

Developing a Self-Assessment Tool for Culturally and Linguistically Appropriate Services in Local Public Health Agencies

FINAL REPORT

Prepared for the
U.S. Department of Health and Human Services
Office of Minority Health
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Rockville, MD 20852

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Contents

Chapters	Page
1. Introduction	1-1
1.1 Evidence of Persistent Disparities in Health Status and Health Care Quality ..	1-2
1.2 The Vital Role LPHAs Play in Maintaining the Overall Health of America's Communities	1-3
1.3 LPHAs' Provision of CLAS Could Lead to Improved Health Outcomes	1-4
1.4 Project Background and Objectives	1-5
1.5 Collaborative Process with Two Advisory Groups	1-7
2. Methodology for Developing a CLAS Self-Assessment Tool	2-1
2.1 Literature Review	2-1
2.1.1 Defining LPHAs	2-1
2.1.2 Provision of CLAS in LPHAs	2-2
2.1.3 The Importance of Culture and Language in Health Care	2-2
2.1.4 CLAS Address Disparities in Health Care	2-4
2.1.5 Defining CLAS	2-6
2.1.6 Identifying Key Components of CLAS	2-8
2.2 MCOs Study Conceptual Framework Review and Revision	2-10
2.3 MCOs Study Instruments Review and Revision	2-14
3. Project Results and Recommendations	3-1
3.1 Results	3-1
3.1.1 Modification of the Project's Title	3-1
3.1.2 Overview of Revisions Made to CLAS Instruments	3-1
3.1.3 Pilot Test Results for the LPHAs CLAS Self-Assessment Tool	3-2
3.2 Recommendations and Conclusion	3-3
3.2.1 Recommendations	3-3
3.2.2 Conclusion	3-5
References	R-1

Exhibits

2-1 Select Definitions of Cultural Competence and Culturally Appropriate Health Care Services	2-7
2-2 Conceptual Framework for Assessing CLAS in LPHAs	2-11

Appendices

- A. Membership Lists of the Project Expert Panel and Federal Project Advisory Group
- B. CLAS Conceptual Framework
- C. *LPHA Director or Designee Telephone Interview Protocol*
- D. *Staffing Questionnaire*
- E. *Client Services Questionnaire*
- F. *Pilot Test Response Form*
- G. CLAS in MCOs Study Data Collection Plan

Chapter 1

Introduction

CHAPTER 1: INTRODUCTION

This report presents the results of the project *Developing a Self-Assessment Tool for Culturally and Linguistically Appropriate Services in Local Public Health Agencies*, sponsored by the U.S. Department of Health and Human Services' (DHHS) Office of Minority Health (OMH). The project's objective was to construct an organizational self-assessment tool for Local Public Health Agencies (LPHAs) that offers sound measures of culturally and linguistically appropriate services (CLAS). In this project, the term LPHA is defined as a publicly funded entity (i.e., local health department, local board of health, and other local government organization) responsible for providing essential public health services within a specific jurisdiction.¹ In addition, CLAS are defined as health care services that are respectful of, and responsive to, the specific needs and preferences of racially, ethnically, culturally, and linguistically diverse populations (OMH 2001). The self-assessment tool and corresponding data collection protocols generated by the project were developed around a conceptual framework of CLAS conceived in a recent OMH-sponsored study which produced a similar tool for collecting data from private-sector health care entities—the *National Study of Culturally and Linguistically Appropriate Services in Managed Care Organizations* (OMH 2003b).²

The U.S. public health care system continues to be challenged by rapid and significant changes in the structure of health care delivery as well as by the increasing cultural and linguistic diversity of the populations served (Anderson et al. 2003). Various organizations and political and economic realities are transforming public health's traditional core functions. For instance, market-driven health care is forcing public health to clarify and strengthen its public role in a now predominantly private system (Institute of Medicine IOM 1996). Projections from the 2000 Census indicate that racial and ethnic minorities will comprise nearly 50 percent of the U.S. population by 2050 (U.S. Bureau of the Census 2001). Also, residents of the U.S. speak an estimated 329 languages, and 32 million speak a language other than English at home (Smith and Gonzalez 2000). Given this trend, the provision of CLAS by LPHAs will continue to be of increasing importance because of the high proportion of racial and ethnic minorities served by LPHAs, the wide range of services they provide, and the critical role they play as safety net providers to the country's communities.

¹The term LPHA was defined by the project's expert panel to help differentiate it from a local health department (LHD), which does not fully capture all local, publicly funded organizations responsible for providing essential public health services.

²While the original intent of the LPHAs project was to mirror the CLAS in MCOs study by developing and administering the tool to a representative sample of LPHAs, the project objectives and timeline were modified due to shifts in departmental priorities.

While many LPHAs currently provide CLAS to their clients in some form, studies indicate that CLAS are delivered in *ad hoc* fashion, vary significantly in their quantity and quality (Association of State and Territorial Health Officials ASTHO 1992; Mertz and Finocchio 1999), and reflect differing views of what constitutes “culturally and linguistically appropriate health care services” (U.S. Conference of Local Health Officers 1993). Studies have shown that racial and ethnic minorities and persons with limited English proficiency (LEP) many times do not receive adequate services, and have to rely on family members, friends, or strangers who are not trained in the use of medical terminology to guide them through a medical encounter (Milne 2000; National Association of County and City Health Officials NACCHO 1992). This is important because it is reported that 25 to 50 percent of words and phrases are incorrectly relayed in *ad hoc* interpretations, which significantly impacts the effectiveness and quality of health care services (Interpreter Standards Advisory Committee 1998). Therefore, it was the project’s goal to aid LPHAs by operationally defining CLAS in a systematic manner and provide an appropriate tool to help them collect important information about the extent of their CLAS provision.

The remainder of this chapter presents current research that identifies evidence of persistent health disparities for racial and ethnic minorities, describes the important role that LPHAs play within the U.S. public health system, and describes the background under which the project was conceived. Chapter 2 presents the project’s methodology, which includes a review of the literature and relevant tools (that guided the revisions to the instruments); the conceptual framework adopted from the CLAS in MCOs study; and the process employed to develop and revise the self-assessment tool. Chapter 3 reviews the resulting instruments which comprise the self-assessment tool, as well as recommendations on how to effectively use the tool.

1.1 EVIDENCE OF PERSISTENT DISPARITIES IN HEALTH STATUS AND HEALTH CARE QUALITY

Despite steady improvements in the overall health of the nation, studies conducted in the last decade confirm that racial and ethnic minorities continue to experience many health disparities (DHHS 1991; HRSA 2000). For instance, between 1997 and 1999, the infant mortality rate was highest for infants of non-Hispanic African American mothers (Pastor et al. 2002), and the infant mortality rate for African Americans was more than twice that of whites (Cohen and Goode 1999). Moreover, in 1999, age-adjusted death rates for the African American population exceeded those for the white population by 38 percent for stroke, 28 percent for heart disease, 27 percent for cancer, and more than 700 percent for HIV disease (Pastor et al. 2002).

In addition, rates for all types of cancer are higher for African Americans than for whites (DHHS 1991), and although African American and white women are screened for

breast cancer at the same rate, breast cancer mortality was 35 percent higher for African American women than for white women in 1999, compared with 15 percent higher in 1990. Also, the survival rate for African American women diagnosed in 1989-1997 with breast cancer was 15 percent lower than for white women. Since 1995, death rates for HIV disease declined sharply for African American men and Hispanic men. In spite of these declines, HIV disease was still the leading cause of death for African American men aged 25 to 44 and the third leading cause of death for Hispanic men aged 25 to 44 in 1999, and HIV deaths remain much higher for African American and Hispanic men than for non-Hispanic white men in this age group (Pastor et al. 2002). Native Americans and Asian and Pacific Islanders also suffer from health disparities. The rate of diabetes for Native Americans is 2.6 times higher than that of whites (OMH 2003a). Their suicide rate is 1.5 times the national average, with 64 percent of suicides being males ages 15 to 24 (COSMOS Corporation 2000). Incidence of tuberculosis is higher in Asian and Pacific Islanders than in other populations (DHHS 1999), as are lactose intolerance and hepatitis B (Jin et al. 2002).

In response to these disparities, Congress commissioned (through OMH) a study by the National Academies' Institute of Medicine (IOM) to: 1) assess the extent of disparities in the types and quality of health services received by U.S. racial and ethnic minorities and non-minorities; 2) explore factors that may contribute to inequities in care; and 3) recommend policies and practices to eliminate these inequities. The study produced a report, *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care* (Smedley et al. 2002), which found that a consistent body of research demonstrates racial and ethnic disparities remain even when controlling for insurance status, income, age, and severity of medical conditions. The research indicates that racial and ethnic minority Americans are less likely to receive even routine medical procedures and experience a lower quality of health services. Also the report shows that racial and ethnic minorities are less likely than whites to receive needed services, including clinically necessary procedures. These disparities exist for a number of diseases, including cancer, heart disease, HIV/AIDS, diabetes, and mental illness. Moreover, evidence suggests racial disparities in care and treatment for cancer and cardiovascular disease are associated with higher mortality rates among racial and ethnic minorities (Bach et al. 1999; Peterson et al. 1997). Furthermore, in the context of these persistent disparities mentioned previously, the nation is becoming increasingly more racially, ethnically, culturally, and linguistically diverse.

1.2 THE VITAL ROLE LPHAs PLAY IN MAINTAINING THE OVERALL HEALTH OF AMERICA'S COMMUNITIES

LPHAs are integral parts of the public health system, as they provide individuals with a variety of health services and administer health-related programs which strengthen and improve the health of communities across the country. Programs and services provided by

LPHAs include: adult and child immunizations, communicable disease control, community assessment, community outreach and education, environmental health services, epidemiology and surveillance, food safety, health education, restaurant inspections, and tuberculosis testing. In addition, some LPHAs provide primary care or direct medical care services, including treatment for chronic diseases such as cardiovascular disease or diabetes, behavioral or mental health services, programs for homeless, and veterinary public health (NACCHO 2001).

LPHAs serve as safety net providers, ensuring health care for vulnerable and at-risk populations. Populations served by LPHAs include the uninsured, racial and ethnic minorities, persons with LEP, those with low income, the homeless, migrant workers, and others with unique or special language and cultural needs (Brown et al. 2000; Kaiser Commission on Medicaid and the Uninsured 2000; Ku and Freilich 2001). The characteristics of the at-risk populations served by LPHAs make the provision of CLAS imperative. For instance, a study found that more than 50 percent of low-income immigrants have no health insurance and rely on LPHAs for care (Ku and Freilich 2001), and racial and ethnic minorities are twice as likely to be uninsured as whites (Collins et al. 2002; Commonwealth Fund 1996). In addition, studies show that racial and ethnic minorities are less likely to have a regular primary care provider or health insurance (Collins et al. 2002), thus having to rely on health services provided by LPHAs. Also, recent immigrants with LEP who are unfamiliar with the U.S. health care system are, for the most part, not eligible for Medicaid or Medicare, which makes them more likely to be uninsured, to lack a regular provider, and to seek health care at a LPHA (Commonwealth Fund 1994, 1996).

1.3 LPHAs' PROVISION OF CLAS COULD LEAD TO IMPROVED HEALTH OUTCOMES

LPHAs directly impact the health of individuals and empower communities to achieve better health by providing essential health services within jurisdictions (NACCHO 2001). The ultimate goals of providing CLAS are to make the local public health care system more responsive to the needs of all clients and to increase their satisfaction with and access to high quality health care; decrease inappropriate differences in the characteristics and quality of care provided; and close the gaps in health status across diverse populations within the country (Anderson et al. 2003). The ten essential public health services listed

under the three core functions of public health³ require effective and meaningful communication, between LPHAs and the community (Harrell 1994).

LPHAs that provide CLAS accommodate differences in language and culture and offer language assistance services such as interpreters or bilingual providers. LPHAs also may provide staff with cultural diversity training and provide clients with culturally sensitive health care services. Together, these services may improve health and decrease disparities, because health care providers increase their ability to understand and treat a culturally diverse clientele with varied health beliefs and practices, thus improving accuracy of diagnoses and selection of appropriate treatment (Becker 1980).

1.4 PROJECT BACKGROUND AND OBJECTIVES

In 1983, the annual issue of *Health, United States* (the report card on the health status of the American people) documented significant progress in the overall health picture of the Nation (National Center for Health Statistics NCHS 1983). The report reinforced the fact that there were continuing disparities in the burden of death and illness experienced by racial and ethnic minority Americans as compared with the U.S. population as a whole—a disparity that has existed ever since accurate federal record keeping began more than a generation ago. In response to the report findings, a Task Force was established by the then Secretary of DHHS to investigate the health problems of African Americans, Native Americans, Hispanics, and Asian/Pacific Islanders. The Task Force was charged with reviewing and analyzing the departmental programs and range of resources available to address the health problems of racial and ethnic minorities, and with recommending ways for the department to exert leadership, influence, and initiative to close the existing gaps.

The result of the Task Force's efforts and deliberations was presented to the Secretary in August 1985 in the "Report of the Secretary's Task Force on Black and Minority Health" (Heckler 1985). This report subsequently led to the establishment of OMH in 1986 within the Office of the Assistant Secretary for Health (now the Office of Public Health and Science), headed by the Deputy Assistant Secretary for Minority Health. That Office—which was legislatively established under the Disadvantaged Minority Health Improvement Act of 1990 (Public Law 101-527) and reauthorized under the Health

³Essential public health services include: monitor health status to identify community health problems; diagnose and investigate health problems and health hazards in the community; inform, educate, and empower people about health issues; mobilize community partnerships to identify and solve health problems; develop policies and plans that support individual and community health efforts; enforce laws and regulations that protect health and assure the provision of health care when otherwise unavailable; link people to needed personal health services and assure the provision of health care when otherwise unavailable; assure a competent public health and personal health care workforce; evaluate effectiveness, accessibility, and quality of personal and population-based health services; and conduct research for identifying new insights and innovative solutions to health problems (Public Health Functions Steering Committee 1995).

Professions Education Partnership Act of 1998 (Public Law 105-392)—has since served as the focal point within the Department for the implementation and monitoring of recommendations originating from the Report of the Secretary’s Task Force, and for providing leadership and coordination of an accelerated national assault on the persistent health disparities between racial and ethnic minorities and the rest of the U.S. population.

In response to the persistent health disparities experienced by the nation’s minority population and in keeping with its mission, OMH funded the CLAS in LPHAs project to develop a self-assessment tool that could be used by LPHAs to gather data which *provides a description of their organizational CLAS provision*. This tool was designed to assist LPHAs in their quality monitoring and improvement efforts. Using the tool will help LPHAs to develop appropriate policy and programmatic responses that meet the unique health needs of the culturally and linguistically diverse populations they serve. Given that this was a first attempt to develop a comprehensive self-assessment tool to measure CLAS within LPHAs, it was important to use a conceptual framework that represents a comprehensive set of essential CLAS components across the health care continuum. Thus, the project employed the CLAS conceptual framework and its corresponding instruments and protocols previously developed and tested in OMH’s CLAS in MCOs study (OMH 2003b).

The CLAS in MCOs study was completed in 2003, but was initiated prior to the development and release of the national recommended standards for CLAS. The CLAS in MCOs study produced a conceptual framework that identifies the essential components of CLAS in health care settings across eight assessment domains, as well as a three-component instrument to measure organizational CLAS provision which was tested and implemented in MCO settings. Study results offer a rich description of the nature and extent of CLAS provision reported by a sample of MCOs in the U.S. In addition, promising CLAS practices reported a number of MCOs are highlighted. The study’s full report (that includes the CLAS conceptual framework, the study design and data collection methods and instruments, and study results) is available at the OMH Internet web site.⁴

As described above, this project to develop a CLAS self-assessment tool for LPHAs is grounded in the successes and lessons learned from the MCOs study. The CLAS conceptual framework and the three-component instrument were revised for this project based on lessons learned during the conduct of the MCOs study and were modified to be appropriate for implementation in LPHA settings.

An important project objective was to *educate health professionals in LPHAs about their organizational CLAS practices*. The goal was to design a self-assessment tool which informs LPHAs during the course of data collection by including a broad range of response

⁴<http://www.omhrc.gov/inetpub/wwwroot/cultural/whatsnew.htm>.

options for each instrument item suggesting how various strategies and practices *could be* considered CLAS. The items themselves provide examples and ideas on which to build and improve service provision and quality of care.

1.5 COLLABORATIVE PROCESS WITH TWO ADVISORY GROUPS

This project was guided by two distinct advisory groups. The project team and OMH convened an advisory group meeting with the members of the Project Expert Panel (PEP) and the Federal Project Advisory Group (PAG) to inform the development of the tool. The PEP was comprised of nine representatives who have expertise in at least one of the following areas: service provision in LPHAs, cultural competency, health care quality, and survey research and evaluation. Members of the PAG included four representatives from DHHS divisions with responsibility for government policies and programs related to health care services, and more specifically, services for diverse populations. While PEP members represented varied expertise and “real-world” experience, PAG members represented a full range of governmental interests. Together the advisory bodies guided the development of the CLAS self-assessment tool. Appendix A contains a membership list for both of these advisory bodies.

Chapter 2

Methodology for Developing a CLAS Self-Assessment Tool

CHAPTER 2: METHODOLOGY FOR DEVELOPING A CLAS SELF-ASSESSMENT TOOL

This chapter describes the methodology which guided the redesign of the CLAS in MCOs study instruments to be appropriate for implementation in LPHAs. A review of the literature, lessons learned from the CLAS in MCOs study, and recommendations of the project's two advisory groups are described.

2.1 LITERATURE REVIEW

The CLAS in LPHAs project adopted the conceptualization of CLAS, along with the essential components identified in the CLAS in MCOs study (OMH 2003b). The following sections briefly revisit the literature which was reviewed to identify how CLAS was defined in the health care field to date and revisit the available definitions and descriptive components of CLAS. The literature review provided a knowledge base from which modifications to the MCO instruments were made to be more appropriate for LPHAs.

2.1.1 Defining LPHAs

In 1977, C. Arden Miller and colleagues described an LPHA as “an administrative and service unit of local or state government, concerned with health, employing at least one full-time person, and carrying some responsibility for health of a jurisdiction smaller than a state.” NACCHO later refined Miller’s definition by excluding the “one full-time person,” as this is not necessarily the case in all LPHAs (1990). LPHAs vary in jurisdiction size, organization, composition, and services offered, yet all are publicly funded and concerned with community health. Populations served can range from under 25,000 to over a million people. Most LPHAs are county-based, while the remaining serve town, city, regional, or city-county jurisdictions (NACCHO 2001; Public Health Practice Program Office 1991). While specific services vary by agency, services most commonly include immunizations, communicable disease testing and control, health and community education, environmental health services, and food safety and restaurant inspection. Public health encompasses many disciplines and services, however the overall focus of all public health is the welfare of populations or communities (Association of Schools of Public Health 1990, IOM 1988). For example, the Seattle health department provides *primary care*, while Cleveland’s health department focuses more on *population-based services* (McHugh et al. 2001).

