Providing Quality Health Care with

CLAS

Culturally and Linguistically Appropriate Services

A Curriculum for Developing Culturally & Linguistically Appropriate Services

Participant Workbook

CDPH California Department of PublicHealth

DHCS California Department of HealthCareServices

CaOMH California Office of Multicultural Health

UCDAVIS HEALTH SYSTEM Center for Reducing Health Disparities

CALIFORNIA DEPARTMENT OF PUBLIC HEALTH

AND

DEPARTMENT OF HEALTH CARE SERVICES

OFFICE OF MULTICULTURAL HEALTH

A Curriculum for Developing Culturally and Linguistically Appropriate Services

Participant Workbook

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Suggested citation: Ton, H., Steinhart, D., Yang, M, S., Sala, M., Aguilar-Gaxiola, S., Hardcastle, L., Méndez, L. & Bodick, D. (2011). *Providing Quality Health Care with CLAS: A Curriculum for Developing Culturally and Linguistically Appropriate Services*. Sacramento, CA: Office of Multicultural Health, California Department of Public Health and Department of Health Care Services.

Acknowledgements

The **Providing Quality Health Care with CLAS Curriculum Tool Kit** is a project of the Office of Multicultural Health, California Department of Public Health and the Department of Health Care Services. It was developed in partnership with the University of California, Davis, Center for Reducing Health Disparities. The goal is to educate providers and health care institutions about Culturally and Linguistically Appropriate Services standards (CLAS). CLAS responds to the important need for cultural and linguistic competency in health care delivery; a crucial component in the reduction of health disparities and provision of quality care to diverse patient populations.

The curriculum tool kit is the result of a multiyear process that involved many special individuals in California and beyond. We extend our appreciation to them:

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- Office of Multicultural Health and UCD/CRHD staff members who assisted with development, editing and data (See page 115).

- The External Advisory Committee for their expertise in cultural and linguistic competency in the health care delivery system, needs of and provision of quality services to diverse patient populations (See pages 116-117).

- Participant organizations for their involvement and insights that resulted in refinements of the final version of the tool kit (See page 118).

- The U.S. Department of Health and Human Services, Office of Minority Health for funding the development of the curriculum tool kit under the State Partnership Grant Program (Grant No. STTMPO51006-01-00).

Health organizations are encouraged to use the **Providing Quality Health Care with CLAS Curriculum Tool Ki**t to train your leaders and program managers on culturally and linguistically appropriate services. Should you use this curriculum tool kit, the Office of Multicultural Health would appreciate your evaluation and feedback. Please send this information to:

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This curriculum tool kit is available online at the Office of Multicultural Health website at

http://www.cdph.ca.gov/programs/OMH/Pages/default.aspx

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Introduction

You have been identified by the top leadership in your organization to participate in the **Providing Quality Health Care with CLAS** Curriculum. This program is designed to help organizational leaders and program managers like you to implement the **Culturally and Linguistically Appropriate Services (CLAS)** standards from the U.S. Department of Health and Human Services, Office of Minority Health. We can help you do this by building upon your organization's existing infrastructure and mission values. We utilize small-group, problem-based discussions that have been shown in many educational contexts to enhance creative problem-solving and to more effectively develop higher-level understanding of topics discussed (Ton et al., 2005). Rather than having a "cookbook" approach that superimposes a model without attention to the unique challenges and strengths of your organization, this strength-based approach can more effectively help you to creatively implement these standards in your organization.

This program consists of three parts. The first part involves taking an anonymous survey that assesses your level of familiarity and comfort with the CLAS standards. This assessment will help us customize the curriculum to match your learning needs, along with those of the other participants. In the second part of the program, participants will attend four workshop sessions, each lasting 4 hours, in order to develop a quality improvement plan that incorporates one or more of the CLAS standards. You will be given assignments after each session that will take between 30 and 60 minutes to complete before the next session. The third part of the curriculum involves attending six monthly 1-hour follow-up sessions that will help you implement and maintain the CLAS quality improvement plan that you develop.

Part I: Pre-Curriculum Survey
Part II: Learning Modules
a. Session I: Introduction to the CLAS Standards
b. Session II: Quality of Care for Culturally Diverse Patients
c. Session III: Getting to Know the CLAS Standards
d. Session IV: System Change and CLAS
Part III: Follow-Up Meetings

Preferred criteria for participation:

In order to participate in this program, you preferably should:

1. Occupy a middle- to upper-level leadership position in your organization.
2. Have interest in diversity and cultural competence.
3. Commit to designing and implementing a project incorporating CLAS standards into your service.
4. Be able to work collaboratively in small-group settings.
5. Agree to participate in four 4-hour training sessions and six 1-hour follow-up meetings.
6. Occupy a position with oversight for one or more of the following organizational domains:

- Direct services: clinic director, nurse manager, or comparable function.
- Organizational supports: continual quality improvement, human resources, staff or provider development, or similar roles.
- Language and community outreach services.

By the completion of the training, you will have acquired the following knowledge, skills, and attitudes.

Knowledge to:

1. Describe factors that contribute to health disparities;
2. Define health disparities, cultural competence, and patient-centered care;
3. Describe the impact of culture on health care decision making;
4. Describe how health disparities affect quality of care for patients of diverse backgrounds;
5. Describe the effects of immigration and acculturation on health status and quality of care;
6. Describe the health status, health disparities, health care barriers, and quality of care experienced by at least two culturally diverse populations;
7. Describe the CLAS standards and why they were developed;
8. Examine your own service in the context of CLAS standards;
9. Describe the roles that other participants play in the overall functioning of the organization;
10. Describe the factors influencing system change at the organization of which you are an employee or representative;
11. Define the concept of illness narrative;
12. Describe the impact of language barriers on care;
13. Describe the potential impact of the CLAS standards on attainment of improvements in quality of care for these communities;
14. Describe a model program that effectively implements the CLAS standards;
15. Describe the relevancy of these standards to your department;
16. Describe the qualities and approaches of effective leaders;
17. Describe the strategies used for system change;
18. Describe how CLAS standards can be applied to your service and the organization as a whole;
19. Understand the ways in which your service is related to other participants' services in order to enhance collaboration and pool resources.

Skills to:

1. Articulate your organizational vision;
2. Operate collaboratively in small-group and discussion format;
3. Use concepts learned about the health status and disparities of communities explicitly discussed in the curriculum to better understand aspects of communities not specifically discussed;
4. Critically examine the organization's ability to perform care for clients from diverse backgrounds;
5. Assess whether and how your department responds to the CLAS standards;

6. Compare and contrast the various approaches taken to implement CLAS standards;
7. Assess the readiness of your service for the CLAS standards;
8. Formulate a strategic plan to implement CLAS standards in your service and in the organization;

Attitudes to:

1. Appreciate the importance of reducing health disparities;
2. Recognize the influence of culture on your fellow participants' lives;
3. Comprehend the importance of understanding the illness experience from a client's perspective;
4. Appreciate the benefits that culturally and linguistically appropriate care can lend to the health status of diverse communities;
5. Acknowledge that these standards can be adopted in numerous effective and practical ways;
6. Commit to improving quality of service through the CLAS standards;
7. Recognize the role that you and others have to collectively and collaboratively implement the CLAS standards.

Providing Quality Health Care with CLAS

Participant Pre-Curriculum Survey

Please select the best answer to define the following:

1. I can describe the role of each participant from my department.

   [ ] Strongly agree [ ] Agree [ ] Disagree [ ] Strongly disagree

Please define the following terms in questions 2–7:

2. Cultural competence
   [ ] Being an expert regarding the particular languages, behaviors and beliefs of diverse communities
   [ ] The ability to speak the same language as the population served
   [ ] A set of knowledge, skills, attitudes, policies, practices, and methods that enable care providers and programs to work effectively with culturally diverse communities
   [ ] Being of the same ethnic background as the population served

3. Patient-centered care
   [ ] Care that integrates the patient's perspectives and promotes greater patient involvement in his or her care
   [ ] Consideration of the patient’s limitations when developing care plans
   [ ] Performing learning needs assessments with patients
   [ ] Integration of methods to mitigate barriers to learning

4. Racial and ethnic health care disparities
   [ ] Discrimination resulting in lack of access to necessary health care services
   [ ] Patient preferences, belief systems and/or language barriers resulting in differential outcomes
   [ ] Racial or ethnic differences in the quality of health care that are not due to access-related factors or clinical needs, preferences, and appropriateness of intervention
   [ ] Differential outcomes related to the unique language, culture, spiritual, or other determinants complicating the health care delivery process

5. Culture
   [ ] Groups of people who have a shared racial or ethnic background
   [ ] A set of meanings, norms, beliefs, and values shared by a group of people
   [ ] Groups of people who have the same racial and/or ethnic heritage with shared language and practices
   [ ] Social behaviors related to shared ethnicity, race, spiritual beliefs, and language

6. Illness narrative
[ ] Documented portion of a patient's medical history
[ ] A person's story of his or her experience of disease
[ ] The patient's version of what ails him or her
[ ] Cultural beliefs regarding illness shared by members of a group

7. Health belief
[ ] An individual's concept of illness and health
[ ] The patient's understanding of steps required to regain better health
[ ] Cultural beliefs regarding health shared by members of a group
[ ] All of the above

8. How many CLAS standards exist?
[ ] 4
[ ] 10
[ ] 14
[ ] 7

9. Which standard(s) is/are mandated for agencies that receive federal funding?
[ ] #1
[ ] All
[ ] #4, #5, #6, #7
[ ] None

10. Which agency developed the CLAS standards?
[ ] JCAHO
[ ] U.S. Department of Health and Human Services, Office of Minority Health
[ ] California Department of Public Health
[ ] California Department of Health Care Services, Medi-Cal

11. The CLAS standards are mandated under what authority?
[ ] JCAHO
[ ] California Department of Public Health
[ ] Title VI
[ ] No mandate

12. Evidence has shown that ethnicity, class, religion, spirituality, sexual orientation, racism and other cultural factors influence health care decision making.

[ ] Strongly agree [ ] Agree [ ] Disagree [ ] Strongly disagree

13. Maintaining current, accurate data regarding patient race, ethnicity, and language preference is necessary to deliver quality health care.

[ ] Strongly agree [ ] Agree [ ] Disagree [ ] Strongly disagree

14. I am familiar with strategies for promoting system-level change.

[ ] Strongly agree [ ] Agree [ ] Disagree [ ] Strongly disagree

15. I am aware of CLAS-based projects in my health system.

[ ] Strongly agree [ ] Agree [ ] disagree [ ] Strongly disagree

16. Language barriers have been shown to inhibit the quality of health care.

[ ] Strongly agree [ ] Agree [ ] Disagree [ ] Strongly disagree

17. In order to overcome health disparities between people of different race, ethnicity, and language, materials and assistance must be offered in each patient's preferred language.

