's hope to improve a child's abilities. So, it is possible if a child improves and gains the skill over a year the assessment will show less eligibility due to improvement of that skill. Whereas, for the very elderly patient it may not be likely that the ability to toilet independently will improve a year later. As parents we wish to always show the best of our off spring. This does not change if our child has a disability; we still wish to show them in a favorable light.

I found myself the other day saying, "Lauren said_____." My daughter, Lauren is actually labeled, non- verbal, she had actually typed on a communication device to say_____. My point here is that we hope to answer the questions that our children are improving or often want to show they are more able than is the reality. We are with these wonderful children daily. We spend time with them after everyone goes home. We know them the best. As parents, we (and the pediatrician) need to help the evaluators get to know our children as accurately as possible.

Face it, those who make decisions about eligibility are unable to spend the real time it would take to get to know and understand the functioning level of every child, so given specific criteria they ask questions to see if your child qualifies. They are seeking information on how much the parent does for their child. (*relative to another child at the same age and stage*). They are trying to figure out if the child or youth is a risk to themselves or others (*relative to the behavior of another child at the same age and stage*). They need to rate him or her on the ability to dress themselves, including understanding types of clothes for types of seasons (*relative to another*

child at the same age and stage). They are assessing if without their parent's help or guidance they can be safe (*relative to another child at the same age and stage*). The hope is to uncover the ability to transfer and move about the house without the aide of a walker, wheelchair or toy (*relative to another child at the same age and stage*). Questions such as, "Do you run the bath for him/her?" This question is really asking, would this child understand the danger of a bath drawn too hot/cold? Related to feeding it is not the preparation that is being evaluated but the actual eating. When answering we need to be clear if there is a risk of choking.

We as parents find it difficult to answer as no two days with our children are the same. We must be honest but consolidate the good days with the bad and report the average. It has helped me to think not so much, "Can she feed herself?", but instead, "Can she do it safely?" Can she do it by herself without choking? Or can she transfer to the tub *safely* without assistance? Now, I feel I answer more realistically for both my peace of mind and more honestly to help the state develop insight.

Christy is a parent of a young adult with disabilities. She is the director of Family Voices CO, www.familyvoiceco.org

Immunization Reminder Study

Tiffany Brown and Christina Ells

We are excited to be kicking off our immunization reminder recall study over the next month. In order to develop the most accurate list of Medicaid children in your practice needing immunizations, please make sure your immunization records are up-to-date and entered in the CIIS registry by April 14th. We will be generating our first list of kids considered late shortly thereafter.

As discussed at the Practice Manager's Meeting, we will provide your practice with a list of patients that have been identified as late receiving their immunizations. This will give you an opportunity to notify us which patients are already scheduled for appointments and whether or not we have identified patients that no longer receive care in your practice.

Tiffany Brown, Director of Quality Improvement for CCHAP, will be contacting your practice over the next few weeks to figure out how we can work together to effectively carry out the reminder recall with the least disruption to your practice. Each practice has the option to provide reminder recall in their office or have CCHAP do it centrally at no cost to you. In order to track effectiveness of the recall, practices that choose to perform their own reminder recall will be asked to please use the same form CCHAP will be using to track communication with the families.

Let's get our kids immunized!

A Website To Help You Learn Medical Spanish

<http://www.practicingspanish.com/index.html>

Child Psychiatry Telephone Consultation on Medicaid Children

The Behavioral Health Organizations and the Mental Health Centers in the greater metro area have very generously made available **telephone consultation by child psychiatrists** to help providers in CCHAP – affiliated practices manage their **Medicaid children with complicated mental health issues or complicated medication regimens.** These child psychiatrists are also willing to come visit your practice to get to know you and even to discuss cases. We are very grateful for this very generous support for your Medicaid children.