LPHAs serve as a safety net for the underserved, i.e., the uninsured, low-income, persons with LEP, immigrants, and racial and ethnic minorities (Felt-Lisk et al. 2001;

Public Health Practice Program Office 1991). This population faces significant barriers to accessing quality health care, because studies have shown racial and ethnic minorities and people who are LEP are more likely to lack health insurance than English speakers (The Henry J. Kaiser Family Foundation 2003; Smedley et al. 2002). Consequently, studies have documented how the uninsured have greater difficulty accessing health care than those who have insurance (Felt-Lisk et al. 2001).

2.1.2 Provision of CLAS in LPHAs

Title VI of the Civil Rights Act of 1964 prohibited discrimination based on race, color, and national origin in programs that receive federal funding, and Executive Order 13166 of 2000 went further, to require that federally funded programs be made accessible to those who are not proficient in English. This order includes LPHAs which receive funding from the federal government. Based on these requirements and other research, OMH issued a set of recommended national CLAS standards developed under another project (Federal Register 2000), which may guide LPHAs in developing their own standards.

LPHAs are aware of the increasing need for CLAS provision and strive to ensure that their clients' needs are met. Some LPHAs have formed committees to investigate their communities' needs (Interpreter Standards Advisory Committee 1998). For instance, the Washington State Department of Health has produced a report describing a formalized training process for cultural awareness, changes in federal and state systems, and current efforts to promote CLAS (Washington State Department of Health 1995). The Arizona Department of Health Services has developed a needs assessment tool to ascertain the knowledge and attitudes of health management and staff regarding different cultures (Arizona Center for Minority Health Service 1996). Such assessments will help identify how CLAS (and overall quality of care) can be improved.

While there is increasing literature that discusses health disparities of the underserved and the need for greater CLAS provision in health care settings, little was found which discussed CLAS in LPHAs. This suggests that this topic should be further researched, especially in terms of quality and effectiveness of services.

2.1.3 The Importance of Culture and Language in Health Care

The term *culture* refers to “the thoughts, communications, actions, customs, beliefs, values, and institutions of racial, ethnic, religious, or social groups” (OMH 2001). All individuals have a culture, and some individuals are associated with multiple cultural groups simultaneously. Cultural categories and groups often are thought of in terms of race, ethnicity, and/or country of national origin. Similarly, an individual's “cultural identity” often is associated with groups of individuals along racial and ethnic lines.

However, race, ethnicity, and/or country of origin are not synonymous with culture. The term culture is much broader than racial and ethnic background, and includes shared attitudes, behaviors, and traditions that are grounded in many other groupings, such as: sex or gender; stage of life (e.g., elderly); socioeconomic status; sexual orientation; religion; physical limitations or disabilities including impaired hearing; or literacy level. With this recognition, the term culture is used in this project in the more limited way, i.e., most often referring to characteristics and experiences related to individuals' racial and ethnic backgrounds and/or countries of national origin.

Culture influences the way we communicate with each other. *Language* is a method of communication that uses a system of sounds, symbols, and gestures that are organized in a patterned way to express and communicate thoughts and feelings. Language is a part of culture and involves both verbal and written communications. *Language dissonance* (when two individuals—e.g., physician and patient—speak a different language) is only one type of language barrier that may be experienced in the health care setting. Other types of verbal communication barriers may include: lack of linguistic clarity (where physician and patient speak the same language, but an unfamiliar or heavy accent impedes understanding); limited or lack of health literacy (where health concepts conveyed by the physician are unclear, or too complex, for patient understanding); or physician use of technical language or jargon (where medical terms used are unfamiliar to the patient, resulting in diminished or total lack of understanding).

Regarding *culturally* appropriate health care, studies have shown that cultural factors influence how individuals perceive the symptoms of illness, how they seek care when ill, and how they respond to treatment regimens (Saint-Germain and Longman 1993). Illness behavior directly affects the health system insofar as it influences the illnesses for which people seek care, the timing of care, and the treatment process. Culture influences an individual's perception of the risk of becoming ill and the utility of treatment and prevention services (Frye 1993; Saint-Germain and Longman 1993). Cultural perceptions, thus, influence when a symptom is defined as a health problem, the severity of the problem, and whether advice or care must be sought. Culture also contributes to an individual's understanding of the cause of disease. Understanding cultural perceptions about disease is critical to effectively engaging individuals in disease prevention and treatment activities.

Health care providers should recognize that in some cultures, Western medicine is often supplemented or mixed with traditional remedies. Therefore, if providers recognize the need to provide treatment that is in some way compatible with traditional health care beliefs, there is a greater opportunity for more effective care. Also, a provider's awareness about his or her own values and how they may bias interactions with individuals from different cultures is viewed as key to providing culturally sensitive care (Dilworthanderson et al. 1993; Eliason 1993; May 1992). Price and Cordell (1994) suggest that providers

assess their own beliefs and have knowledge of general ethnic, regional, and religious beliefs and practices before discussing health care issues with patients.

Linguistically appropriate health care services—i.e., the provision of translated *written* materials and *oral* interpretation services—are vital for a patient’s understanding, compliance, and positive health outcomes. Perhaps the most critical component of quality health care is the patient’s ability to understand and be understood. Key consequences of language barriers in the health care setting include: 1) inadequate communication from the patient to the provider, making it difficult to relay a complete medical history or to accurately report symptoms; and 2) inadequate communication from the provider to the patient, which interferes with accurately informing (or educating) the patient about the illness and treatment (Woloshin et al. 1995).

Also, studies suggest that accurate communication between patient and provider decreases unnecessary diagnostic testing and increases proper diagnosis, patient compliance, and the retention and use of appropriate services (National Committee for Quality Assurance NCQA 1995). Within this context, researchers raise several points in arguing the need for CLAS. When utilizing the health care system, non-English speaking individuals encounter communication challenges that hinder access to care and effective treatment (Putsch 1985). In addition to language, researchers note that cultural issues are relevant throughout the health care delivery system. Although some studies have suggested reduced access to medical care may be due to language barriers or low socioeconomic status (Brach and Fraser 2000; Gany and Thiel de Bocanegra 1996; The Henry J. Kaiser Family Foundation 1999), in other studies, the same disparities have been observed in racial and ethnic minorities of any socioeconomic status (Brach and Fraser 2000; Smedley et al. 2002).

Culture influences the way patients perceive illness (Landrine and Klonoff 1994; Landrine et al. 1994), seek care (Geissler 1991), and participate in and respond to treatment (McCormick 1993; Pilowsky 1993). Receipt of equal care may also be inhibited by biases and stereotypes (HRSA 2000; The Henry J. Kaiser Family Foundation 1999; Smedley et al. 2002).

2.1.4 CLAS Address Disparities in Health Care

Evidence suggests that interaction of genetic differences, environmental factors, and health behaviors propagates health care disparities. These elements include biases of health care workers toward racial and ethnic minorities, lack of prevention messages tailored to specific populations, lack of physician awareness of higher risk factors for some illnesses in particular populations (HRSA 2000), lack of physician knowledge of traditional remedies and folk practices, and diagnostic errors due to miscommunication (Brach and Fraser 2000).

Lack of prevention messages may decrease a patient's awareness of certain risk factors, health options, conditions, and screenings (Brown 2001). This lack of awareness may result in failure to screen or correctly diagnose a patient (Lavizzo-Mourey and Mackenzie 1996; The Henry J. Kaiser Family Foundation 1999; Smedley et al. 2002). Moreover, insufficient knowledge about traditional remedies or practices may lead to serious medical complications. Drug interactions may occur between prescription medications and folk medicines (Brach and Fraser 2000). A traditional remedy may be counterproductive or even dangerous, such as one for colic involving ingestion of a mixture containing lead (Texas Department of Health 1998a). The practice of coin-rubbing could be mistaken for abuse¹ (Graham and Chitnarong 1997; Orr 1996). Miscommunication—including, but not limited to, verbal language barriers—can cause errors in diagnosis and patient misunderstanding (Gany and Thiel de Bocanegra 1996; Perkins 1999; Putsch 1985; Queseda 1976; Villarruel et al. 1999).

Underlying the argument for CLAS is the premise that linguistic and cultural barriers can adversely affect the delivery of health care. There is some evidence that these barriers can be reduced or eliminated through culturally sensitive interventions (Julia 1992; Lieberman 1990; Marin 1993; Moore 1992; Redmond 1990). Such health care interventions require *cultural and linguistic competence*, which is “a set of congruent behaviors, attitudes, and policies, that come together in a system, agency, or among professionals that enables effective work in cross-cultural situations” (Cross et al. 1989). Providers should be knowledgeable about the cultures of their clients—their customs, beliefs, and language (Clermont et al. 1993; Dillard et al. 1992; Fernandez-Santiago 1994; Krajewski-Jaime 1993; Pruegger and Rogers 1994; Redican 1994). For instance, in addressing diabetes in African and Hispanic American communities, Raymond and D'Eramo-Melkus (1993) argue that effective treatment requires a sensitivity to and recognition of such cultural patterns as food preferences, spiritual beliefs, and health practices in order to develop a practical and beneficial treatment regimen.

In any interaction between consumers, patients, and their health care providers, the ability of each party to understand and be understood by others is critical for appropriate and timely access and utilization of health care services, patient compliance, and positive patient health outcomes. Also, in order for any system of health care to be truly effective in serving populations whose national origins, languages, and cultural backgrounds differ from those of employed or contracted staff of that health system, the organization should acknowledge and incorporate into practice the importance of valuing diversity and culture, and the adaptation of services that meet culturally unique needs (Association of Asian Pacific Community Health Organizations AAPCHO 1996a). Such services involve efforts to enhance and ensure that health care providers and other personnel can both

¹Coin rubbing consists of massaging the skin with tiger balm ointment and then rubbing the skin with a hot coin.

communicate with, and clearly understand, the concerns and needs of the consumers being served, as well as provide instructions, interventions, treatment modalities, and other recommended actions in a manner and context that will optimize consumer receptivity and compliance.

In sum, although issues of “cultural competence” or “cultural and linguistic appropriateness” in health care often are framed as “minority” issues, they are, in fact, *human* issues affecting all people. Everyone has a culture and a cultural background that shapes one’s views about health and illness. Similarly, everyone has a language and language needs. However, because some cultural and linguistic needs are met while others are not, the issue becomes yet another of disparity in addressing the health needs of certain groups—most often racial and ethnic minorities. This disparity directly affects the ability to access and utilize high-quality health services.

Given that: 1) disparities in health status and health care services are well-documented among racial, ethnic, cultural, and linguistic minority groups; 2) cultural and language differences may contribute to these gaps; and 3) the increasing racial, ethnic, and linguistic diversity in the U.S., OMH set out to assist LPHAs by developing a CLAS self-assessment tool for monitoring and improving health care quality.

2.1.5 Defining CLAS

At the project’s inception, the term “culturally appropriate” was seldom referenced in the literature, while “cultural competence” was a more widely used term. Exhibit 2-1 provides an overview of various definitions (in the literature at that time) for “culturally appropriate health care services.” Most often, these services were described in terms of *a set of skills* related to understanding, and effectively communicating with, persons who have diverse cultural backgrounds (McManus 1998; Tirado 1996). The term “cultural competence” was also described in the context of *developing* and *using* these skills (Andrulis 1997; California Department of Health Services 1993; Orlandi 1995). Other definitions of cultural competence positioned the term in the health care context by emphasizing awareness and integration of three population-specific issues: health-related beliefs and cultural values, disease incidence and prevalence, and treatment efficacy (Adams 1995; Lavizzo-Mourey and Mackenzie 1996).

Linguistically appropriate services include programs, services, and interventions that meet the specific language needs of the service population (OMH 1996). Such services involve communicating with patients in their primary languages and providing language assistance at key points of service throughout the health care continuum (AAPCHO 1996b).

Exhibit 2-1
SELECT DEFINITIONS OF CULTURAL COMPETENCE
AND CULTURALLY APPROPRIATE HEALTH CARE SERVICES

Study	Definition
Cross, et al., "Towards a Culturally Competent System of Care: A Monograph on Effective Services for Minority Children Who are Severely Emotionally Disturbed," 1989	Cultural competence: Organizations have formal policies, such as mission statements, specifically expressing a commitment to cultural diversity.
Adams, ed., <i>Health Issues for Women of Color: A Cultural Diversity Perspective</i> , 1995	Cultural competence: Cultural or ethnic competence refers to the development of skills that will help people behave in a culturally appropriate way with a given group, demonstrating both sensitivity to cultural differences and similarities in the effective use of cultural symbols in interactions and effective communications with members of diverse populations. (The definition continues.)
Campinha-Bacote, "The Process of Cultural Competence," State of Washington, Department of Health, 1995	Cultural competency: "a set of behaviors, attitudes and policies of a system, agency or individual that enables that system, agency or individual to function effectively in trans-cultural interactions...and a person's or programs's ability to honor and respect the cultural differences (beliefs, interpersonal styles, attitudes and behaviors) of individuals and families who are clients, staff administering programs, and staff providing service at state and local levels. In doing so, it incorporates values at the levels of policy, administration, and practice."
Orlandi, ed., <i>Cultural Competence for Evaluators: A Guide for Alcohol and Other Drug Abuse Prevention Practitioners Working With Ethnic/Racial Communities</i> , 1995	Cultural competence: a set of academic and interpersonal skills that allow individuals to increase their understanding and appreciation of cultural differences and similarities within, among, and between groups. This requires a willingness and ability to draw on community-based values, traditions, and customs, and to work with focused interventions, communications, and other supports.
Association of Asian Pacific Community Health Organizations, <i>State Medicaid Managed Care: Requirements for Linguistically Appropriate Health Care</i> , 1996	Culturally appropriate services: "effectively identify the health practices and behaviors of target populations to design programs, interventions, and services which effectively address cultural language barriers to the delivery of appropriate and necessary health care services."
Lavizzo-Mourey and Mackenzie, "Cultural Competence: Essential Measurements of Quality for Managed Care Organizations," 1996	Cultural competence: the integration of 1) health-related beliefs and cultural values; 2) epidemiology; and 3) treatment efficacy
National Maternal and Child Health Resource Center on Cultural Competency, <i>Journey Towards Cultural Competency: Lessons Learned</i> , 1996	Cultural competency: "a program's ability to honor and respect beliefs, interpersonal styles, attitudes, and behaviors of families who are clients, as well as the multicultural staff who are providing services. It incorporates these values at levels of policy, administration, and practice." Cultural competency is viewed as a continuum, not as a one-time goal. "Competency implies skills which helps to translate beliefs, attitudes, and orientation in action and behavior in the daily interaction with children and families."
Tirado, <i>Tools for Monitoring Cultural Competence in Health Care</i> , 1996	Cultural competency: level of knowledge-based skills required to provide effective clinical care to patients from a particular racial or ethnic group
Andrulis, "Toward a More Culturally Competent System of Care: Implications for Federal Policy, Managed Care Provider and Communities," 1997	Cultural competency: "effectively incorporating the ethnic/cultural characteristics of individuals and their health care needs and in promoting health, and working to achieve the highest quality care."
McManus, ed., "Services to Minority Populations: Cross-cultural Competence Continuum," 1998	Cross-cultural competency: "the knowledge and interpersonal skills that allow providers to understand, appreciate, and work with individuals from cultures other than their own. It involves an awareness and acceptance of cultural differences, self-awareness, knowledge of the patient's culture, and adaptation of skills."

Source: CLAS in MCOs Study (OMH 2003b)

2.1.6 Identifying Key Components of CLAS

Several characteristics or services emerged from the literature as important for health care agencies to be considered “culturally competent.” These key components for cultural competence (described below) provided the basis for adopting the MCOs study conceptual framework (with eight assessment domains) that is detailed in Section 2.2.

Organizational Governance and Policy Development. To be considered “culturally competent,” health care organizations should have formal policies such as written mission statements that specifically express a commitment to cultural diversity (Cross et al. 1989) and policies governing translation and interpretation services (The Asian and Pacific Islander American Task Force [APIATF] 1997; National Public Health and Hospital Institute [NPHHI] 1998). Community members should be recruited for policy-making positions, such as general oversight committees and task forces, and should be well represented on new task forces that can be created to study, evaluate, and address issues related to culturally appropriate care (Cross et al. 1989; Roberts et al. 1990). Strategic planning committees and other decision-making bodies should be representative of the community, in race and ethnicity, as well as other characteristics such as gender and age (APIATF 1997; National Latino Behavioral Health Workgroup [NLBHW] 1996; Washington State Department of Health 1998).

Culturally Inclusive Health Care Environment and Practices. An important strategy for addressing the health care needs of culturally diverse populations is to recognize and learn about a patient’s perspective concerning illness (Randall-David 1989). Understanding cultural perceptions about disease is critical to effectively engaging individuals in disease prevention and treatment activities (Frye 1993; Saint-Germain and Longman 1993). Also, providers’ understanding of cultural differences in familial relationships and roles is often important for effective treatment plans (Ahn and Gilbert 1992). Moreover, health care providers may collaborate with traditional healers to learn more about patients’ use of traditional healing methods in an effort to provide more culturally competent care (APIATF 1997; NLBHW 1996) and utilize practices that are respectful of and responsive to patients’ cultural backgrounds, e.g, diverse religious services and facilities or dietary options available (NPHHI 1998).

Also important for culturally competent care are providers’ awareness about their own values and how they may bias interactions with individuals from different cultures (Dilworth-Anderson et al. 1993; Eliason 1993; May 1992). To improve patient care, providers are encouraged to assess their own beliefs and have knowledge of general ethnic, regional, and religious beliefs and practices before discussing health care issues with patients (Price and Cordell 1994).

Quality Monitoring and Improvement and Data Collection. To measure progress in providing CLAS, health care organizations should periodically collect quality monitoring and improvement (QMI) data on community characteristics and needs (Cross et al. 1989; Washington State Department of Health 1998). Such QMI self-assessments should include the organization's past and present performance in attempting to provide culturally and linguistically appropriate services across several areas of care (Kim et al. 1992). Patient focus groups and patient satisfaction surveys are examples of methods used for monitoring CLAS quality (NPHHI 1998). Moreover, the routine collection and analysis of race and ethnicity data on the populations served is vital for effectively monitoring quality of care (Kim et al. 1992; NLBHW 1996; NPHHI 1998; Perot and Youdelman 2001; Smith 1998).