[ ] Strongly agree [ ] Agree [ ] Disagree [ ] Strongly disagree

18. I am prepared to implement CLAS-based projects relevant to my service area.

[ ] Strongly agree [ ] Agree [ ] Disagree [ ] Strongly disagree

19. The CLAS standards are important to delivery of quality health care.

[ ] Strongly agree [ ] Agree [ ] Disagree [ ] Strongly disagree

20. I agree with the rationale for the CLAS standards.

[ ] Strongly agree [ ] Agree [ ] Disagree [ ] Strongly disagree

21. Implementation of CLAS-based programs is possible within my organization.

[ ] Strongly agree [ ] Agree [ ] Disagree [ ] Strongly disagree

22. Quality improvement efforts must include consideration of the CLAS standards.

[ ] Strongly agree [ ] Agree [ ] Disagree [ ] Strongly disagree

23. A diverse workforce is essential in provision of quality health care.

[ ] Strongly agree [ ] Agree [ ] Disagree [ ] Strongly disagree

24. Understanding the cultural backgrounds of patients is important.

[ ] Strongly agree [ ] Agree [ ] Disagree [ ] Strongly disagree

25. Appreciation of the cultural backgrounds of my co-workers and colleagues is important.

[ ] Strongly agree [ ] Agree [ ] Disagree [ ] Strongly disagree

26. Attainment of equity in health care is essential.

[ ] Strongly agree [ ] Agree [ ] Disagree [ ] Strongly disagree

27. Understanding the way in which a patient experiences illness is necessary in order to deliver quality health care.

[ ] Strongly agree [ ] Agree [ ] Disagree [ ] Strongly disagree

28. Understanding one's culture and/or belief systems is important providing quality health care.

[ ] Strongly agree [ ] Agree [ ] Disagree [ ] Strongly disagree

29. Cultural barriers affect the quality of health care provided.

[ ] Strongly agree [ ] Agree [ ] Disagree [ ] Strongly disagree

30. Culturally appropriate services are important components of quality health care.

[ ] Strongly agree [ ] Agree [ ] Disagree [ ] Strongly disagree

31. Linguistically appropriate services are fundamental aspects of quality health care.

[ ] Strongly agree [ ] Agree [ ] Disagree [ ] Strongly disagree

32. Collaboration is necessary for meaningful system change.

[ ] Strongly agree [ ] Agree [ ] Disagree [ ] Strongly disagree

33. Collaboration with other services is needed to provide quality health care.

[ ] Strongly agree [ ] Agree [ ] Disagree [ ] Strongly disagree

34. CLAS-based efforts can improve quality of health care and/or services in my organization.

[ ] Strongly agree [ ] Agree [ ] Disagree [ ] Strongly disagree

35. Institutionalizing the CLAS standards can lead to reduced health care disparities in my organization.

[ ] Strongly agree [ ] Agree [ ] Disagree [ ] Strongly disagree

36. I have used the CLAS standards to inform service delivery interventions.

[ ] Strongly agree [ ] Agree [ ] Disagree [ ] Strongly disagree

37. Have you actually attempted implementation of CLAS-based quality improvement project/s?

[ ] Yes [ ] No

38. Do you have access to patient data on race?

[ ] Yes [ ] No

39. Do you have access to the patient data on ethnicity?

[ ] Yes [ ] No

40. Do you have access to patient data on preferred language?

[ ] Yes [ ] No

41. Do you adjust service delivery based on racial, ethnic, and language preference data?

[ ] Yes [ ] No [ ] N/A

42. Does your department adjust or change service delivery based on the data?

[ ] Yes [ ] No [ ] N/A

43. I can develop a plan to place one or more of the CLAS standards into operation.

[ ] Strongly agree [ ] Agree [ ] Disagree [ ] Strongly disagree

Workshop Session I: Introduction to the CLAS Standards

Overview: In this workshop session, you will learn about the health disparities that affect culturally diverse communities, and the ways in which cultural competence and the CLAS standards can improve these disparities. We also will review the **Providing Quality Health Care with CLAS** curriculum to give you a clear perspective on the approach and activities used in this program. You will have several opportunities to work in small groups to discuss and compare with your colleagues your departmental vision, along with principles and strategies for effectively implementing system change. For homework, you will be asked to describe an episode of an illness that you or a close acquaintance experienced, and the process of obtaining help for that illness. You will also be asked to complete an organizational assessment survey which must be turned in at the next session.

Learning objectives

By the end of **Workshop Session I**, you will have acquired the following knowledge, skills, and attitudes.

Knowledge to:

1. Define health disparities, cultural competence, and patient-centered care;
2. Describe factors that contribute to health disparities;
3. Describe how health disparities detract from quality of care for patients of diverse backgrounds;
4. Describe the CLAS standards and why they were developed;
5. Describe the roles that other participants play in the overall functioning of the organization;
6. Begin to examine your own service in the context of CLAS standards;
7. Describe the factors that influence system change at the organization where you work or that you represent;

Skills to:

1. Articulate your organizational vision;
2. Operate collaboratively in small-group format;

Attitudes to:

1. Appreciate the importance of reducing health disparities;
2. Appreciate the impact of culture on fellow participants' lives.

Workshop Session I:

1. Providing Quality Health Care with CLAS: Introduction to the CLAS Standards[1] 12

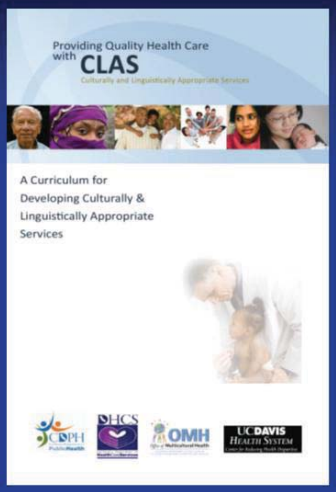
2. Vision Statement Exercise 39

3. Process of Change Challenge.....40

4. Illness Narrative 41

5. Assessment by Leadership 42

[1] A copy of this PowerPoint Presentation is contained in the Participant's CD.



Workshop Session I: Introduction to the CLAS Standards

1

Acknowledgment

The **Providing Quality Health Care with CLAS Curriculum Tool kit,** a project of the Office of Multicultural Health, California Department of Public Health and California Department of Health Care Services, was developed in partnership with the University of California Davis, Center for Reducing Health Disparities to educate providers and health care institutions about the Culturally and Linguistically Appropriate Services Standards which address the important need for cultural and linguistic competency in health care delivery. Funding for the development of the curriculum was provided by the U.S. Department of Health and Human Services, Office of Minority Health State Partnership Grant Program (Grant No. STTMPO51006-01-00)

2

Culture

- A set of meanings, norms, beliefs, and values shared by a group of people.
- Taught, learned, and reproduced.
- Shaping template.
- In constant state of change.

Source: Matsumoto, 1996

3

Definitions

- Race
  - major groups of people related by combination of physical characteristics and theoretically by ancestry
- Ethnicity
  - major groups of people with common behaviors, culture, beliefs, history and ancestry

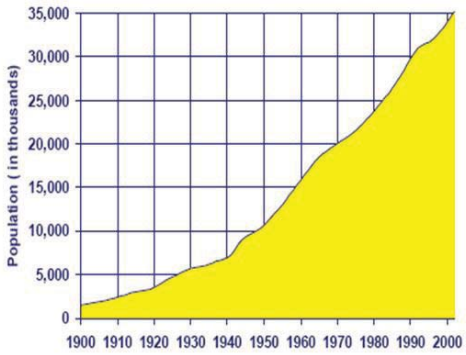
4

Medicine as Culture

- Behavioral norms
- Clearly defined roles
- Belief system and values
- Written and oral language tradition
- Cultural events
- Changes due to other cultural systems

5

California's Population, 1990-2000

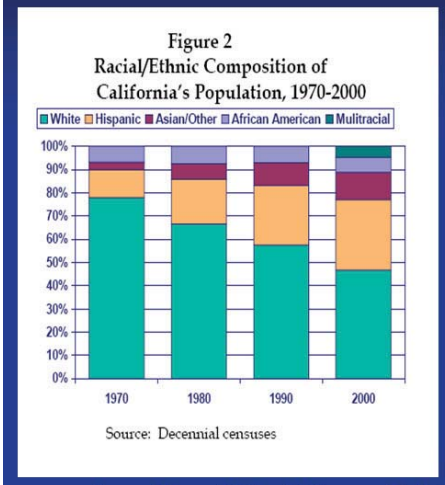


Source: California Department of Finance

Source: Johnson, California's Demographic Future, Public Policy Institute of California, 2003

6

California's Population by Race and Ethnicity

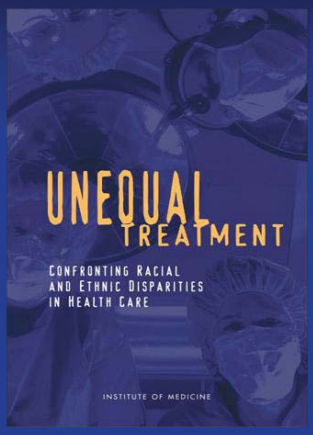


- California leads the nation in diversity.
- As such, the state is challenged with a substantial leadership role in designing and maintaining services that achieve cultural and linguistic competency.

Source: Johnson, California's Demographic Future, Public Policy Institute of California, 2003

7

Health Disparities



- In 2002 the Institute of Medicine published *Unequal Treatment*, which compiled research demonstrating substantial health disparities.
- Racial and ethnic variation in quality of health care that are not due to
  - Access-related factors
  - Patient preferences
  - Clinical needs
  - Appropriateness of intervention

Source: "Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care," IOM, 2002

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Evidence of Racial and Ethnic Disparities

- Across a wide range of disease areas and clinical services
- Found even when clinical factors, such as stage of disease presentation, co-morbidities, age, and severity of disease, are taken into account
- Across a range of clinical settings, including public and private hospitals, teaching and non-teaching hospitals.
- Associated with higher mortality among minorities (e.g., Bach et al., 1999; Peterson et al., 1997; Bennett et al., 1995)
- Magnified when taking into account poverty and level of education

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Black and White Differences in Specialty Procedure Utilization Among Medicare Beneficiaries Age 65 and Older, 1993

	Black	White	Black-to-White Ratio
Angioplasty (procedures per 1,000 beneficiaries per year)	2.5	5.4	0.46
Coronary Artery Bypass Graft Surgery (procedures per 1,000 beneficiaries per year)	1.9	4.8	0.40
Mammography (procedures per 100 women per year)	17.1	26.0	0.66
Hip Fracture Repair (procedures per 100 women per year)	2.9	7.0	0.42
Amputation of All or Part of Limb (procedures per 1,000 beneficiaries per year)	6.7	1.9	3.64
Bilateral Orchiectomy (procedures per 1,000 beneficiaries per year)	2.0	0.8	2.45

Source: Gornick et al., 1996

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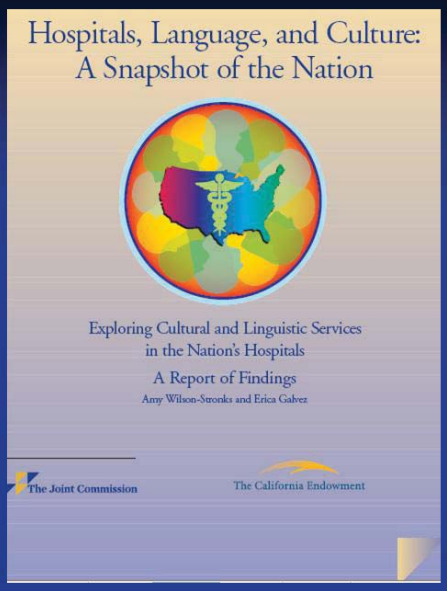

Language, Cultural Competency, and Health Literacy in Health Care

Paul M. Schyve, MD
Senior Vice President
The Joint Commission

11

The Communication Triad

- Language
  - In California 12.5 million (40%) speak a language other than English
  - More than 300 languages spoken in U.S.
- Culture
  - Embedded in language
  - Health practices
- Health literacy
  - Not general literacy or intelligence

Source: Schyve, 2007

The Joint Commission

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Understanding Adverse Events in Patients with Limited English Proficiency (LEP)

- Do LEP patients have a higher risk and/or different patterns of adverse events than English–speaking patients?
- Joint Commission study of 6 hospitals
- Funded in part by the Commonwealth Fund

Source: Schyve, 2007

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Errors in Health Care Were More Likely to Happen to Patients with Limited English Proficiency

	EP	LEP
Error resulted in:		
Some harm	30%	49%
Serious harm	24%	47%
Harm was a result of:		
Communication error	36%	52%
Patient management error	56%	53%
Root cause of harm was due to:		
Human error	39%	45%
Structure/process error	59%	69%

EP = English Proficiency
LEP = Limited English Proficiency

Source: Schyve, 2007

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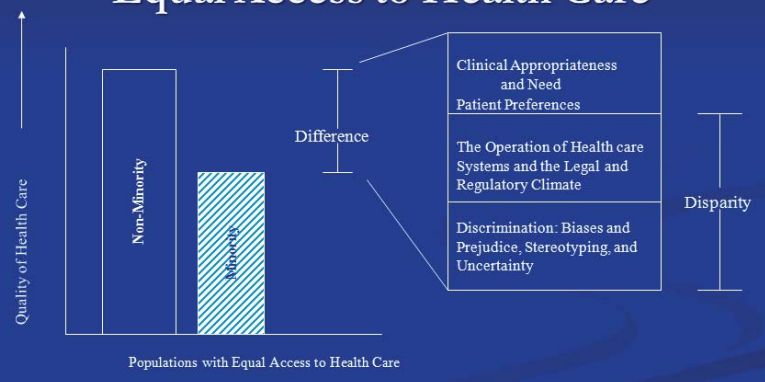
Differences, Disparities, and Discrimination: Populations with Equal Access to Health Care



Source: Gomes and McGuire, 2001

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The Challenge for Health care Organizations

- The perception of illness and disease and their causes varies by culture;
- Diverse belief systems exist related to health, healing and wellness;
- Culture influences help-seeking behaviors and attitudes toward health care providers;

Source: Cohen & Goode, National Center for Cultural Competence, 1999

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The Challenge for Health care Organizations

- Individual preferences affect traditional and non-traditional approaches to health care;
- Patients must overcome personal experiences of biases within health care systems, and;
- Health care providers from culturally and linguistically diverse groups are underepresented in the current service delivery system.