Denver County – Rick March, MD – 303-504-1520

Jefferson County – Don Bechtold, MD – 303-432-5172

Adams, Arapaho and Douglas Counties - Joe Pastor, MD – 303-853-3888

**PROVIDER RESOURCE HOTLINE
(Clarification of previous information)**

**To Help You Find All Appropriate Services and Resources
For Your Chronically Ill or Special Needs Patients**

Including Case Management or Care Coordination for the Child

And Education Resources and Support Services for Their Parents

Call 1-877-731-6017

Fax: 303-691-0846

Email: providerhotline@familyvoicesco.org

The PROVIDER RESOURCE HOTLINE assists providers to identify all appropriate services and resources for children with chronic illness or special needs and for their parents:

- Case management
- Care coordination
- Specialized services, resources, medical equipment, therapies
- Parent/patient education about chronic illness / special needs
- Parent/patient support services
- Help in finding funding for uncovered services

Examples:

- You are seeing a new patient (new to Denver) who is an infant with 22q Deletion Syndrome, congenital heart disease, cleft palate and an oxygen requirement of undetermined etiology. Parents want to link up with all of the support services and a parent group like they had where they used to live.
- A child with multiple developmental delays also has behavioral problems. The parents are not sure they are getting all the help their child is entitled to and they want a parent support group and they are asking for counseling.
- A parent with a disabled child wants your help in applying for some sort of waiver that you aren't familiar with.

Monday thru Friday from 8AM to 4PM

Voicemail available 24/7

Provides follow-up with the provider office and with families

CLARIFICATION

Contact Erlinda or Lorena with CCHAP at PHONE 720-744-5522; FAX 303-751-9048

- **When you are only wondering about socio-economic issues like food stamps, housing, Medicaid eligibility, legal aid, abuse, etc.**

If the hotline can answer your questions immediately, you can pass the information to the family while they are in the office or we can contact the family and give the information to them.

If the information is not immediately available, we will research the question or case and provide the information to you and the family later in what ever manner you and the family wish (via phone, fax, or email).

If you feel the family needs more assistance or follow- up, just let us know and share the family's contact information with us or provide the family with our number for them to contact us directly.

When contacting us, please provide us with the following information:

Your provider office and PCP name

Name of Child

Date of Birth

Medical Condition / Primary Disability

Type of insurance

Resource or service requested

Who should we contact with information?

Family Contact Information

How is it best to provide information back to you: phone, fax, email or voicemail?

DOWNLOAD A REFERRAL FORM AT

www.cchap.org/nl17/#nine

DOWNLOAD AN 8 x 11 FLIER TO KEEP ON HAND AS A REMINDER

www.cchap.org/nl17/#nine

Next time you see a special needs child, call us to see how we can help

Questions about the hotline? Call 1-877-731-6017

*The Provider Hotline Is Sponsored By
Family Voices and CCHAP*

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Integrating Developmental Screening Into a Pediatric Practice

- The Colorado Assuring Better Child Health & Development (ABCD) project has received a three year grant to provide training and technical assistance to providers to implement a “validated” developmental screening tool at well child visits for infants/toddlers birth to five.
- The ABCD project is partnering with CCHAP to provide training and support to pediatric practices to implement developmental screening.
- **Medicaid will reimburse \$34.00 to providers if you use a standardized, validated developmental screening test at an EPSDT visit.**
- The Colorado Chapter of the AAP supports the ABCD project.
- Early detection and intervention improves outcomes. Many delays in children’s development are missed in the first 4-5 years of life without a standardized, validated screening test.
- The **most time-efficient tool** is one in which the parent completes a questionnaire.
- **To comply with 2010 recertification guidelines by the American Board of Pediatrics,** documentation will be required to show levels of involvement in practice improvement initiatives. By implementing the use of a **“validated” developmental screening with a sensitivity and specificity rating of 70% or greater like the ASQ or PEDS,** practices are taking steps to integrate quality improvement into their practices.
- What are providers saying about implementing either the ASQ or the PEDS parent questionnaire developmental screening tool:
 - **It takes 1-2 minutes for an MA, LPN or RN to score.**
 - **It takes less than a minute of the provider’s time if the MA, LPN or RN scores the questionnaire.**
 - In many instances, it reduces the length of the visit.
 - It helps providers concentrate on the concerns/priorities of the parents.
 - It reduces the number of concerns that come up as you are walking out the door at a well care visit.
 - It improves patient satisfaction.
 - It promotes positive parenting practices.
 - It increases provider confidence in decision-making for when to refer a child for further developmental evaluation.
- Eileen Auer Bennett, the Colorado State ABCD Coordinator and her team are available to assist providers in getting started. Training and technical assistance will be provided to practices to implement a standardized tool such as the ASQ or PEDS. Support will also be given to office staff on how to incorporate a standardized developmental screening tool into the current office work flow.