Staff Diversity. Another key component of culturally competent health care is having a racially, ethnically, culturally, and linguistically diverse staff (Washington State Department of Health 1998). Such diversity should be reflected at various staff levels and for various staff types. Although diversity is important regarding staff composition, it may be even more important that staff *reflect* or *represent* the racial, ethnic, cultural, and linguistic composition of the population served. (Kim et al. 1992). An additional staffing issue related to culturally competent care involves strategies for recruiting and retaining a diverse and culturally competent staff (NLBHW 1996; NPHHI 1998; Texas Department of Health 1998b).

Staff Cultural Competence Training. In addition to recruitment, another strategy for developing culturally competent staff is to provide them with training. Staff training in cultural competence can serve "to enhance total system performance" (NLBHW 1996). Cultural competence training can be provided to staff on a continuous basis and may address such topics as health care issues of specific ethnic groups, concepts of culture and CLAS, and ways to utilize community resources (Cultural and Linguistic Standards Task Force 1997). Furthermore, policymakers can encourage or require staff training (for all staff levels) in culturally appropriate service provision and can also set standards for the quality and content of such training (Cross et al. 1989; Washington State Department of Health 1998).

Linguistic Support Services. Communicating with patients in their own language has been shown to improve: patient compliance and understanding of their disease (Manson 1988); patient self-reported well-being and functioning (Perez-Stable et al. 1997); and access to primary care and preventive services (Jacobs et al. 2001). Studies indicate that patients whose main spoken language is not English are less likely to receive timely eye, dental, and physical examinations (Kirkman-Liff and Mondragon 1991). Also, patients with LEP have been shown to have fewer physician visits (Pitkin Derose and Baker 2000); and are less likely to return for follow-up visits after being seen in the emergency room, when compared to patients with English proficiency (Todd et al. 1993).

Given these persistent disparities in health care, the provision of translated written materials and oral interpretation services (e.g., bilingual provider or interpreter) to LEP populations are essential components of CLAS (NLBHW 1996; NPHHI 1998).

2.2 MCOs STUDY CONCEPTUAL FRAMEWORK REVIEW AND REVISION

The first step in the development of the LPHA CLAS self-assessment tool was for the project team, OMH staff, and the two project advisory groups to identify a CLAS conceptual framework from which the self-assessment tool could be constructed. Since one of the objectives of the CLAS in MCOs study was to lay the groundwork and contribute to the broader field by identifying areas of study that are essential for *all* assessments of CLAS in *any* health care setting, the project team and the PEP and PAG members recognized the applicability of the CLAS in MCOs study's conceptual framework to construct the CLAS in LPHAs self-assessment tool. The study domains identified in the MCOs study's conceptual framework comprised independent, mutually exclusive categories that allow examination of a broad range of services that can be described as culturally and linguistically appropriate. The eight domains (identified as essential components of CLAS) included:

- Organizational Governance;
- CLAS Plans and Policies;
- Culturally Inclusive Health Care Environment and Practices;
- Quality Monitoring and Improvement (QMI);
- Management Information Systems (MIS);
- Staffing Patterns;
- Staff Training and Development; and
- Communication Support.

The PEP and PAG members reviewed the conceptual framework used in the CLAS in MCOs study (see Appendix B). Deliberations centered around the completeness of all possible types of CLAS. In addition, lessons learned from the MCOs study were used to modify and improve the framework. Members of the PEP and PAG recommended to adopt the CLAS in MCOs framework, and revise it to be appropriate for the LPHA setting. The (revised) CLAS conceptual framework for LPHAs is provided in Exhibit 2-2.

One notable revision was made to the conceptual framework as a result of lessons learned in the CLAS in MCOs study. A recommendation from the CLAS in MCOs study was to *replace the term "Patient Care" (Domain 3) with a more appropriate term such as "Culturally Inclusive Health Care Environment and Practices."* The term "patient care" was determined to be potentially misleading in that the measures under this domain are not

Exhibit 2-2

CONCEPTUAL FRAMEWORK FOR ASSESSING CLAS IN LPHAs

DOMAIN / KEY ELEMENT	VARIABLES
<p>1. <u>Organizational Governance</u> A. Governing boards, committees, and positions</p> <p>B. Organizational Structure</p>	<p>A. Local Board of Health subcommittee on CLAS Permanent advisory committee Committee recruitment strategies Committee racial/ethnic composition Committee diversity other than race/ethnicity Internal CLAS working group Staff position specifically for CLAS coordination Frequency of meetings Committee's role in CLAS</p> <p>B. Formal grievance procedure Client population size</p>
<p>2. <u>CLAS Plans and Policies</u> A. CLAS planning</p> <p>B. CLAS policies</p>	<p>A. Formal quality improvement plan for culturally and linguistically diverse clients Internal CLAS planning and working groups Staff and community input Mission statement addresses CLAS Committee roles related to CLAS</p> <p>B. CLAS training program review Translation products review Targets for translated materials Description of translation Policies governing written translation Reasons translation policies exists Reasons translation policies do not exist Policies governing interpretation services Reasons interpretation policies exists Reasons interpretation policies do not exist Formal grievance process for CLAS-related concerns Documented policy for interpreters Formal staff diversity plan Formal diversity training program Staff position for CLAS coordination Staff and community input Internal communication strategies for CLAS policies</p>
<p>3. <u>Culturally Inclusive Health Care Environment and Practices</u> A. Assessment and Treatment</p> <p>B. Materials and Environment</p>	<p>A. Cultural differences and preferences considered Family members and preferences consulted during diagnosis and treatment Culturally specific healers and physicians consulted Utilize alternative and complementary treatments</p> <p>B. Cultural differences and preferences considered Family members and preferences consulted during diagnosis and treatment Culturally specific healers and physicians consulted Various culturally responsive strategies implemented Characteristics of written materials Alternative and complementary treatments available</p>

(Continued on next page)

(Exhibit 2-2, Continued)

DOMAIN / KEY ELEMENT	VARIABLES
<p>4. CLAS Quality Monitoring and Improvement (QMI)</p> <p>A. Tracking system</p> <p>B. Needs assessment (NA) and evaluation</p>	<p>A. Quality improvement activities conducted Multiple methods for monitoring CLAS quality CLAS accountability for providers Quality of care data collection Uses of CLAS-specific data Uses of quality improvement data Link client demographic and outcome data Link client and provider data Link client and (other) staff data</p> <p>B. Routine assessments of services, procedures, and policies Frequency of needs assessments Types of community/client groups that participate in needs assessment Client/community needs assessment specifically for CLAS Data sources for client/community CLAS needs assessment Training program evaluated for effectiveness State and local support for quality improvement activities Types of staff who participate in needs assessment Types of agency support for quality improvement and needs assessment activities</p>
<p>5. Management Information Systems (MIS)</p> <p>A. Clients</p> <p>B. Staff</p>	<p>A. Clients' primary language recorded Reasons clients' language not recorded Clients' race/ethnicity recorded Reasons clients' race/ethnicity not recorded Racial/ethnic composition of client population Clients' primary languages other than English Uses of CLAS-specific data Percentage of clients who speak non-English primary language</p> <p>B. Staff linguistic capability recorded Method of determining staff linguistic capability Staff race/ethnicity recorded Reasons staff race/ethnicity not recorded Types of staff for whom race/ethnicity is recorded</p>
<p>6. Staffing Patterns</p> <p>A. Staff diversity</p> <p>B. Staff recruitment, retainment, and promotion</p>	<p>A. Racial/ethnic composition of staff Percentage of bi- or multi-lingual staff Information on the diversity of staff and services available to the community</p> <p>B. Staff diversity plan Types of staff covered in agency diversity plan Strategies to recruit, retain, and promote diverse staff Resources utilized to recruit diverse staff Incentives for multi-lingual providers Organizational support for diverse staff and development Staff position funded for CLAS coordination</p>

(Continued on next page)

limited to the actual clinical encounter. Rather, these measures are meant to capture diverse clinical practices or services, such as alternative or complementary treatments, as well as awareness, inclusion, or representations of cultural differences in the physical environment, dietary options, religious facilities and services, etc. Therefore the term “Culturally Inclusive Health Care Environment and Practices” replaced the former (MCOs study) term for Domain 3 “Patient Care,” because it better represents what is actually being assessed.

2.3 MCOs STUDY INSTRUMENTS REVIEW AND REVISION

With the refinement of the CLAS conceptual framework completed, the next task was to review survey questions and response options from the three CLAS in MCOs instruments to determine the necessary modifications to be applicable to LPHAs. The project team and OMH staff held numerous meetings for this purpose. The review process involved close inspection of each question and its corresponding response options for all three instrument components. The review of the instruments was guided by information learned about LPHA characteristics in the literature and from discussions held with PEP and PAG members.

Throughout the deliberations at the advisory group meeting, members described various characteristics of LPHAs which helped shape the instruments. PEP members conveyed to the project team that there are diverse management structures which govern LPHAs around the country, because states have the authority to organize their own systems of health care delivery. For instance, some states like New Mexico, have created LPHA district offices that report directly to the statewide health care system and not to the local board of health which, in other states, serves as an intermediary between communities and the state. This variability in organizational structure also dictates how LPHAs are staffed. Some LPHAs follow state civil servant laws; some adopt local county and city hiring procedures; and some hire contract staff. In addition, a LPHA’s organization and structure shape its funding streams and how it provides training for staff. Advisory group members also discussed the variability in the types of individuals who manage and lead LPHAs. Some LPHAs are headed by a politically appointed individual who reports to the governor, and other LPHAs are headed by civil servants.

LPHAs vary in their size as well. For instance, a LPHA that serves a county may have more funds available for staff training compared to a LPHA that serves a small city. As discussed earlier, LPHAs also vary in the types of services they provide. Services provided by LPHAs depend on the block grants they currently hold. LPHAs that provide CLAS designate funds for those services from their operating budget, but are not mandated to provide those services by the local board of health. Together, these LPHA

characteristics required revisions to terminology used in the CLAS in MCOs study instruments in order to accommodate the variability among LPHAs around the country.

The three-component instrument developed for the CLAS in MCOs study was revised based on recommendations of expert panel members. The group determined that the protocols developed for the CLAS in MCOs study could be used to collect data from LPHAs if the language contained in the protocols was reflective of an LPHA's organizational structure. As such, a *Director or Designee Interview Protocol* (see Appendix C); a *Staffing Questionnaire* (see Appendix D); and a *Client Services Questionnaire* (see Appendix E) were developed that included a revised version of the CLAS in MCOs data collection instruments.

The *Director or Designee Interview Protocol* was designed to be brief in order to accommodate the busy schedules of LPHA directors. Therefore, the majority of items were to be included in the *Staffing* and *Client Services Questionnaires*. Items related to organizational governance (Domain 1) and CLAS plans and policies (Domain 2) are located in the *Director or Designee Interview Protocol*. Questionnaire items related to staffing patterns (Domain 6), staff diversity training (Domain 7), and patient assessment and treatment services (Domain 3) are found in the *Staffing Questionnaire*. The *Client Services Questionnaire* includes items related to translation and interpretation services (Domain 8) and culturally inclusive health care environment and practices (Domain 3). Information about Management Information Systems (Domain 5) is included in both the *Staffing* and *Client Services Questionnaires*, and questions about CLAS-related quality monitoring and improvement efforts (Domain 4) are included in all three components.

Chapter 3

Project Results and Recommendations

CHAPTER 3: PROJECT RESULTS AND RECOMMENDATIONS

This project produced three instruments for collecting data on CLAS provision in LPHAs. By using the self-assessment tool, health care professionals may examine their own organizational policies and practices in relation to the extensive examples of CLAS practices listed in the tool itself. The tool's questions and response options are designed to inform the respondent of a broad range of strategies and practices related to a particular topic along the continuum of care. LPHAs may use the self-assessment tool to monitor and improve overall health care quality in their agencies. Project results and recommendations are described below.

3.1 RESULTS

3.1.1 Modification of the Project's Title

At the joint meeting of the PEP and PAG, members reached consensus on the need to change the project's title and scope from Local Health Departments (LHDs) to Local Public Health Agencies (LPHAs). Meeting participants mentioned that it was difficult to accurately define LHDs, because LHDs are highly variable and are continuing to evolve. For instance, advisory group participants acknowledged that LHDs are often multi-jurisdictional, and there are other local public health entities (e.g., outreach programs, community health centers, and non-profit organizations) that would be excluded if LHDs were the primary focus of the self-assessment tool. To represent the (intended) more inclusive terminology, the project title was changed to *LPHAs*, because the *LHDs* did not fully capture all local, publicly funded organizations responsible for providing essential public health services.

3.1.2 Overview of Revisions Made to CLAS Instruments

Discussions and deliberations at the PEP and PAG meeting yielded important information on the structure and function of LPHAs and resulted in a number of necessary revisions to the three-component instrument used to measure CLAS provision in MCOs. Survey question wording and response options were revised to reflect LPHA characteristics. These revisions are described below and reflect the considerable differences between private and public health care entities, including differences in organizational structure, size and operating budgets, mechanisms for developing policy, staffing and training, and service delivery practices.

Organizational Structure. As described earlier, advisory group members informed OMH staff and the project team that LPHAs' organizational structures vary from state to state and even by county, and can be regulated by the state department of health and/or the

local board of health. PEP and PAG members recommended to revise response options so they reflect the variability in organizational structure.

Staffing Practices. In addition, LPHAs hire state and county employees, and many times have volunteers on their staff. Therefore, response options were revised to reflect these differences and took into consideration civil servant hiring practices.

Training Practices. LPHAs do not fund training directly (i.e., do not have a line item in their budget for training). Staff training is either funded by the state or the local board of health. Therefore, response options were revised to include, “training funded by the state health department” and “training funded by the local board of health.”

Overall Item Terminology. The project team, in consultation with OMH staff and the PEP and PAG members, identified a number of terms found in the MCOs instruments that needed to be replaced with terminology that accurately represented LPHAs. For instance, while the MCO instruments included many items that made reference to an “organization,” the LPHAs instruments allude to an “agency.” Unlike MCOs, which are managed by senior executives, LPHAs are managed by directors and some even by staff who serve in other capacities. Therefore, the instrument designated for MCO senior executives was designed to be completed by the “local public health agency director or designee.”

Also, the MCOs instruments included a number of items that discussed the composition of the board of directors. Because LPHAs are not managed by a board of directors, the revised instruments substituted the term with “board of health or other governing body.” In addition, unlike MCOs that serve members, wording was changed to “clients,” and “health care services” was substituted with “local public health services.” Response options that referred to a “corporate parent” were replaced with “state health department or other governing body” or “board of health or other governing body.” Finally, response options that include “corporate trainers” were replaced with “trainers provided by the local board of health or other governing body.”

3.1.3 Pilot Test Results for the LPHAs CLAS Self-Assessment Tool

After the self-assessment tool’s three questionnaires were developed, a pilot study was conducted with respondents similar to those who would be completing the questionnaires. The purpose of the pilot study was to test the appropriateness and accuracy of the instrumentation (format and content).

The pilot study was conducted between March and June 2002, and queried three individuals from each of the three participating LPHAs. The three respondents representing a LPHA included a director, a staffing personnel respondent, and a client services personnel respondent. These individuals were asked to review and provide comments on the format and content of the instruments. For each questionnaire component

(cover letter, questionnaire cover sheet with instructions, questionnaire sections A-D), the *Form* asks respondents to rate certain elements (e.g., layout and design, clarity of instructions, clarity of question wording and response categories, ability to provide requested information) based on the level of appropriateness for presenting each component to someone in a similar staff position as themselves. An average rating score was used to summarize the responses to the 4-point scale (i.e., 1 = very appropriate; 2 = appropriate; 3 = somewhat appropriate; and 4 = not appropriate).

Response to the *Pilot Test Response Form* (see Appendix F) were received from three client services personnel and one staffing personnel for average rates of 2.0 and 1.6, respectively. Moreover, only one respondent reported responses of “not appropriate” *in relation to the Response Form, however, not the actual questionnaire.*¹ These results demonstrate that for the pilot participants, the staffing and client services questionnaires were found to be understandable and appropriate—in both format and content.² Again, three questionnaires that represent the final LPHA CLAS self-assessment tool are provided in Appendices C, D, and E.

3.2 RECOMMENDATIONS AND CONCLUSION

Based on information learned during the conduct of this project, recommendations are offered to LPHAs that plan to use the self-assessment tool to monitor quality of services for culturally and linguistically diverse members, and for organizations that plan to conduct future research in this area.

3.2.1 Recommendations

Review findings of the CLAS in MCOs study. Results from the CLAS in MCOs study (OMH 2003b) could provide LPHAs with specific *examples* of how other health care organizations are providing CLAS to diverse groups. LPHAs are encouraged to *examine organizational and service operations implemented or utilized in their own health care settings in relation to the types of practices described in the study.* Numerous examples are provided that show how strategies and services that address the health care needs of diverse groups are currently implemented or utilized. The study results may provide a resource to LPHAs for identifying: 1) gaps in their own agency’s CLAS-related policies or service provision, or 2) new strategies that expand or strengthen existing services. In addition,

¹This respondent noted in the comments section of the *Pilot Test Response Form* that he/she did not understand the meaning of the category “ability to recall information” as written on the *Form*—not the questionnaire.

²Moreover, the MCOs study instruments (on which the LPHA CLAS self-assessment tool is based) were tested and shown to have high validity and reliability (OMH 2003b).

numerous promising CLAS practices are reported as examples of ways organizations are providing health care services to better serve their increasingly diverse service populations.

Use self-assessment tool in quality improvement efforts. Use of the instruments could assist LPHAs in effectively monitoring and improving services for culturally and linguistically diverse groups. *The three-component self-assessment tool could be used in its entirety, or may be customized or expanded to meet particular monitoring needs.* For instance, the tool may be especially useful to agencies that want to expand their management information systems to more closely and carefully monitor health care quality for culturally and linguistically diverse clients.

Conduct domain-specific organizational assessments. LPHAs may want to monitor CLAS quality in a particular area by *focusing on a single domain or multiple domains.* These studies would allow for separate, in-depth investigations to more thoroughly describe practices within individual domains, e.g., CLAS plans and policies (Domain 2), staff diversity training (Domain 7), or communication support (Domain 8).

Explore consumer and health care provider perspectives. The self-assessment tool developed for this project was designed to collect data that represent the *organizational* side of CLAS provision. However, equally interesting and important are data that represent the *patient/consumer* side of CLAS provision. *Research that fully accounts for the perceptions and experiences of culturally and linguistically diverse LPHA clients who depend on and utilize CLAS could provide decision-makers with key insights to the effectiveness of various types of CLAS.* Similarly, *understanding the perspectives and experiences of physicians and other staff would be valuable.* Clinical and non-clinical staff are responsible for the *delivery* of services. Inquiries with this population also could shed light on the benefits and challenges associated with providing CLAS, based on real-world experiences delivering services to culturally and linguistically diverse clients.