Source: Cohen & Goode, National Center for Cultural Competence, 1999

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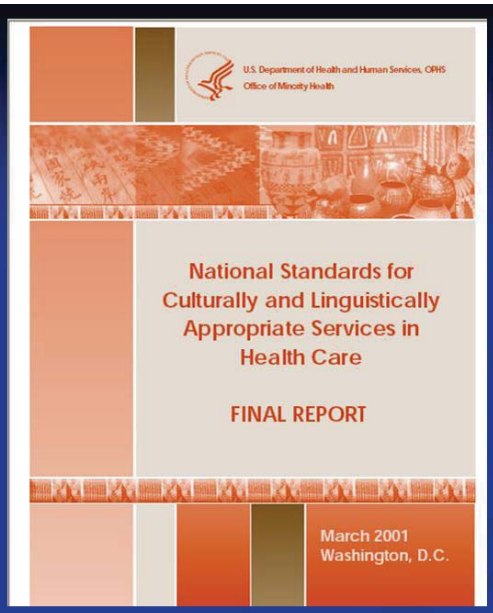

Source: Federal Register: December 22, 2000, Volume 65, Number 247, pages 80865-80879 www.omhrc.gov/CLAS

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Culturally and Linguistically Appropriate Services (CLAS) Standards

- A response to public and private providers, organizations, and government agencies for culturally appropriate standards in the provision of health care;
- Emphasizes the importance of cultural and linguistic competence in health care;
- Developed 14 standards that define key concepts and issues, and present discussion of critical implementation issues.

Source: Office of Minority Health, U.S. Department of Health and Human Services. (2000). National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health Care. Federal Register, 65(247), 80865-80879. http://www.omhrc.gov/clas/finalcultural1a.htm

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Purpose of the CLAS Standards

- Correct disparities in the provision of health services and make these services more responsive to the needs of patients and consumers;
- Intended to be inclusive of all cultures and not limited to any particular population group;
- Designed to address the needs of racial, ethnic, and linguistic population groups that experience unequal access to health services;
- Contribute to the elimination of racial and ethnic health disparities;
- CLAS **mandates** are current federal requirements for recipients of federal funds.

Source: Office of Minority Health, U.S. Department of Health and Human Services. (2000). National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health Care. Federal Register, 65(247), 80865-80879. http://www.omhrc.gov/clas/finalcultural1a.htm

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CLAS Standards Themes

The 14 standards are organized by three themes:

- Culturally Competent Care

  Standards 1-3

- Language Access Services

  Standards 4-7

- Organizational Supports

  Standards 8-14

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Culturally Competent Care

- Staff should provide effective, understandable, and respectful care that is compatible with their patients' cultural health beliefs and practices and preferred language
- Strategies to recruit, retain, and promote diverse staff and leadership that are representative of the demographic characteristics of the service area.
- All staff should receive ongoing education and training in CLAS delivery.

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Language Access Service

- Provide language assistance services at no cost to each patient with limited English proficiency at all points of contact, in a timely manner during all hours of operation.
- Provide patients with verbal and written information about their right to receive language assistance services in their preferred language.
- Provide quality assurance that language assistance is competent and of acceptable quality.
- Provide easily available and understandable patient-related materials and post signage in the languages of the commonly encountered groups represented in the service area.

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Organizational Support

- **Written Strategic Plan** that outlines clear goals, policies, operational plans, and management accountability and oversight mechanisms to provide culturally and linguistically appropriate services.
- **Organizational Self-Assessments** of CLAS-related activities and people are encouraged to integrate cultural and linguistic competence-related measures into their internal audits, performance improvement programs, patient satisfaction assessments, and outcomes-based evaluations.
- **Patient Demographic Data** on race and ethnicity, and spoken and written language, are collected in health records, and integrated into the organization's management information systems.
- Demographic, Cultural, and Epidemiological **Profile of the Community** as well as a needs assessment to accurately plan for and implement services that respond to the cultural and linguistic characteristics of the service area.

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Organizational Support

- **Community Partnerships** should be developed utilizing a variety of formal and informal mechanisms to facilitate community and patient involvement in designing and implementing CLAS-related activities.
- **Grievance Processes** should be culturally and linguistically sensitive and capable of identifying, preventing, and resolving cross-cultural conflicts or complaints by patients.
- **Publicly Available Information** about progress and successful innovations in implementing the CLAS standards and to provide public notice in communities about the availability of this information.

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Rationale for Culturally Competent Health Care

- Responding to demographic changes;
- Eliminating disparities in the health status of people of diverse racial, ethnic, and cultural backgrounds;
- Improving the quality of services and outcomes;
- Meeting legislative, regulatory, and accreditation mandates;
- Gaining a competitive edge in the marketplace;
- Decreasing the likelihood of liability and malpractice claims.

Source: Cohen E, Goode T. Policy Brief 1: Rationale for cultural competence in primary health care. Georgetown University Child Development Center, The National Center for Cultural Competence. Washington, D.C., 1999

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Legislation

New Jersey: "Requires Physician Cultural Competency Training as a Condition of Licensure"
Senate Bill 144, signed into law March 23, 2005
http://www.njleg.state.nj.us

California: Civil Code §51
"Continuing Medical Education on Cultural Competency"
AB 1195—Chapter 514, effective July 1, 2006
http://www.aroundthecapitol.com/Bills/AB_1195

Washington State: "Requiring Multicultural Education for Health Professionals"
2006 Senate Bill 6194S, signed into law March 27 , 2006
http://www.washingtonvotes.org/2006-SB-6194

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Business Case

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Health care Expenditures and Ethnic Minorities

- 2018: One of five US dollars will be spent on health care
- One third of US population is not White
- 47 million have limited English proficiency
- Health care systems need to consider cost, benefit, affordability in efforts to provide services to increasingly diverse populations

Source: US Census 2000

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Financial Incentives to Provide CLAS

- Appeal to minority consumers,
- Competition for private purchaser business,
- Responding to public purchaser demands,
- Improving cost effectiveness

30

Market Share

- 2012: buying power of African Americans, Asian Americans, and Native Americans: $3 trillion.
- Triple 1990 levels
- Growing much faster than White market

Source: Dodson, D. Selig Center for Economic Growth, 2007

31

Staff Turnover

- Academic medical center turnover
  - 3.4 -5.8% of annual budget
  - $17-29 million on a $500 million base

Waldman et al., 2004

- Higher for providers working with underserved communities
- Cultural and linguistic competence
  - improve provider competence, morale, and reduce barriers to sense of self-efficacy.

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Liability

- Failure to provide linguistically appropriate services can lead to malpractice suits.
- Of 3,548 adverse events documented by JCAHO between 1995 to 2005, 65% were due to communication problems.
- Improved communication between providers and patients reduces likelihood of malpractice claims.

Clarke et al ., 2005, Vukmir 2004

33

Cost of Language Services

- Chart review of 500 emergency department (ED) cases
  - English-speaking group
  - Non English speaking without interpreters
  - Patients with interpreters
- Average charge
- Follow-up to clinic
- Bounce back

Berstein et al., 2002

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Cost of Language Services

- Average charge:
  - English speakers: $988
  - With interpreters: $878
  - No interpreters: $710
- Follow-up to clinic:
  - poorest for no interpreter group
- Return visits to ED
  - Lowest for group using interpreters

Berstein et al ., 2002

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Cost of Language Services

"Use of trained interpreters was associated with increased intensity of ED services, reduced return rate, increased clinic utilization, and lower 30-day charges, without any simultaneous increase in length of stay or cost of visit."

Berstein et al., 2002

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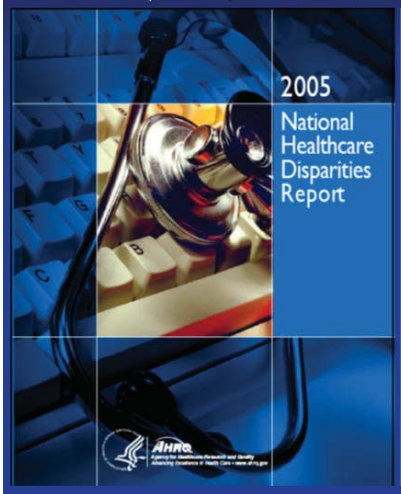
The National Healthcare Disparities 2005 Report

(DHHS, AHRQ Publication No. 06-0017 December 2005)



Key themes:

- Disparities still exist
- Some disparities are diminishing
- Information is improving

Key findings:

- Health care continues to improve at a modest pace
- Disparities narrowing for many, except for Hispanics
- Disparity has widened in both access to and in quality of care measures

37

OMH State Partnership Grant Program to Improve Minority Health

Purpose:

A national strategy to facilitate the improvement of minority health and elimination of health disparities through the development of partnerships with established states and territorial offices of minority health.

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OMH State Partnership Grant Program to Improve Minority Health

A partnership between:

- U.S. Department of Health and Human Service, Office of Minority Health
- California Department of Public Health and Department of Health Care Services, Office of Multicultural Health
- UC Davis Center for Reducing Health Disparities

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Cultural Competency Tool kit/Curriculum Development Project

Primary Goals:

- Develop, implement, and evaluate a training curriculum for health service agencies and organizations based on the *Culturally and Linguistically Appropriate Services* (CLAS) standards.
- Disseminate and provide technical assistance in an effort to improve health service outcomes for minority populations.