For more information, please contact:

Eileen Auer Bennett
720-333-1351
ileanben@yahoo.com

The Ages & Stages Questionnaire (ASQ)

The Ages & Stages Questionnaire (ASQ) is a well respected screening tool. It has the best sensitivity and specificity. It is standardized across various common minorities. Health care providers have identified the following advantages:

- Parent completed—Parents are partners in their child’s assessment and intervention activities.
- Serves as a talking guide with parents identifying a child’s strengths as well as things the child is not doing yet.
- Practical—Scoring takes 1-2 minutes and can be done by paraprofessionals.
- Cost-efficient—May be photocopied repeatedly.
- Scoring is simple—Only three responses:
 1. Sometimes, occasional or emerging response from child = **5 points**
 2. Yes, child performs specified behavior = **10 points**
 3. Not Yet = **0 points**
- If the child’s total score falls in a shaded area of the bar graph for any developmental area, further diagnostic assessment is recommended.

Visit www.brookespublishing.com to view and order the ASQ tool online.

The Parents’ Evaluation of Developmental Status (PEDS)

PEDS is another tool commonly used by practices involved in a pediatric surveillance program. Provider feedback has been positive. “The PEDS is nice because physicians value knowing the issues parents want to address before going into the room.”

Below are other advantages outlined in an article by Frances Glascoe, PhD, Associate Professor, Division of Child Development, Vanderbilt University School of Medicine:

- Developed out of four cross-validation studies on a nationally representative sample of families.
- Uses parent concerns or judgments about the child’s development and behavioral status.
- Easy to score—two minutes to elicit and interpret.
- Enables health care providers to determine the need to refer and where.

Visit www.pedstest.com to view and order the PEDS tool online.

Spanish Interpretation Training for Pediatric Practices

CCHAP offers a convenient, time-efficient, cost-efficient medical Spanish interpretation training program for pediatric office staff and providers. It is provided as a telephone conference, during practice office hours at lunch time.

Training in medical Spanish interpretation includes:

- Medical (pediatric) terminology
- Subtle differences in the two languages in word selection and grammar
- Culturally appropriate communication skills
- Professionalism and etiquette of interpretation
- Confidentiality and HIPPA issues

Who: This program is for people in the practice who already speak Spanish and English

How: The sessions will be conducted via telephone, using handout materials and the Internet, and will also include role-playing.

When: Wednesdays from 12:15 to 1 pm. The next session will begin as soon enough people are interested in attending.

How long: 45 minute sessions weekly for 6 weeks

Registration: Email the information below to ilssoto@aol.com.

Name of student:

Job title:

Pediatric practice name:

Work phone number:

Home phone number:

Is your first language English or Spanish?

If Spanish is your second language, how long have you been speaking it?

What time is your usual lunch hour?

What is your goal in enrolling in this class?

Price: \$20 per session.

After your registration and start date is confirmed, please send a check for \$120, payable to International Language Services
12572 West Brandt Place, Littleton CO 80127.

An assessment of each individual's skill level will be done during a 5-10 minute phone call prior to first telephone conference/class. Maria will contact you to schedule this initial individual telephone call upon receipt of your registration email. A certificate of completion will be given after completion of all 6 sessions. The faculty is Maria Soto, a certified Spanish interpreter and trainer with International Language Services.