Update the CLAS conceptual framework to include measures that account for new practices and technologies. Since the start of the CLAS in MCOs study, new CLAS-related strategies and services have been developed and even tested and publicized by health care entities across the country, such as videoconferencing interpretation systems and other translation devices for patients who need translation services. Therefore, *the framework should be periodically revisited—especially at the key element and variable levels—in an effort to ensure that the framework is representative of current CLAS measures and to continually improve the comprehensiveness of measures.*

Conduct state or national organizational assessments. Although the present project was to develop a self-assessment tool for LPHAs, organizations that are interested in collecting data from LPHAs in a specific state or from a nationally representative sample of LPHAs can *use the self-assessment tool along with the data collection plan developed for the CLAS in MCOs study.* For this purpose, Appendix G includes a description of the

data collection plan, and should these instruments be used to collect data from a national sample of LPHAs, portions of the instructions reflect language for that methodology.

3.2.2 Conclusion

As the nation's communities continue to diversify, the provision of health care services that address the unique needs of culturally and linguistically diverse populations will continue to be of increasing importance to the U.S. public health care system. The *project Developing a Self-Assessment Tool for Culturally and Linguistically Appropriate Services in Local Public Health Agencies* designed the self-assessment tool and its corresponding protocols to collect data from LPHAs, but also can be used by other entities within the U.S. public health care system. In addition, the project was conceived in the belief that through periodic self-assessment, a health care agency or organization can gain a clearer understanding of its strengths and weaknesses, aid directors in prioritizing and planning for CLAS, and improve overall health care quality. Effective planning which targets identified needs and goals can lead to the development of effective strategies, policies, and ultimately to the implementation of CLAS. If implemented correctly, the provision of CLAS will better serve a LPHA's diverse service populations, and in the process, aid in the reduction and eventual elimination of racial and ethnic health disparities nationwide.

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Appendices

Appendix A

Membership Lists of the Project Expert Panel and Federal Project Advisory Group

Appendix A-1 Official Membership List of the Project Expert Panel

Appendix A-2 Official Membership List of the Federal Project Advisory Group

Appendix A-1

Official Membership List of the Project Expert Panel

Appendix A-1

Developing a Self-Assessment Tool for Culturally and Linguistically Appropriate Services in Local Public Health Agencies



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*PEP membership list reflects the organizational affiliations of members at the time of their invitation to participate on the panel.

Appendix A-2

Official Membership List of the Federal Project Advisory Group

Appendix A-2

Developing a Self-Assessment Tool for Culturally and Linguistically Appropriate Services in Local Public Health Agencies



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*PAG membership list reflects the organizational affiliations of members at the time of their invitation to participate on the panel.

Appendix B

CLAS Conceptual Framework

- Appendix B-1 Overview of Eight CLAS Domains
- Appendix B-2 Conceptual Framework for the CLAS in MCOs Study

Appendix B-1

Overview of Eight CLAS Domains

Appendix B-1

Overview of Eight CLAS Domains

Domain 1: Organizational Governance

This domain is intended to measure the extent to which a commitment to providing services that address the specific needs of culturally and linguistically diverse populations is reflected through the organization's governing structures and bodies. The existence of committees, staff positions, and advisory boards that focus specifically on racial, ethnic, cultural, and linguistic minority health care issues indicates a level of formalization and commitment to health care quality by the organization.

Similarly, decision-making bodies within an organization should reflect the cultural (including racial and ethnic) composition of the population served by the organization (Cross et al. 1989; Roberts et al. 1990). By representing the community within the governing bodies, the needs of the community will likely influence policy formation and decision making, thereby rendering services that meet the particular needs of community members (NLBHW 1996; Roberts et al. 1990).

Domain 2: CLAS Plans and Policies

The types of formal policies in place that express a commitment to diversity also indicate a certain organizational commitment to providing quality health services to diverse populations. Policymakers and health plan executives may set a standard of cultural competence, cultural sensitivity, and responsiveness by incorporating such goals into their organizations' written mission statements (Cross et al. 1989). Similarly, formal policies may be developed and implemented which govern translation and interpretation services provided by the organization. Such policies set organizational standards and protocols for service delivery, which in turn improve the quality of care at the service level.

Moreover, utilizing staff and community input on CLAS-related planning and policy development is important for understanding the needs of staff and patients and effectively addressing those needs, thereby improving overall health care quality. Community advisory boards are useful to health care organizations, including MCOs, for designing and conducting community needs assessments, planning and designing services, monitoring and evaluating quality of services, and developing organizational protocols and policies for addressing the needs of culturally and linguistically diverse populations.

Domain 3: Culturally Inclusive Health Care Environment and Practices

This domain captures characteristics of care that are related to (non-communication) cultural barriers experienced throughout the health care continuum.¹ In this sense, patient care is not limited to services provided during the clinical encounter. Rather, key elements and study variables under this domain include conditions and services provided that address cultural barriers across the continuum of care.

The cultural barriers that exist between providers and patients can be reduced or eliminated through the implementation of culturally appropriate services (Julia 1992; Lieberman 1990; Marin 1993; Moore 1992; Redmond 1990). Such services require providers who are knowledgeable about the cultures of their patients, i.e, their customs, beliefs, and languages (Clermont et al. 1993; Dillard et al. 1992; Fernandez-Santiago 1994; Krajewski-Jaime 1993; Pruegger and Rogers 1994; Redican 1994). Effective assessment and treatment require a sensitivity to, and recognition of, cultural patterns related to food preferences, spiritual beliefs, and health practices in order to develop a practical treatment regimen that will result in compliance. Also, health care organizations may encourage their providers to utilize diverse or complementary clinical practices during patient assessment and treatment (e.g., using acupuncture or acupressure treatments, prescribing herbal therapies, or collaborating with culturally-specific healers).

The physical environment also is important to patients' level of comfort and trust. The signage, graphics, and brochures in service areas may reflect the racial, ethnic, cultural, and linguistic composition of the populations served. Similarly, culturally sensitive strategies may be implemented to improve patient care for diverse populations. These strategies may include offering dietary options in food service areas that reflect the cultural beliefs and behaviors of the populations served, or offering facilities or services to accommodate diverse religious faiths.

Domain 4: Quality Monitoring and Improvement (QMI)

This domain captures an organization's processes and strategies for monitoring and improving quality of services provided to culturally and linguistically diverse populations. Community and staff needs assessments are conducted to determine appropriate programs and services for implementation (Cross et al. 1989). Routine assessments and evaluations may be employed to continually monitor and improve quality of services. QMI activities that are typically used by organizations to improve health care quality are covered in this domain and include: consumer satisfaction surveys, grievance and complaint tracking,

¹Characteristics of care related to *communication* barriers (across the health care continuum) are covered in Domain 8 (Communication Support).

consumer focus groups, analysis of outcomes data, and chart reviews or audits (NPHHI 1998).

Using various methods to monitor CLAS quality is a vital step toward improving CLAS quality (Smedley et al. 2002). Equally important, however, is how organizations use the data they have collected through QMI studies. As such, this domain also includes information on the *uses* of QMI data, which may include: setting priorities for health education and promotion, linking patient and provider data, and setting targets or goals for service units.

Domain 5: Management Information Systems (MIS)

This fifth domain—which includes assessment elements related to an organization’s data collection efforts for its staff and clientele—is closely related to Domain 4, Quality Monitoring and Improvement. In order to effectively understand, monitor, and improve quality of health care in general, and to promote consistent and similar standards of care for all patients regardless of demographic characteristics (e.g., race, ethnicity, language, gender, age), information must be collected on the demographic characteristics of health plan staff and the service population (Perot and Youdelman 2001; Smith 1998). Inquiries within this domain include whether the organization collects and records such information for its staff and clientele. If management information systems are in place, actual data on the racial, ethnic, cultural, and linguistic composition of the organization’s staff and clientele would be gathered under this domain.

Domain 6: Staffing Patterns

The racial, ethnic, cultural, and linguistic composition of health care staff—both clinical and non-clinical—should reflect and represent the diversity of its service population (Kim et al. 1992). This domain covers level of staff diversity within an organization as well as organizational efforts to recruit, retain, and promote a diverse staff. Also important in an assessment of staffing patterns are the types of organizational efforts to make information on staff diversity available to its service population (again, for MCOs, its members), such as provider directories that publish languages spoken by physicians or show photographs of physicians and other health care staff who “look like” their members.

Domain 7: Staff Training and Development

One way to improve quality of health services for culturally and linguistically diverse populations is to hire staff who represent the cultural composition and speak the languages of the population served, discussed above in Domain 6. Another way organizations can improve CLAS quality is to provide ongoing staff training in cultural competence or “staff diversity training” (Cultural and Linguistic Standards Task Force 1997; NLBHW 1996). Diversity training refers to *any instructional effort that addresses and promotes greater*

*understanding of diversity issues in general (race/ethnicity; sex/gender; religion; region; sexual orientation; etc.), or more specifically, the unique needs and preferences of culturally and linguistically diverse groups in the health plan membership.*² Participation in these programs often creates opportunities for staff to reflect on their own beliefs and behaviors and how this background affects the way they deliver services (Dilworthanderson et al. 1993; Eliason 1993; May 1992).

In an organizational assessment of CLAS, measures for examining this domain include topical components covered by the diversity training program, frequency of administration, staff types for whom training is available and/or required, and whether the organization provides such training on a one-time, e.g., during employee orientation, or continuous basis. Other staff training and development issues covered by this seventh domain include whether organizations provide opportunities for staff to learn non-English languages.

Domain 8: Communication Support

This domain examines language assistance services provided by health care organizations. Translation and interpretation services are needed to reduce and eliminate communication barriers experienced throughout the continuum of care. Although the terms “translation” and “interpretation” are often mistakenly used synonymously, “translation” refers to *written* materials, and “interpretation” is related to *oral* communication. Areas of inquiry related to communication support include: types of translated materials and interpretation services utilized by the organization; characteristics of interpreters utilized by the organization; methods for determining types and levels of language assistance services needed; and points of service at which language assistance services are available. Perhaps the most critical component of quality health care is the ability of both the provider and the patient to understand and be understood. Linguistically appropriate services—i.e., the provision of translated written materials, and oral interpretation services—are vital to accurate physician diagnosis and appropriate treatment of presenting complaints or conditions, patient understanding, compliance with prescribed actions or treatment plans, and positive health outcomes (Manson 1988; Perez-Stable et al. 1997).

²This definition of “diversity training” was developed by OMH for the purposes of this study.

Appendix B-2

Conceptual Framework for the CLAS in MCOs Study

Appendix B-2

Conceptual Framework for the CLAS in MCOs Study

DOMAIN / KEY ELEMENT	STUDY VARIABLES
<p>1. <u>Organizational Governance</u></p> <p>A. Governing boards, committees and positions</p> <p>B. Organizational Structure</p>	<p>A. Board of directors subcommittee on CLAS Community advisory committee on CLAS Committee recruitment strategies Committee racial/ethnic composition Committee diversity other than race/ethnicity Internal CLAS working group Staff position specifically for CLAS coordination</p> <p>B. Organization type – HMO, PPO, POS Corporate status – profit, non-profit Model type - IPA, group, network, staff Membership size – total enrollment</p>
<p>2. <u>CLAS Plans and Policies</u></p> <p>A. Corporate planning</p> <p>B. Corporate policies</p>	<p>A. Formal QI plan for culturally and linguistically diverse members Staff and community input Mission statement addresses CLAS Frequency of committee meetings Committee roles related to CLAS</p> <p>B. Policy governing written translation Description of translation policy Reasons translation policy exists Reasons translation policy does not exist Policy governing interpretation services Description of interpretation services policy Reasons interpretation services policy exists Reasons interpretation services policy does not exist Formal grievance process for CLAS-related concerns Internal communication strategies for CLAS policies Formal staff diversity plan Formal diversity training program</p>
<p>3. <u>Patient Care</u></p> <p>A. Assessment and Treatment</p> <p>B. Materials and Environment</p>	<p>A. Cultural differences and preferences considered during treatment Collaborate with culturally-specific healers on treatment Utilize alternative and complementary treatments</p> <p>B. Various culturally responsive strategies implemented Characteristics of written materials</p>
<p>4. <u>CLAS Quality Monitoring and Improvement (QMI)</u></p> <p>A. Tracking system</p> <p>B. Needs assessment (NA) and evaluation</p>	<p>A. Multiple methods for monitoring CLAS quality Quality of care data collection Uses of QI data Link member demographic and outcome data Link member and provider data Link member and (other) staff data</p> <p>B. Routine member/community needs assessments (NA) conducted Frequency of member NA Types of community/member groups that participate in NA Member/community NA specifically for CLAS Data sources for member/community CLAS NA Staff NA conducted specifically for CLAS-related issues Frequency of staff NA Types of staff who participate in NA Types of corporate support for QI and NA activities</p>

(Continued on next page)

(Appendix B-2 Continued)

DOMAIN / KEY ELEMENT	STUDY VARIABLES
5. Management Information Systems (MIS) A. Members B. Staff	A. Members' race/ethnicity recorded Reasons members' race/ethnicity not recorded Racial/ethnic composition of membership Members' primary language recorded Reasons members' primary language not recorded Percentage of membership that speaks non-English primary language B. Staff race/ethnicity recorded Reasons staff race/ethnicity not recorded Types of staff for whom r/e is recorded Staff linguistic capability recorded Method of determining staff linguistic capability
6. Staffing Patterns A. Staff diversity B. Staff recruitment, retention, and promotion	A. Racial/ethnic composition of staff Percent of bi- or multi-lingual staff Information on staff diversity available to members B. Types of staff covered in corporate diversity plan Strategies utilized to recruit, retain, and promote diverse staff Resources utilized to recruit diverse staff
7. Staff Training and Development A. Diversity training programs B. Staff development	A. Frequency of diversity training program Racial/ethnic groups covered in diversity training Diverse groups other than r/e covered in diversity training Topical areas covered in diversity training Resources and activities utilized in diversity training Entities responsible for conducting diversity training Entities responsible for developing diversity training Diversity training review and oversight Diversity training evaluation methods Corporate support for diversity training Budget line for diversity training Various benefits of providing staff diversity training Various challenges of providing staff diversity training B. Types of staff for which diversity training is available or required Types of staff receiving one-time or continuous diversity training Strategies for encouraging staff participation in diversity training Strategies for informing staff of diversity training
8. Communication Support A. Translation services B. Interpretation services	A. Types of translated materials available Translation methods utilized Entities responsible for reviewing or approving translated materials Identified minimum threshold for translated materials Methods for determining translation needs Data sources utilized to determine translation needs Members for whom translated materials are available Methods used to inform members of available translated materials Budget line for translation activities B. Types of interpretation services available Characteristics of interpreters utilized Entities responsible for reviewing or approving staffing and operation of interpretation services Identified minimum threshold for interpretation services Methods for determining interpretation service needs Number of interpreters available for members Members for whom interpretation services are available Points of service where interpretation services are available Methods used to inform members of available interpretation services Budget line for interpretation services

Appendix C

LPHA Director or Designee Telephone Interview Protocol



[INSERT NAME OF STUDY OR DATA COLLECTION EFFORT]

**LPHA DIRECTOR OR DESIGNEE
TELEPHONE INTERVIEW PROTOCOL**

DRAFT

Paperwork Reduction Act Statement

A federal agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. Public reporting burden for this collection of information is estimated to vary from 10-15 minutes with an average of 1 minute per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining the necessary data, and completing and reviewing the collection of information.

Pre-Interview Script for LPHA Director

Thank you for agreeing to participate in this interview. The [**insert name of funding agency**], is sponsoring this study as a benchmark for future research on the growing efforts of local public health agencies to provide quality services to all clients—when populations are becoming increasingly diverse. Your agency’s participation in this study contributes to greater understanding of health care provision in the U.S. The interview will take approximately 15 minutes.

As stated in the letter you recently received from [**insert name of funding agency**], the purpose of collecting this information is to ascertain an *accurate description* of health care policies and practices that extend medical support or services to clients of diverse linguistic, national, or cultural backgrounds. *Participation in this study does not require that your agency have any sort of policies or practices in place that address the particular needs of certain cultural groups.* There are no expectations or judgments about services that are (or are not) offered by your agency.

Finally, because organizational policies are sometimes sensitive issues, it is emphasized that none of the information provided will ever identify individual agencies that participate in the study. In the event that certain agencies report unique policies or practices that exceed current standards of care for diverse groups, prior permission will be requested from the participating agency to highlight in future publications information provided from those responses only. Anonymity is assured.

1. Does your agency have a mission statement?
- Yes → go to 1a
 - No → go to 2
 - Don't know → go to 2
 - Declined → go to 2
- 1a. Does your agency's mission statement express a commitment to provide health care services that are appropriate for the needs of each cultural and linguistic group (represented by your clients)?
- Yes
 - No
 - Don't know
 - Declined
2. Does your local board of health or other governing body have a subcommittee or other group responsible for issues involving services provided to racial, ethnic, and linguistic minority groups?
- Yes
 - No
 - Don't know
 - Declined
3. Does your agency use community advisory boards or other similar entities to address community and client issues specifically related to the cultural and linguistic groups (represented by your clients)?
- Yes → go to 3a
 - No → go to 4
 - Declined → go to 4
- 3a. Which of the following strategies do you use to recruit members for this community advisory board or group?
- MARK ALL THAT APPLY**
- Agency newsletter or publication
 - Major regional newspaper
 - Community/neighborhood newspapers or publications
 - Local bulletin postings (i.e., community centers and other sites)
 - Local radio outlets or television broadcasts
 - Web sites
 - Contact leaders and liaisons involved with community health issues and networks (e.g., consumer groups, advocacy groups, local health officials)
 - Other, please specify _____
 - Don't know
 - None of the above
 - Declined

3b. Which of the following are reflected in your advisory group membership?

MARK ALL THAT APPLY

- White
- Black or African American
- Hispanic or Latino
- Asian
- Native Hawaiian or other Pacific Islander
- American Indian or Alaska Native
- Gender diversity
- Sexual orientation diversity
- Religious diversity
- Persons with disabilities
- Geographic diversity
- Other, please specify _____
- Don't know
- None of the above
- Declined

3c. How often does this community advisory body meet?

- Quarterly
- Semi-annually
- Annually
- Within the last two years
- Less regularly
- Other, please specify _____
- Don't know
- Declined

3d. In what ways does your community advisory body assist you in providing services specifically for culturally and linguistically diverse groups?

MARK ALL THAT APPLY

- Planning and designing culturally and linguistically appropriate health services
- Assessing community and clients' needs
- Monitoring and evaluating quality of services
- Developing plans, protocols, and policies related to provision of services
- Providing input in other agency-wide policy formulation and development
- Other, please specify _____
- Don't know
- None of the above
- Declined

4. From which of the following additional groups does your agency utilize input on policies related to services specifically for culturally and linguistically diverse groups?