40

Curricular Approach

- Utilizes established educational methods
  - Group process orientation
  - Problem-based learning
  - Strategically placed didactics

41

Curricular Approach

- Participant-centered, strength-based
- Emphasizes collaborative effort
- Facilitates deeper understanding and creative solutions
- Allows for integration of CLAS standards into infrastructure, mission, and values

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Overview

- Phase I: Organizational Culture Assessment
- Phase II: Four Workshop Sessions
  I. Introduction to the CLAS Standards
  II. Quality Care for Culturally Diverse Patients
  III. Getting to Know the CLAS Standards
  IV. System Change and CLAS
- Phase III: Follow-Up Meetings

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Organizational Culture Assessment

- Custom-tailoring the curriculum to match your resources, strengths, goals and needs, as well as to those of your organization
- Examination of organizational structure
- Interview of key organizational leaders

44

Workshop Session I: Introduction to the CLAS Standards

- Overview
  - Challenges of health systems to provide quality care to diverse communities
  - Rationale and intent of CLAS standards
- Strategies for system change
- Establishing an organizational vision

45

Workshop Session II: Quality of Care for Culturally Diverse Patients

- Shifting to a patient-centered perspective
  - Personal experiences
  - Case vignettes
- Impact of cultural conflicts on quality of care
  - Language, acculturation, health beliefs, health literacy, SES factors, racism
- Organizational factors

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Workshop Session III: Getting to Know the CLAS Standards

- In-depth study of each CLAS Standard
  - Rationale and intent
  - Strategies to implement
- Review of model programs
- Customizing to local setting
  - Assessment of applicability of various standards
  - Review applicable strategies and models

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Workshop Session IV: System Change and CLAS

- Leadership and system change
- Inter-program collaboration
  - Leverage resources
  - Minimize duplication of effort
  - Build for synergy
  - Ripple effect
- **Product:** Quality improvement plan to implement CLAS standards

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Follow Up: Monthly Meetings

- Continue forward momentum
- Ongoing plan development
- Troubleshoot challenges
- Share successful strategies

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Summary

- Working knowledge of CLAS standards
- Practical plan for implementation of CLAS standards
- Effective coordination with other programs for maximal effect

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Table 1	Vision Statement Exercise
Name:	Date:
My role or title in the organization:	
A. Define your service with a vision statement.	
Please address these questions when defining your service: ■ Ideally, what kind of service do you want to have? ■ What reputation do you wish your service to have? ■ What contributions would the service make to the organization and its clients? ■ Ideally, how would your staff members work together? ■ What values would your service embody?	
Notes:	
B. Discuss your vision statement as a group and solicit reactions.	
Notes:	
C. Discuss how your service might relate to that of others in the group.	
Notes:	

Table 2	Process of Change Challenge

Domains critical to system change*:

1. **Leadership:** Leaders are decision makers who have the ability to influence others and guide a system in a way to make it more cohesive and coherent.

2. **Team:** A team is a group of staff members working to implement and sustain a program.

3. **Models and processes**: Models are approaches that have structure or serve as a framework for accomplishing goals. Processes consist of a series of related tasks done in sequence to achieve the goals.

4. **Organizational systems and culture**: Systems refer to the organization's processes, polices, forms, and protocols. Organizational culture refers to the shared values of an organization as well as to the ways in which staff members relate to each other, communicate, and coordinate their activities.

5. **Data measurement and reporting:** These terms refer to all aspects of data management, including what data is measured and how it is collected, stored, processed, updated, and disseminated.

6. **Education and coaching:** These terms refer to ways in which knowledge is generated, shared, and used. They encompass implementation assistance and support, and may take the form of seminars, staff development, and individual consultations.

Discuss one of the six domains of change.
A. How does this domain influence the implementation and sustainability of new programs and projects?
B. What are your strategies to ensure development or support of this domain?
C. What contributions can you make to this area? What are the barriers that prevent you from doing so?
D. What resources are required to strengthen this domain in your system?
E. Can your group present an example of how you have seen this domain effectively applied or developed?
F. Can your group identify other domains not mentioned that you consider important to system change?
Report back to the large group.

* Judge, K. H., Zahn, D., Lustbader, N. J., Thomas, S., Ramjohn, D., & Chin, M. (2007). *Factors contributing to sustaining and spreading learning collaborative improvements*. Primary Care Development Corporation.

Table 3	Illness Narrative

An illness narrative is defined as an individual's story of his or her experience about the effects of illness on his or her life. As with stories, most narratives have a beginning, middle, and end that are defined and held together by common themes that unfold in relation to time. Illness narratives are often used in cross-cultural and client-centered settings to better understand the experiences and perspectives of clients.

Assignment: Please come to the next session prepared to discuss your experience, or that of a close friend or relative, in treatment. You may use the space below to write your thoughts. These will not be collected.

While thinking about the experience, please consider the following:

1. What were the reasons that led to the treatment?
2. Was treatment easy or difficult to obtain?
3. Please describe the process.
4. What was the experience during treatment?
5. What were the provider's strengths and weaknesses, from a client's perspective?
6. Do you think that the treatment was influenced by any socio-cultural factors such as race, ethnicity, gender, language, sexual orientation, age, class, or education level?
   If so, how?

Notes:

Assessment by Leadership

(Adapted from Salimbene, S. (2001). *CLAS A-Z: A practical guide for implementing the national standards for culturally and linguistically appropriate services (CLAS) in health care*. Inter-Face International.

Please answer the following questions for your organization:

1. I believe building a culturally and linguistically competent organization should be a:

   Top priority ___ Priority ___ Somewhat a priority ___ Not a priority ___

2. I believe we have the resources to build a culturally and linguistically competent organization.

   Strongly agree ___ Agree ___ Disagree ___ Strongly disagree ___

3. List up to three specific measures that you already have taken to demonstrate – to clients, staff members, and the community – your commitment to culturally and linguistically appropriate services.

   a._____

   b._____

   c._____

4. Has your organization assigned a specific person or program to promote diversity or cultural competence?

   Yes ___ No ___ Don't know ___

*If you answered **No** or **Don't know**, go to **#8**. If you answered **Yes**, proceed to # **5.***

5. What is the title of that person or program? _____

6. Does that person or program report directly to you?

   Yes ___ No ___

7. Has that person or program been given broad decision-making power?

   Yes ___ No ___ Don't know ___

8. List three measures you would like to implement this year to promote cultural and linguistic competence in your organization.

a._____

b._____

c._____

9. In the first column below, list the **telephone** services (scheduling, hours, location, and other information) your department has created for callers who speak little or no English. In the second column, list the language(s) in which these services are available.

Service	**Language**

10. In your organization or department, what training and instruction do the telephone operators and reception staff members receive to help them appropriately accommodate callers who speak little or no English?

11. Rate the receptiveness of staff members regarding possible health and illness beliefs and practices of the specific client and/or community groups with whom they may interact.

	Excellent	**Above average**	**Average**	**Poor**	**Don't know**
Physicians					
Nurses					
Licensed staff					
Medical assistants					
Clerical					
Outreach/health educators					

12. a. To your knowledge, are all staff members given written guidelines regarding working with clients and communities from diverse cultural, linguistic, and religious backgrounds?

Yes ___ No ___ Don't know ___

b. These guidelines are distributed via: _____

c. Something is being done to reinforce the use of these guidelines.

Yes ___ No ___ Don't know ___

13. a. Specific strategies have been taught (as applicable) for obtaining an accurate history, physical, or other information from culturally and linguistically diverse clients.

Yes ___ No ___ Don't know ___

b. These strategies are consistently followed.

Yes ___ No ___ Don't know ___

14. a. Staff members have easy access to clinical or epidemiological information about diverse communities served.

Yes ___ No ___ Don't know ___

b. Cultural and/or religious information also is available.

Yes ___ No ___ Don't know ___

c. Above information is made available through: _____

15. Staff members have lists of alternative treatments that may be used by diverse clients or communities served.

Yes ___ No ___ Don't know ___

16. Staff members have lists of community resources that may help clients from diverse communities.

Yes ___ No ___ Don't know ___

17. a. Staff members are made aware of treatments, education, information, interventions, or other forms of interaction that may be forbidden or unacceptable based on cultural and/or religious beliefs.

Yes ___ No ___ Don't know ___

b. This awareness is verified via: _____

18. When furnishing spaces, consideration is given to cultural and ethnic community members' preferences in artwork, decorations, wall color, and other design elements.

Yes ___ No ___ Don't know ___

19. Waiting areas offer reading material in the languages of the clients served.

Yes ___ No ___ Don't know ___

20. Appropriate areas for prayer, contemplation, and/or family discussion regarding care, services or treatment are available to clients and their families.

Yes ___ No ___ Don't know ___

21. a. All staff members are trained to identify and deal with cultural, religious, and language differences.

Yes ___ No ___ Don't know ___

b. This training is provided via: _____

c. This training is updated to include new and changing demographics.

Yes ___ No ___ Don't know ___

d. This training is consistently provided to new and existing staff members.

Yes ___ No ___ Don't know ___

22. Forms, signs, education materials, satisfaction surveys, and other relevant materials are offered in the native language of each client or community served.

Yes ___ No ___ Don't know ___

23. Only trained medical interpreters are used when providing care to clients who speak little or no English.

Yes ___ No ___ Don't know ___

24. Interpreting services are available for each language group served.

Yes ___ No ___ Don't know ___

25. Professional (trained) medical interpreters are easily available to clients.

Yes ___ No ___ Don't know ___

26. a. If non-trained staffs provide direct service to clients and/or communities in a language other than English, they have been assessed for competency in that language.

Yes ___ No ___ Don't know ___ N/A ___

b. If **Yes**, these staff members are compensated for use of their interpreting skills.

Yes ___ No ___ Don't know ___

27. My department's mission statement is:

_____
_____
_____

28. Staff diversity is mentioned in the mission statement.

Yes ___ No ___ Don't know ___

29. Culturally and linguistically appropriate services are part of the mission statement.

Yes ___ No ___ Don't know ___

30. The need to offer culturally and linguistically appropriate services to diverse populations is frequently mentioned in staff meetings, internal memos, publications, internal computer notices, and other interactions.

Yes ___ No ___ Don't know ___

31. The need for cultural awareness and sensitivity to colleagues of different races, ethnicities, and cultures is a frequent topic of staff meetings, internal memos, publications, and other interactions.

Yes ___ No ___ Don't know ___

32. **All** staff members must undergo training on the cultural beliefs of the specific communities and/or clients served.

Yes ___ No ___ Don't know ___

(If you answered **No** or **Don't know**, go to **#36**. If you answered **Yes**, proceed to **#33**.)

33. List the topics covered by the training (e.g., religious and cultural beliefs, proper etiquette such as forms of address and "rules of touching," specific health and illness beliefs and practices, and other considerations.)

1	2	3	4
5	6	7	8

34. How long is the training (in hours)?_____ **Don't know ___**

35. How many times per year is such training offered?_____ **Don't know ___**

36. The department presents specific team-building activities to improve the communication and teamwork among employees of different cultural, language, and ethnic groups.

Yes ___ No ___ Don't know ___

37. The department regularly consults with many of the community's cultural, ethnic, and religious groups regarding the forms of care and services that should be made available to their members.

Yes ___ No ___ Don't know ___

38. List all other measures that the department *already has taken* as a means of ensuring a culturally and linguistically competent work environment (e.g., training and development, performance review criteria).

39. I rate the department's status in cultural and linguistic competence at this time as:

Fully competent ___ Mostly competent ___ Somewhat competent ___ Not competent ___

Workshop Session II:

1. Workshop Session II Slides Quality of Care for Culturally Diverse Patients[2] 50

2. CLAS Standards Exercise.....65

[2] A copy of the PowerPoint presentation can be located in the Participant's CD

Workshop Session II: Quality of Care for Culturally Diverse Patients

Overview: In this workshop session, you will examine the difficulties of obtaining quality health and public health services from the perspective of individual clients. You and other participants will have the opportunity to describe your own experiences with health care and discuss vignettes of two clients from culturally diverse backgrounds. Collectively the cases will highlight the impact of issues such as communication, decision-making, health beliefs, health disparities, and socioeconomics on quality of care. You will also learn to identify systems and organizational factors that mediate the impact of these issues. For homework your small group will be asked to prepare a presentation on one or more of the CLAS standards.

Learning objectives

By the end of **Workshop Session II**, you will have acquired the following knowledge, skills, and attitudes.

Knowledge to:

1. Define the concept of illness narrative;
2. Describe the impact of culture on health care decision-making;
3. Describe the impact of language barriers on care;
4. Describe the effect of immigration and acculturation on health status and quality of care;
5. Describe the health status, health disparities, health care barriers, and quality of care experienced by at least two culturally diverse populations;
6. Describe the potential impact of the CLAS standards on improving quality of care for these communities;

Skills to:

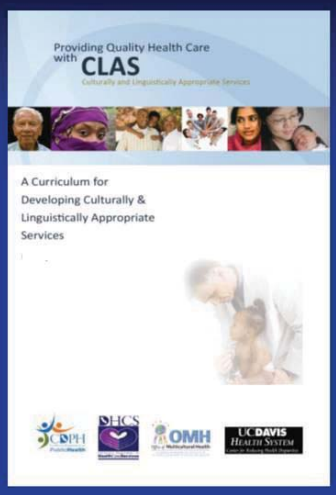
1. Use previously described concepts to better understand the health status and needs of communities not specifically discussed in this session;
2. Operate collaboratively in small groups and discussion formats;
3. Critically examine your organization's ability to provide care to clients from diverse backgrounds;

Attitudes to:

1. Appreciate the importance of understanding the illness experience from a client's perspective;
2. Appreciate the ways in which culturally and linguistically appropriate care can improve the health status of diverse communities.

Workshop Session II

Slides



Workshop Session II: Quality of Care for Culturally Diverse Patients

1

Acknowledgment

The **Providing Quality HealthCare with CLAS Curriculum Toolkit,** a project of the Office of Multicultural Health, California Department of Public Health and California Department of Health Care Services, was developed in partnership with the University of California Davis, Center for Reducing Health Disparities to educate providers and health care institutions about the Culturally and Linguistically Appropriate Services Standards which address the important need for cultural and linguistic competency in health care delivery. Funding for the development of the curriculum was provided by the U.S. Department of Health and Human Services, Office of Minority Health State Partnership Grant Program (Grant No. STTMPO51006-01-00)

2

PERSON CENTERED CARE AND CLAS

3

Tuyet Nguyen

Sixty two year-old widowed Vietnamese woman with poorly controlled hypertension.

4

Scenario #1

5

Scenario #1 Discussion

- What images came up for you as you listened to Ms. Nguyen?
- Can you relate to Ms. Nguyen's challenges? Please elaborate.
- What are the potential factors that impact Ms. Nguyen's health?
- What is the impact of her limited English proficiency on her life?

6

Scenario #2

7

Scenario #2 Discussion

- What thoughts, feelings or images come up for you now?
- What was the impact of her limited English proficiency on her health and overall experience at the clinic?
- Who do you believe should be responsible for ensuring adequate communication between doctors and their patients?
- How might the CLAS standards be applied in this situation?

8

Scenario #3

9

Scenario #3 Discussion

- What thoughts, feelings, or images come up for you?
- How does her son's understanding of hypertension compare to your understanding of it?
- How often do doctors and their patients agree on the importance of symptoms, causes of symptoms, and treatment?
- How might you use the CLAS standards to help you address these issues?

10

Jimena Lopez

Thirty two year-old Mexican American woman who immigrated to the United States 4 years ago.

11

Scenario #1

12

Scenario #1 Discussion

- What feelings, thoughts, or images come to mind as you listen to Ms. Lopez?
- How well does your public health department outreach to culturally diverse communities?
- What do you think about Ms. Lopez's concerns about the flu shot? How would you go about addressing these concerns with her and members of her community?

13

Scenario #2

14

Scenario #2 Discussion

- Please discuss feelings, thoughts, or images that come up for you.
- What is the impact of Ms. Lopez's socioeconomic and insurance status on her health?
- If she is receiving services from your organization, how would your service address these challenges?

15

Scenario #3

16

Scenario #3 Discussion

- Please discuss feelings, thoughts, or images that come up for you.
- What is the impact of stigma of infectious diseases on culturally diverse communities?
- How well does your local public health department address these issues?
- How can the CLAS standards help you to better address these issues?

17

Demographic and Health Disparities Facts

Asian Americans and Native Hawaiians and other Pacific Islanders (AA/NHOPI)

18

Demographics

- Asian Americans and Native Hawaiians and other Pacific Islanders (AA/NHOPI) comprise over 4.7% of the U.S. population[1]
- Thirty percent of the AA/NHOPI population in the U.S. resides in California[1]
- The AA/NHOPI population comprises 12%[1] of the total California population and 1.5%[2] are Vietnamese
- Sixty percent are foreign-born and they represent 30% of the total foreign-born population in the U.S.[1]
- AA/NHOPI are a diverse group with over 30 ethnic sub populations and more than 200 languages and dialects[3]

19

Challenges

In California:

- More AAs (35%) have higher limited English proficiency (LEP) than the statewide average (20%)[2]
- Approximately 10% of AAs are below the poverty level and NHOPIs are 11.4%[2]
- AAs (14%) and NHOPIs (15%) are uninsured[2]

- Health care decision-making does not always rest with the individual, but often involves multiple family members[4]
- There is high use of non-Western healthcare practices in Southeast Asian Americans (90% of Vietnamese immigrants in one study)[4]

20

Demographic and Health Disparities Facts

Hispanics

21

Demographics

- Of the total U.S. Population, 48,901,365 (16%) are Hispanics[1]
- Of this total, 14,342,102 (29%) reside in California[1]
- Hispanics comprise 39% of the total California population[1]
- Forty percent of California's Hispanic population is foreign born compared to 37% of the foreign born U.S. Hispanic population[1]
- Approximately 70% speak a language other than English[3]

22

Financial Impact of H1N1

- With H1N1 outbreak, some Mexican restaurants reported a drop in business (MSNBC 2009)
- Seventeen percent of respondents in a national survey reported avoiding Mexican restaurants/stores due to fears of H1N1 (Blendon et al 2009)

23

Challenges

- The estimated median household income is lower for Hispanics ($38,679) compared to total U.S. median household income (50,233)[5]
- Hispanics account for 54% of the California uninsured and 32% of U.S. uninsured [5]
- Sixty percent of Hispanics in California who are not US citizens or permanent residents lack health insurance (Pew Hispanic Center 2007)
- Rates of vaccination for Hispanics are lower than other population groups (Kreimer medscape)

24

Impact of Language Barrier

25

Limited English Proficiency

- **Time with physicians**
  - Same as with English proficient patients despite use of interpreter
  - But most physicians believe that they spend more time with LEP patients (85.7%)

Tocher TM, Larson EB, 1999

- **Less health care satisfaction**
  - Forty-eight percent for LEP patients vs. 29% for English proficient patients in the Emergency Department

Carrasquillo O, Orav EJ, Brennan TA, Burstin HR,1999

26

Poorer Access to Care, Quality of Care, and Health Status

- **Systematic review of literature for Hispanic populations**
  - Fifty-five percent of studies: LEP strongly impeded access to care
  - Eighty-six percent of studies: LEP associated with poorer quality of care

Timmins CL, 2002.

- **Study of children coming from families with limited English proficiency showed they were at**
  - Triple the odds having fair/poor health status,
  - Double the odds of spending at least one day in bed for illness in the past year, and
  - Significantly greater odds of not being brought in for needed medical care.

Flores G, Abreu M, Tomany-Korman SC, 2005.

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Footnotes:

[1] Current Population Survey (CPS), U.S. Census Bureau, 2010, generated by the California Office of Multicultural Health

[2] U.S. Census Bureau, American Community Survey 2006-2008

[3] U.S. Census Bureau, 2000

[4] DHHS, Mental Health: Culture Race and Ethnicity, 2001; Jenkins et al, 2006

[5] Income, poverty and health insurance Coverage in the U.S.: 2007, U.S. Census Bureau 2008

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- Flores, G., Abreu, M., & Tomany-Korman, S.C. (2005). *Limited english proficiency, primary language at home, and disparities in children's health care: how language barriers are measured matters. Public Health Rep, Jul-Aug 120*(4) 418-430.
- Timmins, C.L. (2002). *The impact of language barriers on the health care of Latinos in the United States: a review of the literature and guidelines for practice. Journal of Midwifery Womens Health, Mar-Apr 47*(2), 80-96.
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Table 4	CLAS Standards Group Presentation

Using the National Standards for Culturally and Linguistically Appropriate Services in Health Care: Final Report (found on the Participant's CD), please work together, as a group, to examine the assigned standard(s). Be prepared to lead a 10-minute presentation and discussion about each of your assigned standards at the next session.

When researching your standard(s), please keep in mind the following considerations for your presentation:

Be sure to address these four objectives:

1. **Describe what the standard(s) mean in plain language.**
2. **Explain the rationale for the standard(s).**
3. **Examine how this standard(s) is relevant to your service and to the organization as a whole.**
4. **Describe one or more strategies to implement this standard(s) in your service area or the organization as a whole.**

When answering question 4, please consider the following:

Who are the stakeholders, and how can you engage them?

What resources would be required, and how would they be accessed?

What challenges would be faced?

How might you measure progress and success of implementation?

Notes:

Workshop Session III:

1. CLAS Quality Improvement Plan Worksheet 68

2. CLAS Standards Feasibility Worksheet 71

3. CLAS Quality Improvement Plan Evaluation Checklist 80

Workshop Session III: Getting to Know the CLAS Standards

Overview: This module presents a more detailed understanding of the CLAS standards, including the rationale and intent of each. Each group will present the CLAS standard(s) that it was responsible for researching. At the end of the presentations, you will know more than many cultural competence trainers in the field about the CLAS standards and ways to implement them. You will also have the opportunity to learn about an existing program in your organization that incorporates one or more of the CLAS standards, particularly the resources used and obstacles faced during its implementation. At the end of the session, you will be asked to develop a quality improvement plan related to the CLAS standards, using the knowledge that you have gained in this and the prior two sessions.

Learning objectives

By the end of **Workshop Session III**, you will have acquired the following knowledge, skills, and attitudes.

Knowledge to:

1. Describe the rationale and intent behind each CLAS standard;
2. Describe a model program that effectively implements the CLAS standards;
3. Describe the relevancy of these standards to your department;

Skills to:

1. Assess whether and how your department addresses the CLAS standards;
2. Compare and contrast the various approaches taken to implement CLAS standards;

Attitudes to:

1. Appreciate the effective and practical ways to implement these standards.

CLAS Quality Improvement Plan Worksheet

Date:

Department/Service area:

Project title:

Project members :

This is important now because:

CLAS standard(s) addressed:

Aim Statement (what do you hope to accomplish?):

We aim to improve…

INPUTS

BASELINE ASSESSMENT – What do we know about this issue?

STAKEHOLDERS – Please describe the target audience. Who else would have an interest in this project? Who needs to be involved for this project to succeed? How will they be engaged?

RESOURCES – What resources will be needed? Types of resources are people, money, equipment, facilities, supplies, people's ideas, and people's time. Resources also can be various laws and regulations. Who is responsible for acquiring or accessing the resources?

PROCESSES

PLAN – What steps will lead to the project's aim? How will you engage the stakeholders and secure the resources? What, if any, policy changes or new policies may be necessary? What processes will be required for implementation?

TIME LINE – How long will each step (described in the "PLAN" section) take?

CHALLENGES – What challenges, obstacles, and possible resistance may be encountered? What strategies will you use to respond? Identify and explain types of strategies or methods to overcome obstacles or barriers.

OUTPUTS

TANGIBLE PRODUCTS – What activities will result from the project plan? Examples include workshops, publications, announcements, or new policies or procedures.

OUTCOMES

OUTCOME – Will these tangible products result in the desired improvements in culturally and linguistically appropriate services as described in the AIM statement? How will you measure this? Please describe the expected short-, medium-, and long-term outcomes. Short-term outcomes include changes in knowledge, skills, and attitudes. Medium-range outcomes might focus on changes in behaviors, practices, or policies. Long-term goals may entail changes in the environment, such as improved health care access, reduced health disparities, or better language access.