MARK ALL THAT APPLY

- State Department of Health
- Other State agency
- Management and supervisors within your local health agency
- Physicians, nurses, other clinical staff
- Client services staff
- Front line personnel (appointment clerks, receptionists, secretaries)
- Information specialists
- Local community leaders and liaisons involved with community health issues and networks
- Faith-based organizations representing local communities
- Civic organizations representing local communities
- Consumer or advocacy groups
- Other, please specify _____
- Don't know
- None of the above
- Declined

5. Does your agency conduct periodic needs assessments of community and/or clients' needs?

- Yes → go to 5a
- No → go to 6
- Don't know → go to 6
- Declined → go to 6

- 5a. Do these assessments include a component that specifically measures the need for culturally and linguistically appropriate services?

- Yes
- No → go to 6
- Don't know
- Declined

- 5b. Which of the following sources does your agency use to assess the need for culturally and linguistically appropriate services (for clients or service area)?

MARK ALL THAT APPLY

- U.S. Census data
- Client utilization data
- Data from school systems and community organizations
- Focus groups research
- Other, please specify _____
- Don't know
- Declined

6. Does your agency have a formal plan for improving the quality of services provided to your clients?
- Yes → go to 6a
 - No → go to 7
 - Don't know → go to 7
 - Declined → go to 7

- 6a. Does your agency's plan include a component that improves the quality of services provided specifically to culturally and linguistically diverse clients?
- Yes
 - No
 - Don't know
 - Declined

7. Which of the following activities does your agency use to monitor the quality of culturally and linguistically appropriate services?

MARK ALL THAT APPLY

- Collection, review, and analysis of quality outcome data
- Client satisfaction surveys
- Internal working group or committee
- Grievance and complaint tracking
- Chart reviews or audits
- Client focus groups
- Other, please specify _____
- Don't know
- None of the above
- Declined

8. Is there a position in your agency specifically designated to promote and coordinate culturally and linguistically appropriate services?
- Yes → go to 8a
 - No → go to 9
 - Don't know → go to 9
 - Declined → go to 9

- 8a. This position is:
- A volunteer
 - A full-time staff position
 - A part-time staff position
 - Currently in the planning phase

9. Does your agency have a written policy governing language translation of written information for your clients?

- Yes → to 9a
- No, a written policy is in the planning phase → go to 9b
- No → go to 9b
- Don't know → go to 10
- Declined → go to 10

9a. Which of the following describes your agency's policies governing language translation?

MARK ALL THAT APPLY

- A State policy
- A local policy
- A policy within your local health agency
- Exists to promote translation of materials to meet clients' needs
- The policy establishes a method for identifying the need for translated materials (e.g., a minimum threshold of population for translation of materials)
- The policy ensures that commonly used materials (e.g., vital documents such as in-take and consent forms) are translated
- The policy establishes an organizational entity with programmatic responsibility for translation of materials
- The policy provides notification of translated materials to clients
- Other, please specify _____
- Don't know
- Declined

9b. Which of the following describes the reasons why your agency does not currently have a policy governing translation?

MARK ALL THAT APPLY

- Your clients are not very culturally or linguistically diverse
- The population in your service area is not very culturally or linguistically diverse
- These programs are too costly in comparison to their benefits
- It is difficult to make staff time available for planning, assessment, or training
- Other, please specify _____
- Don't know
- Declined

10. Which of the following describes the reasons your agency provides translation services?

MARK ALL THAT APPLY

- Federal requirement
- State requirement
- Required by the local board of health or other governing body
- Client demands
- Other, please specify _____
- Not applicable
- None of the above
- Declined

11. Does your agency have a written policy governing interpretation services and assistance for your clients?

- Yes → go to 11a
- No, a written policy is in the planning phase → go to 11b
- No → go to 11b
- Don't know → go to 12
- Declined → go to 12

11a. Which of the following best describes your agency's policy governing interpretation services and assistance for your clients?

MARK ALL THAT APPLY

- A State policy
- A local policy
- A policy within your local health agency
- Exists to promote interpretation services and assistance to meet clients' needs
- The policy establishes a method for identifying the communication needs of your clients (e.g., a minimum threshold for interpretation services)
- The policy ensures that a range of oral language options are provided
- The policy establishes an organizational entity with programmatic responsibility for interpretation services and assistance
- The policy provides for notices of interpretation services to clients
- The policy ensures that staff, contractors, and/or partnership members are periodically trained
- Other, please specify _____
- Don't know
- Declined

11b. Which of the following describes the reasons why your agency does not currently have a policy governing interpretation services?

MARK ALL THAT APPLY

- Your clients are not very culturally or linguistically diverse
- The population in your service area is not very culturally or linguistically diverse
- These programs are too costly in comparison to their benefits
- It is difficult to make staff time available for planning, assessment, or training
- Other, please specify _____
- Don't know
- Declined

12. Which of the following describes the reasons for providing your interpretation services program?

MARK ALL THAT APPLY

- Federal requirement
- State requirement
- Required by the local board of health or other governing body
- Client demands
- Other, please specify _____
- Not applicable
- None of the above
- Declined

13. Which of the following activities or programs does your agency use to address concerns about culturally insensitive or discriminatory treatment, or difficulty in accessing services, or denial of services?

MARK ALL THAT APPLY

- A formal grievance process
- Cultural navigators
- Ombudsmen personnel
- Systematic reminders/notices to staff promoting non-discriminatory practice
- Other, please specify _____
- None of the above
- Don't know
- Declined

Begin Post-Interview Script.

Post-Interview Script for LPHA Director

That concludes the questions we have for you about your agency. However, we are requesting that you recommend other individuals in your agency who can provide additional information on your clients and staff by completing two questionnaires.

As explained earlier, we will contact the individuals you recommend by mailing a package that includes information on obtaining the appropriate questionnaire and instructions for completing and submitting the form. Options for returning the completed questionnaire include Internet web site submission, electronic mail, facsimile, and postal mail.

We would like you to recommend at least two individuals in your agency whose roles and responsibilities appropriately match the topics covered in each questionnaire, as indicated in the topical description that was enclosed with the letter. You may recall that one questionnaire requires knowledge of programs and practices aimed at your general clientele, and the other requires knowledge of programs and practices related to your staff.

Although the focus of both questionnaires is on health care services provided to members of diverse cultural groups, each questionnaire is divided into sections that cover specific topics within the broader inquiry. Depending on the structure of your agency, it may be appropriate for different individuals to complete certain sections or questions of one questionnaire, thereby greatly reducing individual time and effort. Please recommend a primary contact responsible for the receipt and completion of each questionnaire (this person could either complete the entire questionnaire or delegate certain sections to other individuals who are knowledgeable about particular topical sections).

Post-Interview Script (Continued)

Topics covered in each questionnaire are as follows:

Client Services Questionnaire – Total, 46 questions

Section A: Quality Monitoring and Improvement (QI)

Includes 11 questions on your basic systems for tracking data about your clients and services you provide, and how these data are used in planning, promoting, and evaluating services that address the specific needs of diverse groups in your community.

Section B: Management Information Systems (MIS)

Includes 8 questions on demographic data your agency may collect on your clients.

Section C: Translation and Interpretation Services

Includes 21 questions about translation services and interpretation services that are provided by your agency or by individual or group providers that you contract with or partner with.

Section D: Other Related Client Services and Benefits

Includes 6 questions on your agency's culturally inclusive health care environment and benefits available to your clients.

Staffing Questionnaire – Total, 49 questions

Section A: Quality Monitoring and Improvement (QI)

Includes 9 questions on quality assessments of clinical services provided to your clients. These would include internal routine information systems and quality monitoring and improvement procedures.

Section B: Management Information Systems (MIS)

Includes 12 questions about demographic data your agency may collect on your employed staff, contractors, and/or partnership members.

Section C: Diversity Training

Includes 21 questions about "diversity training" that may be provided to your employed staff, contractors, and/or partnership members.

Section D: Diversity, Recruitment and Retention

Includes 7 questions about policies or plans your agency may have in place that address diversity in your employed staff, contractors, and/or partnership members, as well as questions about your agency's culturally inclusive health care environment and practice.

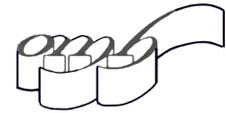
Recommended Contact Person:

(Name, title, mailing address, phone number)

This concludes the interview. We will follow-up with these recommended individuals and look forward to their participation in the study. Thank you again for taking the time to speak with us.

Appendix D

Staffing Questionnaire



[INSERT NAME OF STUDY OR DATA COLLECTION EFFORT]

STAFFING QUESTIONNAIRE

Thank you for taking the time to complete this questionnaire. The purpose of this request is to collect information on health care policies and practices that provide medical support or services to meet the needs of clients of diverse linguistic, national, or cultural backgrounds. *Participation in this study does not require that your agency have any sort of policies in place that address the particular needs of certain cultural groups.* There are no expectations or judgments about services that are, or are not, offered by your agency. In the event that certain agencies report unique policies or practices that exceed current standards of care for diverse groups, prior permission will be requested from the participating agency to highlight in future publications information provided from those responses only. Anonymity is assured; data will be reported as summaries without individual agency identification. A unique benefit of your participation in this study is that your agency will receive a copy of actual responses submitted by your staff that may be useful to your health agency in identifying and monitoring CLAS provision for quality improvement and other reporting purposes.

Although the focus of this questionnaire is on health care services provided to members of diverse cultural groups, the form is divided into four sections that cover specific topics within the broader inquiry. Depending on the structure of your agency, it may be appropriate for different individuals in your agency to complete certain sections of the questionnaire based on their roles, responsibilities, and knowledge—thereby greatly reducing individual time and effort. You are encouraged to distribute certain sections or questions to the appropriate colleague in your agency in order to complete as many questions as you can. Some questions call for your best single answer. Questions that call for multiple responses are labeled “Mark All That Apply.”

RETURN INSTRUCTIONS

Thank you again for your participation. There are two options for returning your completed questionnaire:

1. Mail the completed form using the enclosed pre-paid envelope.
If you have misplaced the envelope, please send the completed form to:

Complete as appropriate

2. Submit your completed form by facsimile transmission to:

Complete as appropriate

Paperwork Reduction Act Statement

A federal agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. Public reporting burden for this collection of information is estimated to vary from 20-30 minutes with an average of .5 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining the necessary data, and completing and reviewing the collection of information.

A. QUALITY MONITORING AND IMPROVEMENT (QI)

The following questions are about quality assessments of services provided to your clients. These would include internal routine information systems and quality monitoring and improvement procedures.

1. Does your agency collect information on the quality of services provided to your clients?
- Yes → go to 1a
 - No → go to 2
 - Don't know → go to 2
- 1a. Does this QI information collection include specific activities related to culturally and linguistically appropriate services?
- Yes
 - No
 - Don't know
- 1b. For what purpose(s) does your agency collect this information?
- MARK ALL THAT APPLY**
- Federal reporting requirement
 - State reporting requirement
 - Local board of health or other governing body reporting requirement
 - To improve services
 - Other, please specify _____
- 1c. Who developed your agency's QI information collection plan?
- MARK ALL THAT APPLY**
- Federal agency
 - State agency
 - National organization
 - State organization
 - Local board of health or other governing body
 - Local health agency staff
 - Other, please specify _____
- 1d. Which of the following QI activities are used to collect information on the quality of culturally and linguistically appropriate services provided?
- MARK ALL THAT APPLY**
- Collection, review, and analysis of quality outcomes data
 - Client satisfaction surveys
 - Grievance and complaint tracking
 - Chart reviews or audits
 - Client focus groups
 - Other, please specify _____
 - Don't know
 - None of the above

2. Does your agency conduct periodic assessments of the needs of employed staff, contractors, and/or partnership members to better serve culturally and linguistically diverse clients?

- Yes → go to 2a
- No → go to Section B on p.3
- Don't know → go to Section B on p.3

2a. How often are these needs assessments conducted?

- Annually
- Every two years
- Less regularly
- Within the last 2 years
- Other, please specify _____
- Don't know

2b. Which of the following are involved in these needs assessments (regardless if categories represent staff, contractors, or partnership members)?

MARK ALL THAT APPLY

- Executive level administrators
- Supervisors and program managers
- Client services staff
- Physicians
- Dentists
- Physician assistants and nurse practitioners
- Nursing professionals
- Pharmacy, lab, and X-ray staff
- Allied or associated health professionals
- Information specialists
- Front line personnel (e.g., appointment clerks, receptionists, secretaries)
- Interpreters
- Accounts/billing staff
- Other, please specify _____
- Don't know
- None of the above

2c. How is the needs assessment information communicated to your employed staff, contractors, and/or partnership members?

MARK ALL THAT APPLY

- Initial orientation (employment, contract, membership)
- Annual report or publication
- Other agency publications
- Periodic workshops
- Regular meetings
- Other, please specify _____
- Don't know
- None of the above

B. MANAGEMENT INFORMATION SYSTEMS (MIS)

The following questions are about demographic data your agency may collect on your employed staff, contractors, and partnership members.

1. Please indicate for which of the following you keep data on racial and ethnic composition.

MARK ALL THAT APPLY

- Employed staff → go to 2
- Contractors → go to 2
- Partnership members → go to 2
- Don't know → go to 3
- None of the above → go to 1a

1a. To your knowledge, what are the reasons you do not record their race and ethnicity?

MARK ALL THAT APPLY

- Privacy rights → go to 5
- Concerns about quality or completeness of data → go to 5
- Concerns about legal liability → go to 5
- Other, please specify _____ → go to 5
- Don't know → go to 5

2. For which of the following do you keep data on racial and ethnic composition of your employed staff, contractors, and/or partnership members?

MARK ALL THAT APPLY

	Employed Staff	Contractors	Partnership Members
--	----------------	-------------	---------------------

- | | | | |
|---|--------------------------|--------------------------|--------------------------|
| a. Executive level administrators | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Supervisors and program managers | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Client services staff | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Accounts/billing staff | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| e. Information specialists | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| f. Appointment clerks, receptionists, secretaries, other front line personnel | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| g. Physicians | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| h. Dentists | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| i. Physician assistants and nurse practitioners | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| j. Nursing professionals | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| k. Pharmacy, lab, and X-ray staff | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| l. Allied or associated health professionals | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| m. Interpreters | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Other, please specify _____ | | | |
| <input type="checkbox"/> None of the above | | | |

3. Please report or estimate what percentage of your employed staff, contractors, and partnership members falls into the following racial groups.

	<u>Record Percent</u>	<u>Actual</u>	<u>Estimated</u>
a. Black or African American	<input type="text"/> %	<input type="checkbox"/>	<input type="checkbox"/>
b. Asian	<input type="text"/> %	<input type="checkbox"/>	<input type="checkbox"/>
c. Native Hawaiian or other Pacific Islander	<input type="text"/> %	<input type="checkbox"/>	<input type="checkbox"/>
d. American Indian or Alaska Native	<input type="text"/> %	<input type="checkbox"/>	<input type="checkbox"/>
e. White	<input type="text"/> %	<input type="checkbox"/>	<input type="checkbox"/>

If reporting the actual percentage, what is the source used for your response? _____

Don't know

4. Please report or estimate what percentage of your employed staff, contractors, and partnership members falls into the following ethnic group.

	<u>Record Percent</u>	<u>Actual</u>	<u>Estimated</u>
a. Hispanic or Latino	<input type="text"/> %	<input type="checkbox"/>	<input type="checkbox"/>

If reporting the actual percentage, what is the source used for your response? _____

Don't know

5 Please indicate for which of the following you keep data on linguistic capability (including sign language).

MARK ALL THAT APPLY

- Employed staff
- Contractors
- Partnership members
- Don't know
- None of the above

6. How is the linguistic capability of your employed staff, contractors, and/or partnership members determined?

MARK ALL THAT APPLY

- Self-identification
- Proof of training completion or certification
- Testing
- Other, please specify _____

7. Please indicate, if you know, the percentage of your employed staff, contractors, and partnership members who are conversationally fluent in languages other than English that are spoken by your clients. (Your best estimate is fine.)

Record Percentage % Actual Estimated

If reporting the actual percentage, what is the source used for your response? _____
 Don't know

8. Do your management information systems allow for linking client information with information on any of the following for performance assessments and QI activities?

MARK ALL THAT APPLY

- Staff information
 Contractor information
 Partnership member information
 Other, please specify _____
 Don't know
 None of the above

9. Please indicate the size of your agency's employed staff by marking the appropriate box. (Your best estimate is fine.)

- Fewer than 50
 50-99
 100-499
 500-999
 1,000-5,000
 Greater than 5,000
 Don't know

10. Please indicate the number of contractors your agency is currently working with by marking the appropriate box. (Your best estimate is fine.)

- Fewer than 50
 50-99
 100-499
 500-999
 1,000-5,000
 Greater than 5,000
 Don't know

11. Please indicate the number of partners your agency is currently working with. (Your best estimate is fine.)

- Fewer than 50
 50-99
 100-499
 500-999
 1,000-5,000
 Greater than 5,000
 Don't know

C. DIVERSITY TRAINING

This section includes questions about language training and cultural competence or diversity training that may be provided to your staff, contractors, and/or partnership members. Cultural competence or diversity training would include any instructional effort that addresses and promotes greater understanding of diversity issues in general (race/ethnicity, sex/gender, religion, region, sexual orientation, etc.), or more specifically, the unique needs and preferences of diverse groups represented by your clients. Please answer about diversity training programs that are either stand-alone or integrated with other training, and whether or not they are operated internally or by contractors.

1. Please indicate for which of the following your agency provides opportunities to learn languages other than English that are commonly spoken by the clients they serve?

MARK ALL THAT APPLY

- Employed staff → go to 1a
- Contractors → go to 1a
- Partnership members → go to 1a
- Don't know → go to 2
- None of above → go to 2

- 1a. Which of the following features apply to the language training opportunities for employed staff, contractors, and/or partnership members?

MARK ALL THAT APPLY

- Opportunities on an as-needed basis
- Opportunities at regular intervals on an ongoing basis
- Opportunities to attend or participate during standard work hours
- Training funded by the Federal government
- Training funded by the State
- Training funded by the local board of health or other governing body
- Other, please specify _____
- Don't know
- None of the above

- 1b. How are employed staff, contractors, and/or partnership members informed of the availability of language training opportunities?

MARK ALL THAT APPLY

- Initial orientation (employment, contract, or membership)
- Notices via agency bulletin boards or newsletters
- Meetings
- Through other in-service, continuing education, and professional development opportunities
- Other, please specify _____
- Don't know
- None of the above

1c. Please indicate for which categories language training is available, and is available with medical terminology covered (regardless if categories represent staff, contractors, or partnership members).