Table 5	CLAS Standards Feasibility Worksheet

While completing this exercise, consider each of the 14 CLAS standards in the context of your service area.

- Rate the applicability of each standard to your service area. If the standard is not applicable, indicate why not.
- Rate the feasibility of implementing each standard in your service area. If you believe it would not be feasible, indicate why not.
- Consider what impediments might be faced when implementing each standard.
- What might you do to overcome the obstacles?

1. *Health care organizations should communicate with patients using clear, understandable terminology and perform respectful care compatible with patients' cultural health beliefs and preferred language.*

Degree of applicability:
[ ] Very applicable [ ] Applicable [ ] Somewhat applicable [ ] Not applicable*

*Why is this standard inapplicable?

Feasibility to implement:
[ ] Very feasible [ ] Feasible [ ] Somewhat feasible [ ] Not feasible*

*Why would it be unfeasible?

Anticipated obstacles to implementation:

Ideas to overcome obstacles:

2. *Health care organizations should implement recruitment, retention, and promotion of diverse staff employees and leaders who represent the demographic characteristics of the service area.*

Degree of applicability:
[ ] Very applicable [ ] Applicable [ ] Somewhat applicable [ ] Not applicable*

*Why is this standard inapplicable?

Feasibility to implement:
[ ] Very feasible [ ] Feasible [ ] Somewhat feasible [ ] Not feasible*

*Why would it be unfeasible?

Anticipated challenges to implementation:

Ideas to overcome challenges to:

3. *Health care organizations should ensure ongoing education in CLAS delivery.*

Degree of applicability:
[ ] Very applicable [ ] Applicable [ ] Somewhat applicable [ ] Not applicable*

*Why is this standard inapplicable?

Feasibility to implement:
[ ] Very feasible [ ] Feasible [ ] Somewhat feasible [ ] Not feasible*

*Why would it be unfeasible?

Anticipated impediments in implementation:

Ideas to overcome impediments:

4. *Health care organizations must provide language assistance services at all points of contact, in a timely manner, and during all hours of operation.*

Degree of applicability:
[ ] Very applicable [ ] Applicable [ ] Somewhat applicable [ ] Not applicable*

*Why is this standard inapplicable?

Feasibility to implement:
[ ] Very feasible [ ] Feasible [ ] Somewhat feasible [ ] Not feasible*

*Why would it be unfeasible?

Anticipated challenges to implementation:

Ideas to overcome challenges

5. *Health care organizations must inform patients verbally, in writing, and in their preferred language about their right to receive language assistance services.*

Degree of applicability:
[ ] Very applicable [ ] Applicable [ ] Somewhat applicable [ ] Not applicable*

*Why is this standard inapplicable?

Feasibility to implement:
[ ] Very feasible [ ] Feasible [ ] Somewhat feasible [ ] Not feasible*

*Why would it be unfeasible?

Anticipated challenges to implementation:

Ideas to overcome challenges:

6. *Health care organizations must assure the competence of language assistance. Family and friends should not be used to provide interpretation services unless requested by the patient.*

Degree of applicability:
[ ] Very applicable [ ] Applicable [ ] Somewhat applicable [ ] Not applicable*

*Why is this standard inapplicable?
Feasibility to implement:
[ ] Very feasible [ ] Feasible [ ] Somewhat feasible [ ] Not feasible*

*Why would it be unfeasible?

Anticipated challenges to implementation:

Ideas to overcome challenges:

7. *Health care organizations must make available patient-related materials and post signage in the languages of the commonly encountered groups.*

Degree of applicability:
[ ] Very applicable [ ] Applicable [ ] Somewhat applicable [ ] Not applicable*

*Why is this standard inapplicable?

Feasibility to implement:
[ ] Very feasible [ ] Feasible [ ] Somewhat feasible [ ] Not feasible*

*Why would it be unfeasible?

Anticipated challenges to implementation:

Ideas to overcome challenges:

8. *Health care organizations should have a written strategic plan that identifies goals, policies, operational plans, and management accountability that support delivery of CLAS.*

Degree of applicability:
[ ] Very applicable [ ] Applicable [ ] Somewhat applicable [ ] Not applicable*

*Why is this standard inapplicable?
Feasibility to implement:
[ ] Very feasible [ ] Feasible [ ] Somewhat feasible [ ] Not feasible*

*Why would it be unfeasible?

Anticipated challenges to implementation:

Ideas to overcome challenges:

9. *Health care organizations should have ongoing organizational self-assessments of CLAS, and integrate CLAS into internal audits and evaluations of performance improvement, patient satisfaction, and outcomes.*

Degree of applicability:
[ ] Very applicable [ ] Applicable [ ] Somewhat applicable [ ] Not applicable*

*Why is this standard inapplicable?

Feasibility to implement:
[ ] Very feasible [ ] Feasible [ ] Somewhat feasible [ ] Not feasible*

*Why would it be unfeasible?

Anticipated challenges to implementation:

Ideas to overcome challenges:

10. *Health care organizations should collect, integrate, and periodically update data on patient race, ethnicity, and spoken and written language in the health records and management information systems.*

Degree of applicability:
[ ] Very applicable [ ] Applicable [ ] Somewhat applicable [ ] Not applicable*

*Why is this standard inapplicable?
Feasibility to implement:
[ ] Very feasible [ ] Feasible [ ] Somewhat feasible [ ] Not feasible*

*Why would it be unfeasible?

Anticipated challenges to implementation:

Ideas to overcome challenges:

11. Health care organizations should maintain current demographic, cultural, and epidemiologic profiles of the community, and perform needs assessments to plan and implement CLAS.

Degree of applicability:
[ ] Very applicable [ ] Applicable [ ] Somewhat applicable [ ] Not applicable*

*Why is this standard inapplicable?

Feasibility to implement:
[ ] Very feasible [ ] Feasible [ ] Somewhat feasible [ ] Not feasible*

*Why would it be unfeasible?

Anticipated challenges to implementation:

Ideas to overcome challenges:

12. Health care organizations should develop participatory, collaborative partnerships with communities to facilitate community and patient involvement in CLAS.

Degree of applicability:
[ ] Very applicable [ ] Applicable [ ] Somewhat applicable [ ] Not applicable*

*Why is this standard inapplicable?

Feasibility to implement:
[ ] Very feasible [ ] Feasible [ ] Somewhat feasible [ ] Not feasible*

*Why would it be unfeasible?

Anticipated challenges to implementation:

Ideas to overcome challenges:

13. Health care organizations should have conflict and grievance procedures that identify, prevent, and resolve cross-cultural complaints by patients.

Degree of applicability:
[ ] Very applicable [ ] Applicable [ ] Somewhat applicable [ ] Not applicable*

*Why is this standard inapplicable?

Feasibility to implement:
[ ] Very feasible [ ] Feasible [ ] Somewhat feasible [ ] Not feasible*

*Why would it be unfeasible?

Anticipated challenges to implementation:

Ideas to overcome challenges:

14. Health care organizations should make information about CLAS implementation available to the public.

Degree of applicability:
[ ] Very applicable [ ] Applicable [ ] Somewhat applicable [ ] Not applicable*

*Why is this standard inapplicable?

Feasibility to implement:
[ ] Very feasible [ ] Feasible [ ] Somewhat feasible [ ] Not feasible*

*Why would it be unfeasible?

Anticipated challenges to implementation:

Ideas to overcome challenges:

CLAS Quality Improvement Plan Evaluation Checklist
Instructions

GOALS

The **CLAS Quality Improvement Plan Evaluation Checklist** is not intended to be used for organizational self-assessment of CLAS activities. Rather, it is specifically designed to evaluate CLAS-based quality improvement plans.

The goal of using the checklist is twofold. First, it provides a quantitative summation of the ways in which CLAS standards are integrated in a given plan. Second, it enables a quantitative assessment of which aspects of each CLAS standard the plan identifies. It is intended to be an objectively, quantitative measure of the relevance of individual participant project plans to targeted CLAS standard(s).

Although the evaluation checklist is designed to evaluate plans after they have been written, it may be helpful to participants in the process of developing their plans.

USAGE

The evaluator will:

- Obtain copies of all CLAS-based quality improvement plans.
- Complete an evaluation checklist for each of the plans based solely on the information included in the written plan.

Validity of the checklist can be tested at the discretion of the evaluator by asking participants to complete a checklist on their own plans. The evaluator and participant scoring can then be compared for internal consistency. This test may identify discrepancies between a participant's conceived plan and efforts to accurately document it using the **CLAS Quality Improvement Plan** Worksheet.

Table 6 CLAS Quality Improvement Plan Evaluation Checklist

Department, organization or service area:
Project title:
CLAS standard(s) on which this project focuses:

When reviewing a plan, consider whether the plan directly states the criteria as its only goal or as part of a larger goal. If neither, the response to the evaluation criteria should be "No".		
Standard 1: Health care organizations should communicate with patients using clear, understandable terminology, and perform respectful care compatible with clients' cultural health beliefs and preferred language.	**Yes**	**No**
Respectful care taking into consideration the values, preferences, and expressed needs of the client		
Understandable care communicated in the preferred language of clients and ensuring the patient understands all clinical and administrative information		
Effective care resulting in desirable outcomes, appropriate preventive services, diagnosis, treatment, adherence, and improved health status		
Compatibility with the cultural health beliefs of clients		
Compatibility with the cultural practices of clients		
Compatibility with the preferred language of clients		
Standard 2: Health care organizations should implement recruitment, retention, and promotion of diverse staff employees and leaders who represent the demographic characteristics of the service area.	**Yes**	**No**
To recruit a diverse staff		
To use proactive strategies to build a diverse workforce		
To retain a diverse staff		
For responsiveness toward the ideas and challenges that a culturally diverse staff offers		
To promote a diverse staff		
To recruit, retain, or promote diverse staff representative of the demographic of the service area		
For representation based on continual assessment of staff demographics		
For representation based on continual assessment of community demographics		
To recruit, retain or promote diverse staff at all levels of the organization		
For continuing efforts to design, implement, and evaluate strategies not on numerical goals or quotas		
To staff diversity in mission statement		
To staff diversity in strategic plans		
To staff diversity in goals		

Standard 3: Health care organizations should ensure ongoing education in CLAS delivery.	**Yes**	**No**
For ongoing education and training in culturally appropriate service delivery		
For ongoing education and training in linguistically appropriate service delivery		
To ensure staff participation		
For formal CME		
For time off or compensated time given for participation		
For mandatory participation		
For staff at all levels and across all disciplines		
For community representatives to participate in the development of CLAS education and training		
Standard 4: Health care organizations must provide language assistance services at all points of contact, in a timely manner, and during all hours of operation.	**Yes**	**No**
Offer and provide language assistance services		
Measure bilingual staff		
Increase bilingual staff		
Measure interpreter services		
Increase interpreter services		
Measure points of contact for language services		
Increase points of contact for language services		
Measure hours of operation when interpreter services are offered		
Measure the wait times in which interpreter services are offered		
Increase hours of operation when interpreter services are offered		
Decrease wait times in which interpreter services are offered		
Measure the languages of clients and staff		
Catalogue types of interpreters – bilingual staff, face-to-face interpreting, telephone		
Provide language assistance services at no cost to each client		
Standard 5: Health care organizations must inform clients verbally, in writing, and in their preferred language about their right to receive language assistance services.	**Yes**	**No**
To explicitly inquire about the preferred language of each client		
To record the preferred language in one place		
To record the preferred language in all places		
To make verbal offers to clients to receive services in their preferred language		
For verbal notice of the right of clients to receive services in their preferred language		
For written notice of the right of clients to receive services in their preferred language		