MARK ALL THAT APPLY

	Available	Available with Medical Terminology Covered
--	-----------	--

- a. Executive level administrators
- b. Supervisors and program managers
- c. Client services staff
- d. Physicians
- e. Dentists
- f. Physician assistants and nurse practitioners
- g. Nursing professionals
- h. Pharmacy, lab, and X-ray personnel
- i. Allied or associated health professionals
- i. Front line personnel (appointment clerks, receptionist, secretaries)
- k. Information specialists
- Others, please specify _____
- Don't know
- None of the above
- Not applicable

2. Please indicate to which of the following your agency provides cultural competence or diversity training to strengthen the ability to serve diverse patient populations?

MARK ALL THAT APPLY

- Employed staff → go to 3
- Contractors → go to 3
- Partnership members → go to 3
- Don't know → go to 18
- None of the above → go to 18

3. How does your agency offer or assure cultural competence or diversity training for employed staff, contractors, and/or partnership members?

MARK ALL THAT APPLY

- Offer or assure diversity training as one of many topics in a general staff training program, other than new employee orientation
- Offer or assure diversity training as a major emphasis or component of related training programs (e.g., patient-centered care)
- Don't know

4. How does your agency encourage staff, contractors, and/or partnership members to participate in cultural competence or diversity training?

MARK ALL THAT APPLY

- Opportunities to participate during work hours
- Opportunities to participate outside of work hours
- Opportunities to participate at no cost to staff
- Awards or certificates of achievement granted to those who successfully complete such training
- Registry maintained of names and dates of all employees, contractors, and/or partnership members who have completed such training
- Other, please specify _____
- Don't know
- None of the above

5. How are staff, contractors, and/or partnership members informed of the availability of cultural competence or diversity training opportunities?

MARK ALL THAT APPLY

- Initial orientation (employment, contract, or membership)
- Notices via agency bulletin boards or newsletters
- Meetings
- Through other inservice, continuing education, and professional development opportunities
- Other, please specify _____
- Don't know
- None of the above

6. Please indicate for which categories diversity training is available and is required (regardless if categories represent employed staff, contractors, or partnership members).

MARK ALL THAT APPLY

	Available	Required
a. Executive level administrators	<input type="checkbox"/>	<input type="checkbox"/>
b. Supervisors and program managers	<input type="checkbox"/>	<input type="checkbox"/>
c. Client services staff	<input type="checkbox"/>	<input type="checkbox"/>
d. Physicians	<input type="checkbox"/>	<input type="checkbox"/>
e. Dentists	<input type="checkbox"/>	<input type="checkbox"/>
f. Physician assistants and nurse practitioners	<input type="checkbox"/>	<input type="checkbox"/>
g. Nursing professionals	<input type="checkbox"/>	<input type="checkbox"/>
h. Pharmacy, lab, and X-ray personnel	<input type="checkbox"/>	<input type="checkbox"/>
i. Allied or associated health professionals	<input type="checkbox"/>	<input type="checkbox"/>
j. Front line personnel (appointment clerks, receptionists, secretaries)	<input type="checkbox"/>	<input type="checkbox"/>
k. Information specialists	<input type="checkbox"/>	<input type="checkbox"/>
l. Others, please specify _____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Don't know		
<input type="checkbox"/> None of the above		
<input type="checkbox"/> Not applicable		

7. For any staff, contractors, or partnership members who participate in diversity training, do they participate on a one-time basis, for example, at hiring or contract/membership orientation, or on a continuous or periodic basis?

	One-time		Continuous		Don't Know
	<u>At hiring/ orientation</u>	<u>Later</u>	<u>At least annually</u>	<u>Less regularly</u>	
a. Employed staff	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Contractors	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Partnership members	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

8. Which of the following racial and ethnic population groups are addressed in the cultural competence or diversity training provided or assured by your department?

MARK ALL THAT APPLY

- Black or African American
- Hispanic or Latino
- Asian
- Native Hawaiian or other Pacific Islander
- American Indian or Alaska Native
- White
- Recent immigrants born and/or raised in countries outside of the U.S.
- Don't know
- None of the above

9. Which of these other population groups are addressed in the diversity training program?

MARK ALL THAT APPLY

- Women
- Religious minorities (e.g., Christian Scientists, Muslims, Orthodox Jews)
- Sexual minorities (e.g., gays, lesbians)
- The elderly
- Persons with physical limitations or disabilities
- Persons with mental disabilities
- Low-literate or illiterate persons
- Persons with limited English proficiency
- Persons with terminal illness or other end of life issues
- Low income or poor
- Rural populations
- Homeless persons
- Other, please specify _____
- Don't know
- None of the above

10. Which of the following topical areas are typically included in the diversity training program?

MARK ALL THAT APPLY

- Definitions and discussions of relevant concepts (e.g., diversity, culture, race, ethnicity)
- Cultural beliefs, values, and behaviors
- Laws and regulations against discrimination
- Organizational policies, plans, and protocols regarding culturally and linguistically appropriate services
- Health disparities (e.g., nature, extent, contributing factors)
- Differential epidemiology and symptomatology
- Treatment and medication response
- End of life issues
- Bias in health care delivery
- Complementary and alternative healing practices
- Ethical issues such as patient confidentiality and informed consent procedures
- Other, please specify _____
- Don't know
- None of the above

11. Which of the following resources or activities are included in the diversity training?

MARK ALL THAT APPLY

- Handbooks and other educational resources (e.g., website)
- Conferences
- Clinical experiences with diverse patient populations
- Modules for patient-provider communication
- Work with interpreters
- Coordination with traditional healers
- Other, please specify _____
- Don't know
- None of the above

12. Which of the following entities are responsible for conducting the diversity training?

MARK ALL THAT APPLY

- Client services department within the agency
- Human resources department within the agency
- Other position or department within the agency, please specify _____
- Local board of health or other governing body
- State Health Department or other State governing body
- Contracted organization or training center
- Don't know
- None of the above

13. Which of the following entities developed your agency's diversity training program?

MARK ALL THAT APPLY

- The State Health Department
- Local board of health or other governing body
- University (e.g., Centers of Excellence)
- Other contracted cultural competence training center
- Don't know
- None of the above

14. Is your agency's diversity training program reviewed by any of the following?

MARK ALL THAT APPLY

- The State Health Department
- Local board of health or other governing body
- An internal diversity working group
- Your community advisory body
- Other, please specify _____
- Don't know
- None of the above

15. How is your diversity training program evaluated for effectiveness?

MARK ALL THAT APPLY

- Supervisor survey
- Participant survey
- Participant credentialing examination or exercise
- Participant pre- and post-tests of knowledge, attitudes, skills
- Client satisfaction survey
- Client exit interview
- Other, please specify _____
- Don't know
- None of the above

16. Which of the following kinds of support do you receive to provide or assure diversity training?

MARK ALL THAT APPLY

- Budget line that allocates funds for diversity training
- Trainers provided by the State
- Trainers provided by the local board of health or other governing body
- Standardized training curricula and materials
- Other, please specify _____
- Don't know
- None of the above
- Not applicable

17. Which of the following benefits of providing or assuring cultural competency or diversity training has your agency experienced?

MARK ALL THAT APPLY

- Increased employee morale
- More effective use by staff, contractors, and/or partnership members of available interpretation and translation services
- Greater compliance by staff, contractors, and/or partnership members with agency requirements for client encounter data documentation
- Decreased client complaints or grievances regarding insensitivity
- Increased involvement of clients in diagnosis and treatment plan
- Increased client satisfaction
- Other, please specify _____
- Don't know
- None of the above

18. Which of the following challenges to providing cultural competency or diversity training for staff, contractors, and/or partnership members has your agency experienced?

MARK ALL THAT APPLY

- Lack of interest or resistance to participation
- Poor reaction of participants
- Inability to locate appropriate trainers
- Cost of trainers and materials
- Loss of work time
- Lack of backups or substitutes for trainers
- Lack of opportunity to apply skills acquired
- Other, please specify _____
- Don't know
- None of the above
- Not applicable

D. DIVERSITY, RECRUITMENT, AND RETENTION

The following questions are about recruitment and retention of your staff, contractors, and partnership members. Because personnel policies are sometimes sensitive issues, it is emphasized that none of the information you provide will ever identify individual agencies that participate in the study. Anonymity is assured.

1. Does your agency have a staffing diversity plan that addresses recruitment and retention of staff, contractors, and/or partnership members who reflect the diversity of your clients?
 - Yes → go to 2
 - No → go to 3
 - Don't know → go to 3

2. Which of the following applies to your staffing diversity plan?

MARK ALL THAT APPLY

- Covers executive level administrators and managers
- Covers other employed staff
- Covers contractors
- Covers partnership members
- Don't know
- None of the above

3. In which of the following ways does your agency support or encourage the development of a diverse staff, contractor pool, and/or partnership membership?

MARK ALL THAT APPLY

- Provides financial incentives (e.g., to obtain additional non-English languages or diversity training)
- Offers recruitment incentives (e.g., finder's fees)
- Maintains or regularly uses a regional or national recruiting network or information system
- Provides enhanced benefits packages
- Other, please specify _____
- Don't know
- None of the above

4. Which of the following strategies does your agency utilize to recruit staff, contractors, and/or partnership members that reflect the racial, ethnic, and linguistic diversity of your clients?

MARK ALL THAT APPLY

- Agency newsletter or publication
- Major regional newspaper
- Community/neighborhood newspapers or publications
- Local bulletin postings (e.g., community centers and other sites)
- Local radio outlets or television broadcasts
- National employment database
- Web sites
- Contact leaders and liaisons involved with community health issues and networks (i.e., consumer groups, advocacy groups, local health officials)
- Other, please specify _____
- Don't know
- None of the above

5. Which of the following practices apply to your agency's recruitment efforts (for staff, contractors, and/or partnership members) to address clients' needs for culturally and linguistically appropriate services?

MARK ALL THAT APPLY

- Document non-English language skills
- Identify non-English language skills as preferred or required in recruitment announcements
- Hire, contract with, or partner with, candidates with non-English language skills when other qualifications are comparable
- Identify diversity training and experience as preferred or required
- Hire, contract with, or partner with, candidates with diversity training or experience when other qualifications are comparable
- Appoint a selection committee trained in cultural competence
- Offer "sign up" bonuses paid directly to new employees, contractors, or partners with skills or training related to providing culturally and linguistically appropriate services
- Other, please specify _____
- Don't know
- None of the above

The last two questions are about diverse clinical practices that may be encouraged by your agency.

6. In which of the following ways does your agency encourage its (employed, contracted, or partnership) providers to integrate alternative and complementary treatments regarding patient care?

MARK ALL THAT APPLY

- Promotes consideration of cultural differences and preferences when developing treatments
- Promotes consultation with family members, as appropriate, when diagnosing or developing treatment for the patient
- Promotes collaboration with local culturally-specific healers about patient care or treatment
- Don't know
- None of the above

7. Which of the following alternative and complementary treatments are utilized by your (employed, contracted, or partnership) providers either directly or indirectly in collaboration with culturally-specific healers?

MARK ALL THAT APPLY

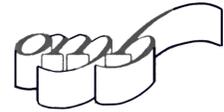
- Acupuncture/acupressure
- Physical or occupational therapies
- Chiropractic therapies
- Herbal therapies (e.g., St. John's Wort, milk thistle, ginseng)
- Relaxation techniques (e.g., progressive muscle relaxation, deep breathing, hypnosis, biofeedback)
- Diet/nutrition
- Music, dance, or art therapies
- Other, please specify _____
- Don't know
- None of the above

DRAFT

*Thank you again for your participation.
Please see cover for return instructions.*

Appendix E

Client Services Questionnaire



[INSERT NAME OF STUDY OR DATA COLLECTION EFFORT]

CLIENT SERVICES QUESTIONNAIRE

Thank you for taking the time to complete this questionnaire. The purpose of this study is to collect information on health care policies and practices that extend medical support or services to meet the needs of members of diverse linguistic, national, or cultural backgrounds. *Participation in this study does not require that your agency have any sort of policies in place that address the particular needs of certain cultural groups.* There are no expectations or judgments about services that are, or are not, offered by your agency. In the event that certain agencies report unique policies or practices that exceed current standards of care for diverse groups, prior permission will be requested from the participating agency to highlight in future publications information provided from those responses only. Anonymity is assured; data will be reported as summaries without individual or agency identification. A unique benefit of your participation in this study is that your agency will receive a copy of actual responses submitted by your staff that may be useful to your health agency in identifying and monitoring CLAS provision for quality improvement and other reporting purposes.

Although the focus of this questionnaire is on health care services provided to members of diverse cultural groups, the form is divided into four sections that cover specific topics within the broader inquiry. Depending on the structure of your agency, it may be appropriate for different individuals in your agency to complete certain sections of the questionnaire based on their roles, responsibilities, and knowledge—thereby greatly reducing individual time and effort. You are encouraged to distribute certain sections or questions to the appropriate colleague in your agency in order to complete as many questions as you can. Some questions call for your best single answer. Questions that call for multiple responses are labeled “Mark All That Apply.”

RETURN INSTRUCTIONS

Thank you again for your participation. There are two options for returning your completed questionnaire:

1. Mail the completed form using the enclosed pre-paid envelope.
If you have misplaced the envelope, please send the completed form to:

Complete as appropriate

2. Submit your completed form by facsimile transmission to:

Complete as appropriate

Paperwork Reduction Act Statement

A federal agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. Public reporting burden for this collection of information is estimated to vary from 20-30 minutes with an average of .5 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining the necessary data, and completing and reviewing the collection of information.

A. QUALITY MONITORING AND IMPROVEMENT (QI)

The following questions are about your basic systems for tracking data about your clients and services you provide, and how these data are used in planning, promoting, and evaluating services that address the specific needs of culturally and linguistically diverse groups represented by your clients. These would include internal routine information systems and quality monitoring and improvement procedures.

1. Does your agency have a formal plan for collecting information on the quality of culturally and linguistically appropriate services provided to clients?
 - Yes, a plan developed by our local agency
 - Yes, a plan developed by the local board of health or other governing body
 - Yes, a plan developed by the State
 - No
 - Don't know

2. Which of the following activities are used to collect information on the quality of culturally and linguistically appropriate services?

MARK ALL THAT APPLY

- Collection, review, and analysis of quality outcomes data
- Client satisfaction surveys
- Grievance and complaint tracking
- Chart reviews and audits
- Client focus groups
- Other, please specify _____
- Don't know
- None of the above

3. For what purpose(s) does your agency collect this information?

MARK ALL THAT APPLY

- Federal reporting requirement
- State reporting requirement
- Local board of health or other governing body reporting requirement
- To improve services
- Other, please specify _____

4. Which of the following outcome data are collected in the quality improvement (QI) studies you conduct?

MARK ALL THAT APPLY

- Client health status and functioning
- Client mental health status and functioning
- General utilization reviews
- General health outcomes
- Infectious diseases outcomes
- Hospital discharge outcomes
- Post-surgical outcomes
- Geriatric health outcomes
- Pediatric health outcomes
- Ob/Gyn health outcomes
- Prescription drug efficacy
- Prescription drug adverse effects
- Mental health service outcomes
- Substance abuse treatment outcomes
- Other, please specify _____
- Don't know
- None of the above

5. In which of the following ways are data from various QI studies used?

MARK ALL THAT APPLY

- Identify and address health care differences in race, ethnicity, gender, and other demographic variables
- Set benchmarks, targets or goals for individual service units
- Set priorities for health education and health promotion programs
- Determine performance bonuses and contract renewals
- Don't know
- None of the above

6. Does your agency conduct periodic assessments of community and/or clients' needs?

- Yes → go to 6a
- No → go to 7
- Don't know → go to 7

6a. How often are community and/or client needs assessments conducted?

- Annually
- Every two years
- Less regularly
- Within the last 2 years
- Other, please specify _____
- Don't know

6b. Which of the following community and/or client groups are involved in these needs assessments?

MARK ALL THAT APPLY

- Community advisory body
- Faith-based organizations representing local communities
- Civic organizations representing local communities
- Consumer or advocacy groups representing local communities
- Local health or government officials
- Other, please specify _____
- Don't know
- None of the above

7. In which of the following ways does your State Health Department or local board of health support QI activities and needs assessments?

MARK ALL THAT APPLY

	State Health Department	Local Board of Health
--	------------------------------------	----------------------------------

- | | | |
|--|--------------------------|--------------------------|
| a. Allocates financial resources for diversity initiative: | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Sets benchmarks for quality and outcome indicators | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Provides models for assessments | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Sends advisory personnel to your local site | <input type="checkbox"/> | <input type="checkbox"/> |
| e. Conducts them for your local site | <input type="checkbox"/> | <input type="checkbox"/> |
| f. Don't know | <input type="checkbox"/> | <input type="checkbox"/> |
| g. None of the above | <input type="checkbox"/> | <input type="checkbox"/> |
- Not applicable

8. Does your agency have an internal working group or committee that coordinates, advises, or serves as a resource for planning and evaluation of services provided specifically to culturally and linguistically diverse groups?

- Yes
- No
- Don't know

9. Are provider and client information for performance assessments and QI activities linked?

- Yes
- No
- Don't know

B. MANAGEMENT INFORMATION SYSTEMS (MIS)

The following questions are about demographic data your agency may collect on your clients.

1. Does your agency's client information database record race and ethnicity?

- Yes, for all client → go to 2
- Yes, for certain clients → go to 2
- No → go to 1a
- Don't know → go to 2

1a. To your knowledge, what are the reasons you do not record race and ethnicity for your clients?

MARK ALL THAT APPLY

- Clients' privacy rights → go to 4
- Concerns about quality or completeness of data → go to 4
- Concerns about legal liability → go to 4
- Other, please specify _____ → go to 4
- Don't know → go to 4

2. Please report or estimate what percentage of your clients falls into the following racial groups.

	Record Percent	Actual	Estimated
a. Black or African American	<input style="width: 100px; height: 20px;" type="text"/> %	<input type="checkbox"/>	<input type="checkbox"/>
b. Asian	<input style="width: 100px; height: 20px;" type="text"/> %	<input type="checkbox"/>	<input type="checkbox"/>
c. Native Hawaiian or other Pacific Islander	<input style="width: 100px; height: 20px;" type="text"/> %	<input type="checkbox"/>	<input type="checkbox"/>
d. American Indian or Alaska Native	<input style="width: 100px; height: 20px;" type="text"/> %	<input type="checkbox"/>	<input type="checkbox"/>
e. White	<input style="width: 100px; height: 20px;" type="text"/> %	<input type="checkbox"/>	<input type="checkbox"/>

If reporting the actual percentage, what is the source used for your response? _____

- Don't know

3. Please report or estimate what percentage of your clients falls into the following ethnic group.

	<u>Record Percent</u>	<u>Actual</u>	<u>Estimated</u>
a. Hispanic or Latino	<input type="text"/> %	<input type="checkbox"/>	<input type="checkbox"/>

If reporting the actual percentage, what is the source used for your response? _____

Don't know

4. Does your agency's client information database record the primary language spoken by each client?

- Yes, for all clients → go to 5
- Yes, for certain clients → go to 5
- No → go to 4a
- Don't know → go to 5

4a. To your knowledge, what are the reasons you do not record primary language spoken for your clients?