Standard 6: Health care organizations must assure the competence of language assistance. Family and friends should not be used to provide interpretation services unless requested by the patient.	**Yes**	**No**
To measure if bilingual clinicians have a command of English and target language		
To measure if bilingual staff members have a command of English and target language		
To measure if interpreters have a command of English and target language		
To formally test bilingual clinicians		
To formally test bilingual staff members		
To formally train and test Interpreters in techniques, ethics, and cross-cultural issues – minimum 40 hours		
To measure if family, friends, minor children, or others are encouraged to interpret		
To document interpreter use		
Standard 7: Health care organizations must make available patient-related materials and post signage in the languages of the commonly encountered groups.	**Yes**	**No**
Translate vital documents		
Measure commonly encountered languages		
Verbally notify patients of the right to receive oral translation of written materials in uncommon languages		
Deliver oral translation of written materials in uncommon languages		
Measure signage in commonly encountered language identifying clients' rights		
Increase signage in commonly encountered language identifying clients' rights		
Measure signage in commonly encountered language describing available conflict and grievance resolution processes		
Increase signage in commonly encountered language describing available conflict and grievance resolution processes		
Measure direction-finding signage in commonly encountered language		
Increase direction-finding signage in commonly encountered language		
Measure materials in alternative formats for illiterate, non-written languages and/or sensory, developmentally, or cognitively impaired patients		
Increase materials that are in alternative formats		
Measure the responsiveness to cultures of materials		
Increase the responsiveness to cultures of materials		
Measure the responsiveness to the levels of literacy of clients in materials		
Increase responsiveness to the levels of literacy of patients in materials		
Develop policies and procedures to ensure the development of quality non-English signage and materials appropriate for target audience		
Use back translation to ensure accuracy of written translated materials		
Check if state or local non-discrimination laws supersede federal requirements		

Standard 8: Health care organizations should have a written strategic plan that identifies goals, policies, operational plans, and management accountability to provide CLAS.	**Yes**	**No**
For goals to provide CLAS		
For policies to provide CLAS		
For operational plans to provide CLAS		
For management accountability and oversight mechanisms to provide CLAS		
To include a person with authority to implement CLAS-specific activities		
To monitor responsiveness of the whole organization to cultural and linguistic needs of patients		

Standard 9: Health care organizations should have ongoing organizational self-assessments of CLAS, and integrate CLAS into internal audits and evaluations of performance improvement, patient satisfaction, and outcomes.	**Yes**	**No**
Measure organizational self-assessment of all CLAS-related activities		
Initiate organizational self-assessment of all CLAS-related activities		
Promote organizational self-assessment of all CLAS-related activities		
Measure a self-assessment of a specific CLAS activity		
Initiate a self-assessment of a specific CLAS activity		
Promote a self-assessment of a specific CLAS activity		
Identify an initial inventory of organizational policies, practices, and procedures		
Identify an ongoing evaluation of progress		
Integrate cultural and linguistic competence-related measures into existing quality improvement activities		
Integrate cultural and linguistic competence-related measures into internal audits		
Integrate cultural and linguistic competence-related measures into performance improvement activities		
Integrate cultural and linguistic competence-related measures into outcomes-based evaluation		
Make a client or consumer and community survey		

Standard 10: Health care organizations should collect, integrate, and periodically update data on client race, ethnicity, and spoken and written language in the health records and management information systems.	**Yes**	**No**
Promote the collection of clients' race data		
Promote the collection of clients' ethnicity data		
Promote the collection of clients' spoken language data		
Promote the collection of clients' written language data		
Promote the collection of data about clients' additional identifiers		
Initiate the collection of clients' race data		
Initiate the collection of clients' ethnicity data		
Initiate the collection of clients' spoken language data		
Initiate the collection of clients' written language data		
Initiate the collection of data about clients' additional identifiers		

Document identifiers in client records		
Document identifiers in client information systems		
Inform patients about the purposes of collecting data on race, ethnicity, and language		
Emphasize that identifiers are confidential and will not be used for discriminatory purposes		
Inform clients that revealing identifiers is not required		
Use self-identification and avoid use of observational or visual assessment methods whenever possible		
Standard 11: Health care organizations should maintain current demographic, cultural, and epidemiologic profiles of the community and perform needs assessments to plan and implement CLAS.	**Yes**	**No**
Use focus groups, interviews, and surveys		
Initiate a current demographic profile of a community		
Initiate a current cultural (needs, attitudes, behaviors, health practices, concerns about using health care services) profile of a community		
Initiate a current epidemiological profile of a community		
Promote a current demographic profile of a community		
Promote a current epidemiological profile of a community		
Use U.S. Census figures		
Use voter registration data		
Use school enrollment profiles		
Use county or state health status reports		
Use data from community agencies and organizations		
Use the profile to accurately plan for services that respond to the cultural characteristics of the service area		
Use the profile to accurately implement services that respond to the cultural characteristics of the service area		
Use the profile to accurately plan for services that respond to the linguistic characteristics of the service area		
Use the profile to accurately implement services that respond to the linguistic characteristics of the service area		
Standard 12: Health care organizations should develop participatory, collaborative partnerships with communities to facilitate community and client involvement in CLAS.	**Yes**	**No**
For community partnerships to include public comments about broad organizational policies, evaluation mechanisms, marketing and communication strategies, and staff training		
To initiate a participatory and collaborative community partnership		
To promote a participatory and collaborative community partnership		
To make “token” partnerships more participatory and collaborative		
To initiate a variety of formal and informal mechanisms to address community partnership		

To promote a variety of formal and informal mechanisms to address community partnership		
Standard 13: Health care organizations should have conflict and grievance procedures that identify, prevent, and resolve cross-cultural complaints by clients.	**Yes**	**No**
Ensure that conflict and grievance resolution processes are culturally and linguistically sensitive for matters that encompass difficulties related to informed consent and advanced directive, accessing services or denial of services, and outright discrimination		
Ensure that conflict and grievance resolution processes are capable of identifying, preventing, and resolving cross-cultural conflicts or complaints		
Ensure that all staff members are trained to recognize these potential conflicts		
Ensure that all staff members are trained to prevent these potential conflicts		
Ensure that clients have access to complaint and grievance services		
Ensure that clients are informed about complaint and grievance services		
Standard 14: Health care organizations should make information about CLAS implementation available to the public.	**Yes**	**No**
Make available to the public information about the system's progress and successful innovations in implementing CLAS		
Promote public information about implementing CLAS standards		
Initiate public notice about the availability of this information		
Promote public notice about the availability of this information		

U.S. Department of Health and Human Services, Office of Minority Health. (2001). *National standards for culturally and linguistically appropriate services in health care, final report*. Rockville, MD: USDHHS.

Workshop Session IV:

1. Participant Post-Curriculum Survey 88

2. Participant Satisfaction Survey 93

Workshop Session IV: System Change and CLAS

Overview: An established leader from the organization will discuss leadership strategies and his or her management philosophy with you in this session. Take this important opportunity to reflect on how you can be an effective leader and an agent for system change. You also will discuss your CLAS quality improvement plan with others whose plans have similar goals, in order to determine opportunities for collaboration and sharing of resources. The coordination of your plan with that of other participants will help to comprehensively implement CLAS at the organization as a whole. At the end of the session, you will be asked to fill out a Post-Curriculum Survey and a Satisfaction Survey. This session concludes the 16-hour learning workshop. The facilitators will coordinate with you to determine a follow-up meeting time one month later to assist with further development and implementation of the CLAS quality improvement plan.

Learning objectives

At the end of **Workshop Session IV**, you should have acquired the following knowledge, skills and attitudes.

Knowledge to:

1. Describe the qualities and approaches of effective leaders;
2. Describe the strategies used for system change;
3. Describe how the CLAS standards can be applied to your service and the organization as a whole;
4. Understand the ways in which your service is related to other participants' services in order to enhance collaboration and pool resources;

Skills to:

1. Assess the readiness of your service for the CLAS standards;
2. Formulate a strategic plan to implement CLAS standards in your service and in the organization;

Attitudes to:

1. Commit to improving the quality of your service through the CLAS standards;
2. Appreciate the role that you and others have to collectively and collaboratively implement the CLAS standards.

Providing Quality Health Care with CLAS

Participant Post-Curriculum Survey

Please select the best answer to define the following:

1. I can describe the role of each participant from my department.

[ ] Strongly agree [ ] Agree [ ] Disagree [ ] Strongly disagree

Please define the following terms in questions 2–7:

2. Cultural competence
   - [ ] Being an expert regarding the particular languages, behaviors and beliefs of diverse communities
   - [ ] The ability to speak the same language as the population served
   - [ ] A set of knowledge, skills, attitudes, policies, practices, and methods that enable care providers and programs to work effectively with culturally diverse communities
   - [ ] Being of the same ethnic background as the population served

3. Patient-centered care
   - [ ] Care that integrates the patient's perspectives and promotes greater patient involvement in his or her care
   - [ ] Consideration of the patient's limitations when developing care plans
   - [ ] Performing learning needs assessments with patients
   - [ ] Integration of methods to mitigate barriers to learning

4. Racial and ethnic health care disparities
   - [ ] Discrimination resulting in lack of access to necessary health care services
   - [ ] Patient preferences, belief systems and/or language barriers resulting in differential outcomes
   - [ ] Racial or ethnic differences in the quality of health care that are not due to access-related factors or clinical needs, preferences and appropriateness of intervention
   - [ ] Differential outcomes related to the unique language, culture, spiritual, or other determinants complicating the health care delivery process

5. Culture
   - [ ] Groups of people who have a shared racial or ethnic background
   - [ ] A set of meanings, norms, beliefs, and values shared by a group of people
   - [ ] Groups of people who have the same racial and/or ethnic heritage with shared language and practices
   - [ ] Social behaviors related to shared ethnicity, race, spiritual beliefs, and language

6. Illness narrative

[ ] Documented portion of a patient's medical history
[ ] A person's story of his or her experience of disease
[ ] The patient's version of what ails him or her
[ ] Cultural beliefs regarding illness shared by members of a group

7. Health belief

[ ] An individual's concept of illness and health
[ ] The patient's understanding of steps required to do to regain better health
[ ] Cultural beliefs regarding health shared by members of a group
[ ] All of the above

8. How many CLAS standards exist?

[ ] 4
[ ] 10
[ ] 14
[ ] 7

9. Which standard(s) is/are mandated for agencies that receive federal funding?

[ ] #1
[ ] All
[ ] #4, #5, #6, #7
[ ] None

10. Which agency developed the CLAS standards?

[ ] JCAHO
[ ] U.S. Department of Health and Human Services, Office of Minority Health
[ ] California Department of Public Health
[ ] California Department of Health Care Services, Medi-Cal

11. The CLAS standards are mandated under what authority?

[ ] JCAHO
[ ] California Department of Public Health
[ ] Title VI
[ ] No mandate

12. Evidence has shown that ethnicity, class, religion, spirituality, sexual orientation, racism, and other cultural factors influence health care decision making.

[ ] Strongly agree [ ] Agree [ ] Disagree [ ] Strongly disagree

13. Maintaining current, accurate data regarding patient race, ethnicity, and language preference is necessary to provide quality health care.

[ ] Strongly agree [ ] Agree [ ] Disagree [ ] Strongly disagree

14. I am familiar with strategies for promoting system-level change.

[ ] Strongly agree [ ] Agree [ ] Disagree [ ] Strongly disagree

15. I am aware of CLAS-based projects in my health system.

[ ] Strongly agree [ ] agree [ ] Disagree [ ] Strongly disagree

16. Language barriers have been shown to inhibit the quality of health care.

[ ] Strongly agree [ ] Agree [ ] Disagree [ ] Strongly disagree

17. In order to overcome health disparities between people of different race, ethnicity, and language, materials and assistance must be offered in each patient's preferred language.