MARK ALL THAT APPLY

- Clients' privacy rights
- Concerns about quality or completeness of data
- Concerns about legal liability
- Other, please specify _____
- Don't know

5. Approximately what percentage of your clients speak a primary language other than English?

	<u>Actual</u>	<u>Estimated</u>
Record Percentage <input type="text"/> %	<input type="checkbox"/>	<input type="checkbox"/>

If reporting the actual percentage, what is the source used for your response? _____

Don't know

6. In your agency's data systems, can client demographic information (such as race/ethnicity and language) be linked with other data (such as client satisfaction, grievances/complaints, and dis-enrollment)?

- Yes
- No
- Don't know

C. TRANSLATION AND INTERPRETATION SERVICES

Written Translation Services

1. Which of the following types of written materials are available to your clients in one or more languages other than English?

MARK ALL THAT APPLY

One non- English Language	Two non- English Languages	Three or more non-English Languages
------------------------------------	-------------------------------------	---

- | | | | |
|--|--------------------------|--------------------------|--------------------------|
| a. In-take forms | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Materials regarding services available to clients | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Materials on how to access and appropriately use services | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Health education materials | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| e. Patient care instructions and forms | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| f. Medication instructions and forms | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| g. Grievance/complaint procedures and forms | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| h. Client satisfaction questionnaires/surveys | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| i. Notification of language assistance | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Other, please specify _____ | | | |
| <input type="checkbox"/> None of the above | | | |

2. Which of the following activities are used to develop written materials in languages other than English?

MARK ALL THAT APPLY

- Verbatim translations from English into other languages
- Translations into other languages that are sensitive to specialized terms or concepts used in both languages
- Translations into other languages that are prepared for the reading levels needed by persons with limited English proficiency (LEP)
- Community input to ensure cultural sensitivity and appropriateness (e.g., pretest with focus groups, community-based organizations, or members with LEP)
- Translated materials (from English into other languages) are back-translated into English
- Materials are originally developed in languages other than English
- Don't know
- None of the above

3. Which of the following practices generally apply to the translations of written materials provided by your agency to its clients?

MARK ALL THAT APPLY

- Specific training and/or demonstrated ability to write professionally in the language of interest is required
- Specific training and/or demonstrated ability to write to the reading and comprehension level of the audience in the language of interest is required
- Don't know
- None of the above

4. Which of the following entities provide review and/or approval of translated materials and products available to your clients?

MARK ALL THAT APPLY

- State Health Department
- Local board of health or other governing body
- An agency internal working group or body
- An external group (e.g. community members, community-based organizations)
- Client focus groups
- Other, please specify _____
- Don't know
- None of the above

5. Does your agency set and monitor targets or threshold levels for which vital documents and other written materials are translated to meet the language needs of your clients?

- Yes → go to 5a
- No → go to 6
- Don't know → go to 6

- 5a. What percentage or number of clients who speak a language other than English is used as the target or minimum threshold for translating materials into that language?

Percentage _____

Number _____

- No minimum threshold
- Don't know

6. What methods are used by your agency to determine the need for translation of written materials into languages spoken by your clients?

MARK ALL THAT APPLY

- Number or percent of persons in the community who speak a language other than English
- Number or percent of clients who speak a language other than English
- Client requests/demand
- Staff requests/demand
- Other, please specify _____
- Don't know
- None of the above

7. Which of the following sources are used to determine the languages spoken by the populations served by your agency?

MARK ALL THAT APPLY

- U.S. Census data
- Client utilization data
- Data from community agencies/organizations
- Data from school systems
- Other, please specify _____
- Don't know
- None of the above

8. Which of the following methods are used to inform clients of the availability of translated documents and materials?

MARK ALL THAT APPLY

- Translated inserts in general documents (e.g. brochures, manuals)
- Translated recorded messages on telephone lines
- Interpreters in reception area
- Translated signage and notices at key points of contact throughout the agency
- Other, please specify _____
- Don't know
- None of the above

9. Is there a specific budget line in your agency for the allocation of funds to support translation of written documents and materials into languages spoken by your clients?

- Yes
- No
- Don't know

Oral Interpretation Services

10. Which of the following interpretation services are available to your clients?

MARK ALL THAT APPLY

	One non- English Language	Two non- English Languages	Three or more non-English Languages
--	--	---	--

- | | | | |
|--|--------------------------|--------------------------|--------------------------|
| a. Telephone interpreter language line | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Bilingual and/or bicultural non-clinical staff | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Bilingual and/or bicultural clinical staff | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Full-time staff interpreters | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| e. Contracted interpreters | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| f. Volunteer interpreters | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| g. Simultaneous interpretation | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Other, please specify _____ | | | |
| <input type="checkbox"/> No formal services available; utilize assistance from members, families and friends | | | |
| <input type="checkbox"/> Don't know | | | |
| <input type="checkbox"/> None of the above | | | |

11. Which of the following characteristics apply to language interpreters used by your agency?

MARK ALL THAT APPLY

- Certified in medical interpretation
- Demonstrated proficiency in English and the other language(s)
- Trained in ethics of interpreting
- Trained in sequential or consecutive interpreting
- Trained in simultaneous interpreting
- Knowledge (in both languages) of specialized terms or concepts
- Trained in interpreting for individuals with limited English proficiency
- Don't know
- None of the above

12. Which of the following entities review and/or approve staffing and operation of interpretation services available to your clients?

MARK ALL THAT APPLY

- State Department of Health
- Local board of health or other governing body
- Your community advisory board
- An agency internal working group or body
- An external group (e.g., community members, community-based organizations)
- Client focus groups
- Other, please specify _____
- Don't know
- None of the above

13. Does your agency set and monitor targets or threshold levels for which interpretation services are systematically made available to meet the language needs of your clients?

- Yes → go to 13a
- No → go to 14
- Don't know → go to 14

13a. What percentage or number of clients who speak a language other than English is used as the target or minimum threshold for the provision of interpretation services in that language?

Percentage _____

Number _____

- No minimum threshold
- Don't know

14. What methods are used by your agency to determine the need for interpretation services?

MARK ALL THAT APPLY

- Number or percent of persons in the community who speak a language other than English
- Number or percent of clients who speak a language other than English
- Identification of clients with low literacy
- Client requests/demand
- Staff requests/demand
- Other, please specify _____
- Don't know
- None of the above

15. Please provide the best estimate of how many employed, contracted, and certified medical interpreters are available to provide language assistance to your clients and staff?

Employed (on staff) interpreters, estimated number _____

Contracted interpreters, estimated number _____

Certified medical interpreters, estimated number _____

- Don't know

16. At which of the following key entry or contact points does your agency provide interpretation services in languages other than English spoken by your clients?

MARK ALL THAT APPLY

- Telephone emergency line service
- Telephone general information service
- Emergency services entry point
- Information desk/main lobby
- Walk-in clinic services
- Pharmacy services
- Other, please specify _____
- Don't know
- None of the above

17. Which of the following methods are used to inform clients of the availability of bilingual speakers and interpretation services in your agency?

MARK ALL THAT APPLY

- Translated informational documents
- Translated recorded messages on telephone lines
- Translated signage and notices at key points of contact throughout the agency
- Other, please specify _____
- Don't know
- None of the above

18. Is there a specific budget line for the allocation of funds to support bilingual speakers and interpretation services in your agency?

- Yes
- No
- Don't know

19. For which of the following groups are translated materials and interpretation services generally made available by your agency?

MARK ALL THAT APPLY

- All individuals in the community
- All individuals entering our facilities and requiring services
- All individuals eligible for services
- Other, please specify _____
- Don't know
- None of the above

D. OTHER RELATED CLIENT SERVICES

1. Which of the following are provided or assured by your agency in an effort to be more culturally responsive to your clients?

MARK ALL THAT APPLY

- Scheduled days and hours of operation other than the usual 8 a.m. to 5 p.m. range
- Culturally friendly physical environment with interior design, pictures, posters, and artwork throughout of diverse populations engaged in meaningful activity
- Dietary options in cafeteria or food service areas that reflect the cultural beliefs and behaviors of your clients
- Facilities or services specifically intended to accommodate groups of diverse religious faiths
- Signage and directions translated and available in predominant languages of service population
- Signage in braille at critical points of service for the blind
- Print materials prepared in larger fonts for older and visually-impaired audiences
- Use of language identification cards to identify the language spoken by clients
- Handicapped access to all key entryways, exits, and service areas
- Services for the hearing impaired, including phones and personnel trained in American Sign Language
- Publicly disseminated annual report or publication of agency's efforts to provide culturally and linguistically appropriate services
- Other, please specify _____
- None of the above

2. Which of the following complementary or alternative healing practices are offered to your clients?

MARK ALL THAT APPLY

- Acupuncture/acupressure
- Physical or occupational therapies
- Chiropractic therapies
- Herbal therapies
- Hydrotherapy
- Homeopathy
- Stress management and relaxation techniques (e.g., progress relaxation, deep breathing, hypnosis, biofeedback)
- Diet/nutrition
- Music, dance, or art therapies
- Other, please specify _____
- Don't know
- None of the above

3. Which of the following kinds of information are available to your clients to promote the ability of your employed staff, contractors, and/or partnership members to serve culturally and linguistically diverse groups?

MARK ALL THAT APPLY

- Proficiency in languages other than English
- Proficiency in American Sign Language
- Racial/ethnic background
- State and/or national origin
- Special training and/or certification in cultural competency
- Special training and/or certification in complementary or alternative healing practices
- Other, please specify _____
- Don't know
- None of the above

4. Which of the following characteristics pertain to written materials available to your clients?

MARK ALL THAT APPLY

- Graphics and depictions reflect the racial and ethnic diversity of the populations served
- Graphics and depictions reflect other forms of diversity reflected in the populations served (e.g., religious, gender, functional ability, age)
- Graphics and depictions are free of generalizations and stereotypes based on race, ethnicity, gender, age, religion, sexual orientation, income, and disability
- Content is geared to persons of varying reading levels
- Readability testing is performed on written materials to ensure that content is geared to average reading level of the audience
- Don't know
- None of the above

5. Which of the following benefits have been achieved by your agency as a result of providing or assuring services that are responsive to the cultural and linguistic diversity of your clients?

MARK ALL THAT APPLY

- Fewer complaints, grievances, and legal actions from clients and staff
- Increased client satisfaction
- Increased staff/employee morale and retention
- Enhanced reputation for community consciousness and service
- Stronger marketing potential
- Enhanced communication and comprehension between patients and providers
- Better diagnostic accuracy
- Better compliance by clients with treatment plans
- Better disease management
- Better long-term health outcomes for clients
- Lower overall costs per client
- Other, please specify _____
- Don't know
- None of the above
- Not applicable

6. Which of the following factors present challenges for your agency in providing or assuring services that are responsive to the needs of culturally and linguistically diverse clients?

MARK ALL THAT APPLY

- Your clients are not very culturally or linguistically diverse
- The population in your service area is not very culturally or linguistically diverse
- You are not aware of programs that are effective for your situation
- Current knowledge about cultural and linguistic impacts on health and treatment is not scientifically reliable
- These programs are too costly in comparison to their benefits
- It is difficult to make staff time available for planning, assessment, or training
- Your agency is not primarily responsible for design of services
- Your agency is not primarily responsible for management of quality or utilization
- You do not have any training programs for your contractors
- Other, please specify _____
- Don't know
- None of the above
- Not applicable

*Thank you again for your participation.
Please see cover for return instructions.*

Appendix F

Pilot Test Response Form

Appendix F

Organization Code: _____
Questionnaire: _____

PILOT TEST RESPONSE FORM

Instructions:

1. Please use this form to record your responses to the Pilot Test Questionnaire Package. If different staff members share the effort of completing the questionnaire, please allow each individual to complete this form for the appropriate section(s). For example, if one staff member completes sections A through C of the questionnaire and another staff member completes section D, each staff member should record their responses in the table on page 2 of this form *only for the section(s) that correspond to the section(s) they completed in the questionnaire.*
2. On page 2, rate the utility of each component (cover letter; questionnaire cover sheet; and questionnaire sections A-D) based on the categories provided and the following rating scale: *(1 = very appropriate); (2 = appropriate); (3 = somewhat appropriate); and (4 = not appropriate).* In using the rating scale, consider the level of appropriateness for presenting each component to someone in a similar staff position to yours. Also, if you rate a particular component category as "3" (somewhat appropriate) or "4" (not appropriate), please let us know why, or give suggestions for change, by commenting in the box provided on page 3 of this form.

Please evaluate each questionnaire section as a whole, but feel free to provide written comments in the box on page 3 if there are particular items of concern within a section. If you provide written comments on a particular question or item, please indicate the questionnaire section and question number you are referring to.

3. In addition, your general comments and suggestions about the design or topical content of the questionnaire, or specific questions within, are greatly appreciated.
4. Finally, please return this Pilot Test Respondent Evaluation Form with your completed questionnaire.

Thank you.

**RESPONDENT EVALUATION
OF THE QUESTIONNAIRE PACKAGE**

COMPONENT	<u>RATING SCALE (please circle)</u>			
	<u>Very Appropriate</u>	<u>Appropriate</u>	<u>Somewhat Appropriate</u>	<u>Not Appropriate</u>
<u>Cover Letter</u>				
1. Layout and Design	1	2	3	4
2. Clarity of Information	1	2	3	4
3. Motivational Effect to Participate	1	2	3	4
<u>Questionnaire Cover Sheet</u>				
1. Layout and Design	1	2	3	4
2. Clarity of Information	1	2	3	4
3. Clarity of Return Instructions	1	2	3	4
4. Options for Returning Completed Questionnaire	1	2	3	4
<u>Questionnaire, Section A</u>				
1. Layout and Design	1	2	3	4
2. Clarity of Instructions	1	2	3	4
3. Question Wording	1	2	3	4
4. Response Categories	1	2	3	4
5. Ability to Recall Information	1	2	3	4
<u>Questionnaire, Section B</u>				
1. Layout and Design	1	2	3	4
2. Clarity of Instructions	1	2	3	4
3. Question Wording	1	2	3	4
4. Response Categories	1	2	3	4
5. Ability to Recall Information	1	2	3	4
<u>Questionnaire, Section C</u>				
1. Layout and Design	1	2	3	4
2. Clarity of Instructions	1	2	3	4
3. Question Wording	1	2	3	4
4. Response Categories	1	2	3	4
5. Ability to Recall Information	1	2	3	4
<u>Questionnaire, Section D</u>				
1. Layout and Design	1	2	3	4
2. Clarity of Instructions	1	2	3	4
3. Question Wording	1	2	3	4
4. Response Categories	1	2	3	4
5. Ability to Recall Information	1	2	3	4

**Please estimate the amount of time it took you to complete the questionnaire: _____

Would it be useful to have an additional option for completing and submitting the questionnaire on an Internet web site? Yes ____ No ____

SPECIAL COMMENTS OR SUGGESTIONS

(If referring to a particular item, please indicate section and question number.)



If your comments require more space, please feel free to attach additional pages.

Appendix G

CLAS in MCOs Study Data Collection Plan

Appendix G

CLAS in MCOs Study Data Collection Plan

1. DATA COLLECTION DESIGN CONSIDERATIONS

1.1 Identifying Appropriate Respondents

An important component of the study's data collection plan was to determine who, i.e., which MCO staff types, would be most appropriate for answering questions related to the study domains and key elements. Brainstorming exercises were conducted, and extensive deliberations were held among the research team, OMH staff, and the experts from the field to examine the domains and key elements in terms of the types of respondents who would be knowledgeable of, and therefore able to answer questions related to, particular areas of inquiry.

An examination of the domains, key elements, and study variables revealed a clear conceptual division, or categorization of topical inquiries, to be paired with respondent types who would be appropriate for gathering the needed information. The conceptual framework was studied and discussed at length, both in its entirety and within each domain. Through these discussions, the following pattern of topical inquiries emerged: the framework was found to comprise measures of CLAS practices as they relate to: 1) the organization; 2) its staff; and 3) its members. As such, these discussions resulted in a three-tiered approach for collecting data within each MCO. One respondent would be responsible for completing a questionnaire component that covered each of these three main areas of inquiry, so that three respondents per MCO would participate in the study's data collection effort.

Questions related to CLAS practices at the organization level (e.g., CLAS-related corporate planning and policy development) should be directed toward a senior executive within the organization, such as a Chief Executive Officer (CEO) or Medical Director. This decision to identify and approach an MCO's senior executive for the organization-related topics of inquiry was strengthened by the fact that the American Association of Health Plans (AAHP) managed care directory, that would be used as the study's sampling frame maintained by the American Association of Health Plans (AAHP) included contact information for each organization's CEO or Medical Director.

An important consideration was offered by members of the expert panel regarding the level of variation among MCOs and their staffing patterns. Because organizations vary by size and function, identifying the two remaining respondents within each MCO may prove to be more complicated. As such, the panelists recommended that appropriate respondents for completing the questionnaire components covering staff- and member-related CLAS practices be identified by someone within the organization such as a high-level executive.

Also, it was recommended that the appropriate respondents for completing the staff- and member-related components of the instrument be based on *function and knowledge*, not title or

position, as titles will likely vary by organization. Therefore, the research team, OMH staff, and the advisory groups agreed that these two respondent types would be described very broadly as “staffing respondents” and “membership respondents.” The individuals within each organization would be identified by the senior executive based on individuals’ roles, responsibilities, and knowledge that best suit the topical nature of each staff- and member-related questionnaire component.

1.2 Designing a Three-Component Questionnaire

A three-component instrument was developed to be administered to the three respondents within each MCO: a *Senior Executive Telephone Interview Protocol* (see Appendix C); a *Staffing Questionnaire* (see Appendix D); and a *Membership Questionnaire* (see Appendix E).

The *Senior Executive Telephone Interview Protocol* was designed to be brief in order to accommodate the busy schedules of executive respondents. Therefore, the majority of survey items were to be included in the *Staffing* and *Membership Questionnaires*. As indicated, items related to organizational governance (Domain 1) and CLAS-related corporate policies (Domain 2) are located in the *Senior Executive Telephone Interview Protocol*. Questionnaire items related to staffing patterns (Domain 6), staff training (Domain 7), and patient assessment and treatment services (Domain 3) are found in the *Staffing Questionnaire*. The *Membership Questionnaire* includes items related to translation and interpretation services (Domain 8), and the health care environment (Domain 3). Information about Management Information Systems (Domain 5) is asked in both the *Staffing* and *Membership Questionnaires*, and questions about CLAS-related quality monitoring and improvement efforts (Domain 4) are included in all three components.

1.3 Selecting an Appropriate Study Universe and Sampling Strategy

Because this study involves data collection from a sample of MCOs, or health plans, the most appropriate sampling frame was identified as the directory maintained by AAHP. AAHP represents approximately 1,000 health plans which cover about 170 million individuals in the U.S.

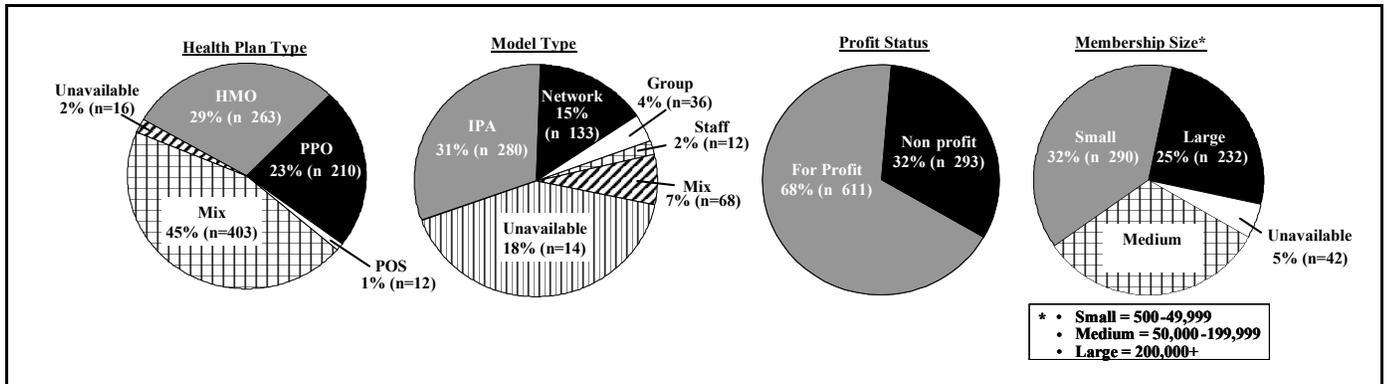
The Association was created in 1995 through a merger of the Group Health Association of America and the American Managed Care and Review Association. AAHP’s mission is to advance health care quality and affordability through leadership in the health care community, advocacy and the provision of services to member health plans. AAHP provides a wide range of services to its members, including: federal- and state-level advocacy within regulatory agencies, a strategic communications program, quality assessment and improvement programs, public policy and research, and educational programs (e.g., the Minority Management Training and Outreach Program) on the latest developments in managed care.

At the time of sample selection (i.e., February 2002), the 2001 edition of the *AAHP Directory of Health Plans* offered the most current and complete coverage of MCOs nationwide and included a total listing of 904 organizations. The directory identifies metropolitan market

areas of MCOs and contains information on health plan type, profit status, membership size, and model type. Organizational characteristics of the universe of MCOs are provided in Exhibit 1.

Exhibit 1

ORGANIZATIONAL STRUCTURE OF MCOS IN THE AAHP 2001 DIRECTORY OF HEALTH PLANS



Disadvantages associated with using an association’s directory as a study sampling frame are shared by any similar directory. First, directory listings typically have a lag of about a year between information collection and publication, which could be especially problematic for this study considering the level of consolidation occurring in the health care system at that time. Second, because directories often serve as a sort of yellow pages where purchasers can seek out organizations in certain geographic locales, listings are often too detailed and repetitious. Such repetition may require a fair amount of file manipulation to remove duplicate listings, at some cost.

During the study design phase, several characteristics and conditions were explored and considered for developing an appropriate sampling strategy. The most important component was to ensure that the study sample would reflect a nationally representative group of MCOs. A second consideration was that the MCOs selected for study participation should include organizational, membership, and geographic variation.

Discussions were held among the research team, OMH staff, and the project advisory groups to determine the appropriate strategy. Initially, the research team proposed several variables for stratifying the sample of MCOs, including the metropolitan statistical areas (MSAs) in which the organizations reside; organizational characteristics such as health plan type, profit/non-profit status, or membership size of each MCO; and demographic characteristics (e.g., racial, ethnic, cultural, and linguistic composition) of the population served by each MCO.

Following extensive deliberations, members of the expert panel advised that the rapidly-changing landscape of health plans—at both the service and organizational levels—was too

complex and uncertain at the time to employ a stratified sampling strategy of any sort. Because the health care system was in a fluid and evolutionary state, many MCOs were merging with other organizations, and many were going out of business. As such, characteristics or conditions that would normally be used to stratify a sample of MCOs were transient during the time of this study. Therefore, the group concluded that the most appropriate strategy for selecting the study sample was the most parsimonious one, i.e., a national random selection of MCOs.

To ensure that the sample drawn would be representative of all MCOs, calculations were performed to determine the degree of precision with which generalizations could be made to the target national population. The most typical measure of survey precision is the widths of confidence intervals for simple univariate estimates and for estimates within analytical subgroups. An analysis of confidence intervals for this study revealed that a sample of 240 MCOs (from the universe of approximately 1,100 at the time) would allow 95 percent confidence intervals for categorical variables that have widths of approximately 4-7 percent. For typical subgroup analyses utilizing six subgroups, a sample of 240 MCOs would yield confidence intervals that range in width from 6-15 percent, depending on the size of the subgroup sample and the particular variable.

2. DEVELOPING THE DATA COLLECTION PLAN

Once the three respondent types (per MCO) were identified, the next step was to develop a data collection plan which would most likely render a high response rate. Here too, however, the rapidly-changing structure of MCOs at the time—i.e., the evolution of the organizations themselves, as well as changes in the staff within the organizations—influenced the decisions made during the data collection planning phase.

The first point of contact with each MCO would be an introductory letter mailed to the organization's senior executive, as listed in the AAHP directory, with a follow-up telephone call conducted to confirm receipt of the letter and determine the senior executive's availability for study participation. The contact information in the directory provided a starting point for penetrating the MCOs and for determining the appropriate senior executive to complete the telephone interview.

An interview is the most appropriate method for gathering information on an organization's policies, histories, and future plans; because the types of information to be collected typically require the participation of senior-level executives who have busy schedules, these respondents are more likely to agree to a telephone interview than to a face-to-face interview (Marshall and Rossman 2000). The telephone interviews for this study would be conducted using Computer Assisted Telephone Interviewing (CATI) by experienced interviewers who would receive training specifically for this data collection effort. The use of CATI provides a number of time-saving advantages in the data collection process including: electronic recording of a participant's responses (eliminating the manual data entry step); electronic guidance through the interview (e.g., making appropriate skips automatically based on the respondent's answers); and logic checking capability to ensure consistent responses.

In an effort to make the telephone interviews with senior executives even more efficient, the final question posed would be to ask the executive to identify or recommend appropriate staff within the organization to complete the *Staffing and Membership Questionnaires*. Because a minimum of 480 Staffing and Membership respondents—i.e., two respondents in each of the 240 MCOs—would be asked to complete a questionnaire (that would be much lengthier than the senior executive’s inquiry), these data would be collected by mail rather than telephone, to reduce costs. Once Staffing and Membership respondents were identified by the senior executive at the conclusion of the telephone interview, a personalized introductory letter would be mailed to invite the individuals to participate in the study, along with a copy of the respective questionnaire and instructions for submitting the completed questionnaire.

The need for follow-up contacts with respondents who do not submit a completed questionnaire in a timely manner was considered during the data collection planning phase. The research team, OMH staff, and members of the advisory groups agreed that multiple follow-up contacts may be required with these respondents. As such, a *series* of reminders in *various forms* were determined necessary for this population. Reminder postcards would be disseminated to respondents as a first step, and up to three reminder telephone calls per respondent would become part of the data collection plan.

2.1 Conducting the Pilot Test

In order to test the appropriateness of the data collection process and the study instruments, a pilot assessment using cognitive testing techniques was conducted with nine respondent representatives—one Senior Executive respondent, one Staffing respondent, and one Membership respondent from each of three MCOs—between March and June 2001. The six Staffing and Membership respondents completed a *Pilot Test Response Form* (see Appendix F) that was designed to provide respondent feedback on the format and content of the instruments. For each questionnaire component (cover letter; questionnaire cover sheet with instructions; each of four questionnaire sections), respondents were asked to rate certain elements (e.g., layout and design; clarity of instructions; clarity of question wording and response categories; ability to provide requested information) based on the level of appropriateness for presenting each component to someone in a similar staff position as themselves.

An average rating score was used to summarize the responses to the 4-point scale (i.e., 1 = very appropriate; 2 = appropriate; 3 = somewhat appropriate; and 4 = not appropriate). The three Staffing pilot respondents reported an average rate of 1.4, and the three Membership pilot respondents reported an average rate of 1.3. Moreover, there were no responses of “not appropriate” for any component of the *Staffing* or *Membership Questionnaires*. These results demonstrated that for the pilot participants, the *Staffing* and *Membership Questionnaires* were found to be understandable and appropriate—in both format and content—for the purposes of this study.

By implementing the initial data collection plan with a test group of respondents, several methodological changes were found to be necessary. These modifications are described below.

1. *Incorporate a confirmation pre-call to MCOs selected in the sample.* This adjustment was determined necessary in order to verify and update contact information that was outdated. These limitations however, did not influence the selection of the MCOs into the sample; the procedural modification was needed to expedite the process of reaching the appropriate first contact in the particular MCO.

During the pilot, certain obstacles were encountered when initial contact letters were mailed to each MCO selected for the sample. For example, the information on the identified senior executive (to whom the initial contact letter was addressed) was found to be outdated in two ways: either the individual no longer held the position, or the individual was the correct contact but was located at the health plan headquarters at another address. Also, the telephone numbers listed in the directory for MCO senior executives were sometimes a general number, not a direct line to the senior executive's office. In this situation, it became difficult to ascertain whether the MCO (specifically, the identified senior executive) had received the initial contact letter. Due to these difficulties, the procedure was modified to include a confirmation pre-call to be made before the initial contact letter was mailed to the selected MCOs.

The confirmation pre-call was incorporated to verify the following:

- The telephone number is *not* an automated service, but allows direct contact with the identified senior executive's office to confirm name and address;
- The identified senior executive still holds the relevant position. If not, the current senior executive is identified; and
- The identified senior executive is based in the local office being called. If the identified senior executive is not based out of the local office, another senior person or manager is identified to receive the initial contact letter from OMH.

2. *Add an Internet web site option for accessing, completing, and submitting follow-up questionnaires for Staffing and Membership respondents.* In the *Pilot Test Response Form*, most respondents (4 out of 6) indicated an option for completing and submitting the (follow-up) questionnaires on the Internet would be useful. Based on these reports, the *Staffing and Membership Questionnaires* were converted into HTML format so that the web site submission option would be available to respondents at the time of data collection.

3. *Reduce the size of the Staffing and Membership respondent mail packages.* During the pilot phase, personnel that were recommended by the senior executive were mailed packages that included a copy of the actual survey. As a result of information learned through the pilot regarding the desirability of completing and submitting the questionnaires electronically (either by electronic mail or Internet web site), hard copies of the instruments were no longer to be included in the initial contact packages for these respondents. Instead, Staffing and Membership respondents would receive an introductory letter from OMH and instructions for participating in

the study, including information on options for accessing and completing the questionnaire, through electronic mail, Internet web site, facsimile, or postal mail.

4. *Develop an alternate contact letter for sending two follow-up questionnaires to one individual staff member (to distribute to others in the organization).* On one occasion during the pilot, the senior executive requested to recommend only one individual to receive the information for both the *Staffing* and *Membership Questionnaires*. This single designee was to receive the contact materials and then distribute the two questionnaires to the appropriate staff in the organization. To accommodate these unforeseen circumstances, a third (alternate) contact letter from OMH was developed to use under these conditions.

The final data collection methodology that resulted from information learned through the literature review; discussions and deliberations among the research team, OMH staff, and the two advisory groups; and the pilot administration, is presented in Exhibit 2.

2.2 Incorporating Efforts to Maximize Response Rate and Reduce Respondent Burden

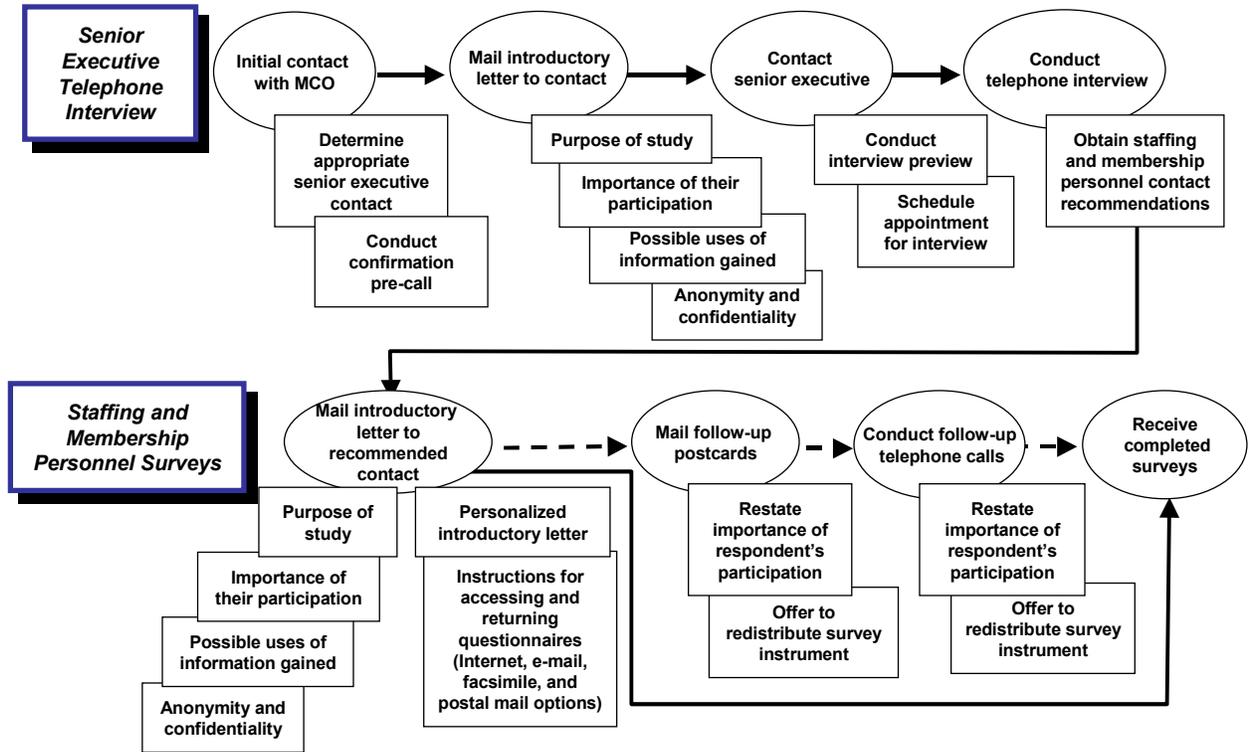
Because of the changing landscape of the health care system at that time, as well as their concerns about obtaining a high response rate, members of the expert panel advised the research team and OMH staff that obtaining the needed sample size of 240 MCOs would be difficult at best. With this caution, a significant attempt was made to anticipate reasons for non-response and incorporate strategies for increasing response rate into the data collection design prior to going into the field. The initial strategies that were included in the original data collection plan are described below. Additional strategies to increase response rate were utilized *after* the actual data collection process started.

Sample Over-recruitment. To ensure an adequate sample size and account for attrition, the initial sample of MCOs was over-recruited from the universe of MCOs. The original study sample size was 240, but an over-sampling strategy was employed prior to sample selection to increase the sample size by 20 percent (48 additional organizations).

Respondent Contact Materials and Protocols Provide Clear Descriptions of the Study, its Purpose, and its Importance. To stress the study's importance, a formal introductory letter signed by the Deputy Assistant Secretary for Minority Health would be mailed to all identified senior executives of MCOs selected for study participation. The letter would announce and describe the study, its purpose, and its importance. Several enclosures would accompany the letter to emphasize the credibility of the study. The enclosures would include: 1) a letter from a senior representative of AAHP stating the organization's support for the study and encouraging participation of each MCO; and 2) membership lists of the study's two advisory committees. All materials to be received by respondents (including questionnaires, letters, and postcards), would provide assurance of confidentiality and anonymity. Also, respondents would be assured data would be reported as aggregated summaries without individual or organizational identification.

Exhibit 2

DATA COLLECTION PROCESS



Varied Modes of Administration and Submission. To minimize individual burden and, as a result, increase the study response rate, the *Staffing and Membership Questionnaires* were designed so that more than one individual may share the completion of each survey. Each questionnaire would include four color-coded sections, representing the most likely divisions for sharing (e.g., Management Information Systems and Staff Recruitment and Retention). This technique enables the materials to be readily passed to the most knowledgeable informant with the understanding that each individual is responsible for completing only a relatively small portion of the form.¹ In addition, multiple options would be made available to respondents for submitting completed questionnaires, including Internet web site submission, an option to submit via electronic mail with the questionnaire attached, and options for facsimile or postal mail return with postage paid.

Thorough Follow-up Contact Procedures. Extensive and aggressive follow-up contact procedures would be utilized in an attempt to increase the study response rate. The dates of

¹The color-coding technique has an additional benefit in that the questionnaire is both attractive and attention-getting, thus making it less likely to be overlooked and forgotten, should the respondent temporarily set it aside upon receipt.

initial contact and all follow-up correspondence with the MCOs would be thoroughly documented and tracked. Reminder postcards were to be mailed to those respondents who had not submitted completed questionnaires two weeks after the requested submission date. If there was no response within two weeks of the first reminder, up to three follow-up telephone calls would be made to each respondent who still had not submitted a completed questionnaire. For each respondent, these calls were to be placed at different times of the day, and voice mail messages would be left when the option was available. Each follow-up contact would restate the importance of participation and include an offer to redistribute the questionnaire.

Incentives for study participation. During the study's planning phase, OMH staff explored several potential options that would allow the data submitted by participating MCOs to satisfy existing reporting requirements related to quality monitoring and improvement. Although this type of incentive would be ideal for the participating MCOs, such a "deeming" effort could not be accomplished. Nevertheless, an effort to offer some type of incentive for participation was needed, so the introductory letter to each MCO senior executive would state that all participating MCOs would receive a copy of the study's Final Report when released. In addition, at the request of any participating senior executive, copies of their organization's completed questionnaires (i.e., raw data) would be provided. The idea for this incentive emerged from the assumption that the organization may use the tool and the actual data submitted for this study for its own monitoring and reporting purposes.

Implementation of the MCOs study data collection plan and study results are described in the study's Final Report (OMH 2003b).