[ ] Strongly agree [ ] Agree [ ] Disagree [ ] Strongly disagree

18. I am prepared to implement CLAS-based projects relevant to my service area.

[ ] Strongly agree [ ] Agree [ ] Disagree [ ] Strongly disagree

19. The CLAS standards are important to delivery of quality health care.

[ ] Strongly agree [ ] Agree [ ] Disagree [ ] Strongly disagree

20. I agree with the rationale for the CLAS standards.

[ ] Strongly agree [ ] Agree [ ] Disagree [ ] Strongly disagree

21. Implementation of CLAS-based programs is possible.

[ ] Strongly agree [ ] Agree [ ] Disagree [ ] Strongly disagree

22. Quality improvement efforts must include consideration of the CLAS standards.

[ ] Strongly agree [ ] Agree [ ] Disagree [ ] Strongly disagree

23. A diverse workforce is essential to provision of quality health care.

[ ] Strongly agree [ ] Agree [ ] Disagree [ ] Strongly disagree

24. Understanding the cultural backgrounds of patients is important.

[ ] Strongly agree [ ] Agree [ ] Disagree [ ] Strongly disagree

25. Appreciation of the cultural backgrounds of my co-workers and colleagues is important.

[ ] Strongly agree [ ] Agree [ ] Disagree [ ] Strongly disagree

26. Attainment of equity in health care is essential.

[ ] Strongly agree [ ] Agree [ ] Disagree [ ] Strongly disagree

27. Understanding the way in which a patient experiences illness is necessary in order to deliver quality health care.

[ ] Strongly agree [ ] Agree [ ] Disagree [ ] Strongly disagree

28. Understanding one's own culture and/or belief systems is mandatory in providing quality health care.

[ ] Strongly agree [ ] Agree [ ] Disagree [ ] Strongly disagree

29. Cultural barriers affect the quality of health care provided.

[ ] Strongly agree [ ] Agree [ ] Disagree [ ] Strongly disagree

30. Culturally appropriate services are important components of quality health care.

[ ] Strongly agree [ ] Agree [ ] Disagree [ ] Strongly disagree

31. Linguistically appropriate services are fundamental aspects of quality health care.

[ ] Strongly agree [ ] Agree [ ] Disagree [ ] Strongly disagree

32. Collaboration is necessary for meaningful system change.

[ ] Strongly agree [ ] Agree [ ] Disagree [ ] Strongly disagree

33. Collaboration with other services is needed to provide quality health care.

[ ] Strongly agree [ ] Agree [ ] Disagree [ ] Strongly disagree

34. CLAS-based efforts can improve quality of health care and/or services.

[ ] Strongly agree [ ] Agree [ ] Disagree [ ] Strongly disagree

35. Institutionalizing the CLAS standards can lead to reduced health care disparities in my organization.

[ ] Strongly agree [ ] Agree [ ] Disagree [ ] Strongly disagree

36. I have used the CLAS standards to help me develop programs.

[ ] Strongly agree [ ] Agree [ ] Disagree [ ] Strongly disagree

37. Have you actually attempted implementation of CLAS-based quality improvement project/s?

[ ] Yes [ ] No

38. Do you have access to patient data on race?

[ ] Yes [ ] No

39. Do you have access to patient data on ethnicity?

[ ] Yes [ ] No

40. Do you have access to patient data on preferred language?

[ ] Yes [ ] No

41. Do you adjust service delivery based on racial, ethic, and language preference data?

[ ] Yes [ ] No [ ] N/A

42. Does your department adjust or change service delivery based on the data?

[ ] Yes [ ] No [ ] N/A

43. I can develop a plan to place one or more of the CLAS standards into operation.

[ ] Strongly agree [ ] Agree [ ] Disagree [ ] Strongly disagree

Participant Satisfaction Survey

Please rate the following components of the curriculum

Session I: Introduction to the CLAS Standards					
	Excellent	Good	Fair	Poor	N/A
Overall rating of Session I					
Degree to which session met the learning objectives					
Cultural meaning of names exercise					
PowerPoint presentation					
Vision statement exercise and discussion					
Systems change exercise and discussion					
Small-group sessions					
In-class assignments					
Intersession assignment: CLAS A to Z					
Intersession assignment: Illness narrative					
Handouts					
Quality of facilitation					
Comments:					

Session II: Quality of Care for Culturally Diverse Patients					
	Excellent	Good	Fair	Poor	N/A
Overall rating of Session II					
Degree to which session met the learning objectives					
Illness narrative exercise					
Person Centered Care: Tuyet Nguyen					
Person Centered Care: Jimena López					
Case vignettes: Large-group discussion					
Case vignettes and CLAS: Small-group discussion					
Intersession assignment: Research CLAS standards					
Handouts					
Quality of facilitation					
Comments:					

Session III: Getting to Know the CLAS Standards					
	Excellent	Good	Fair	Poor	N/A
Overall rating of Session III					
Degree to which session met the learning objectives					
Participant presentation of CLAS standards					
Guest speaker: Model program					
Handouts					
Intersession assignments: CLAS QI plan					
Quality of facilitation					
Comments:					

Session IV: System Change and CLAS					
	Excellent	Good	Fair	Poor	N/A
Overall rating of Session IV					
Degree to which session met the learning objectives					
Developing CLAS: Small-group discussion					
Guest speaker: Leadership talk					
Handouts					
Quality of facilitation					
Comments:					

Overall Rating of the Series					
	Excellent	Good	Fair	Poor	
Overall rating					
Degree to which session met the learning objectives					
Audio recordings					
PowerPoint presentations					
Guest speakers					
Handouts					
Small-group sessions					
In-class assignments					
Intersession assignments					
Quality of facilitation					
Would you recommend this course to colleagues?	[ ] Yes	[ ] No			
Comments:					

Facilitator #1 Evaluation				
Facilitator name:				
	Excellent	Good	Fair	Poor
Knowledge of subject				
Level of organization				
Presentation style				
I would recommend using this facilitator again (Circle your selection)	Strongly agree	Agree	Disagree	Strongly disagree

Facilitator #2 Evaluation				
Facilitator name:				
	Excellent	Good	Fair	Poor
Knowledge of subject				
Level of organization				
Presentation style				
I would recommend using this facilitator again (Circle your selection)	Strongly agree	Agree	Disagree	Strongly disagree

Facilitator #3 Evaluation				
Facilitator name:				
	Excellent	Good	Fair	Poor
Knowledge of subject				
Level of organization				
Presentation style				
I would recommend using this facilitator again (Circle your selection)	Strongly agree	Agree	Disagree	Strongly disagree

Comments:

Facilities					
	Excellent	Good	Fair	Poor	NA
Room accommodations:					
Catering:					
Comments:					

Logistics and Planning					
	Excellent	Good	Fair	Poor	NA
Written communication (e-mail):					
Directions (location, time, date):					
Location:					
Time:					
Date:					
Access to facilities:					
Physical space: air temperature:					
Audiovisual equipment quality:					
Noise level:					
Comments:					

Follow-Up Meetings: Maintaining the Momentum

Overview: The purpose of the monthly follow-up meetings is to help you and your fellow participants continue the implementation of your CLAS quality improvement plans.

Learning objectives

At the end of the **Follow-up Meetings**, you should have acquired the following knowledge, skills and attitudes.

Knowledge to:

1. Describe the key accomplishments and difficulties that you have encountered in implementing your quality improvement plan;
2. Describe the key accomplishments and difficulties that other members of your group have encountered in implementing their respective quality improvement plans;
3. Describe potential strategies to build upon accomplishments and resolve problems;

Attitudes to:

4. Maintain your commitment toward implementing your quality improvement plan;
5. Maintain your interest in the implementation of the other members' quality improvement plans;

Skills to:

6. Be able to apply the potential strategies discussed previously in practical steps to resolve problems and build upon successes;
7. Be able to apply the challenges and success of other participants' plans to the implementation of your own plan.

Follow-Up Sessions form:

CLAS QI Project Update Worksheet.....100

CLAS QI Project Update Worksheet

Date:

Session number:

Project name:

Project participants:

Interval accomplishments:

Interval obstacles:

Group responses:

Identified next steps:

Appendix A: Culturally and Linguistically Appropriate Services (CLAS) Standards (abbreviated version)

Health care organizations should:

1. Implement respectful care, using easily understandable terminology, compatible with cultural health beliefs and in the preferred language;
2. Engage recruitment, retention, and promotion of diverse staff employees and leaders who are representative of the demographic characteristics of the service area;
3. Conduct ongoing education in CLAS delivery;
4. Provide language assistance services at all points of contact, in a timely manner, and during all hours of operation;
5. Inform patients verbally, in writing, and in their preferred language about their right to receive language assistance services;
6. Assure the competence of language assistance. Family and friends should not be used to provide interpretation services unless requested by the patient;
7. Make available patient-related materials and signage in the languages of the commonly encountered groups;
8. Have a written strategic plan that identifies goals, policies, operational plans, and management accountability that supports delivery of CLAS;
9. Have ongoing organizational self-assessments of CLAS, and integrate CLAS into internal audits and evaluations of performance improvement, patient satisfaction, and outcomes;
10. Implement data collection on patient race, ethnicity, spoken and written language, and integrate and update that information in the health records and management information systems;
11. Maintain current demographic, cultural, and epidemiologic profiles of the community, and perform a needs assessments to implement CLAS;
12. Have participatory, collaborative partnerships with communities to facilitate community and patient involvement in CLAS;
13. Have CLAS-inspired conflict and grievance procedures that identify, prevent, and resolve cross-cultural complaints by patients;
14. Make information about CLAS implementation available to the public.

U.S. Department of Health and Human Services, Office of Minority Health. (2001). *National standards for culturally and linguistically appropriate services in health care, final report*. Rockville, MD: USDHHS.

Appendix B: Recommend Readings

Please note that citations we considered important were annotated

CLAS standards

*Office of Minority Health, U.S. Department of Health and Human Services. (2000). *National standards for culturally and linguistically appropriate services (CLAS) in health care*. Federal Register, 65(247), 80865-80879. Retrieved from http://www.omhrc.gov/clas/finalcultural1a.htm

*Putsch, P., SenGupta, I., Sampson, A., & Tervalon, M. (2003). *Reflections on the CLAS standards: Best practices, innovations and horizons*. The Cross Cultural Health Care Program, Seattle, WA: Office of Minority Health, Office of Public Health and Science United States Department of Health and Human Services.

*U.S. Department of Health and Human Services, Office of Minority Health. (2001). *National standards for culturally and linguistically appropriate services in health care, final report*. Rockville, MD: USDHHS.

This is the full report that set forth the CLAS standards. It is essential reading for anyone developing, implementing, and evaluating any project in accordance with the CLAS standards.

*U.S. Department of Health and Human Services, Office of Minority Health. (2001). *National standards for culturally and linguistically appropriate services in health care, executive summary*. Rockville, MD: USDHHS.

This is the executive summary of the CLAS standards. The executive summary appears in English at http://www.omhrc.gov/assets/pdf/checked/executive.pdf and in Spanish at http://www.omhrc.gov/assets/pdf/checked/spanishexeSum.PDF. The full version contains much information that is not included in the summaries, although the summaries consist of more than 40 pages.

Implementation of CLAS standards

*American Institutes for Research. (2005). *A patient-centered guide to implementing language access services in health care organizations*. Prepared for the U.S. Department of Health and Human Services Office of Minority Health. Retrieved from http://www.omhrc.gov/Assets/pdf/Checked/HC-LSIG.pdf

* A copy is contained in the Resources and Reading section of the Facilitator's Manual and the Participant's CD.

This additional reading is a valuable resource that can improve understanding of linguistic competence within the larger construct of cultural competence.

Cross, T. L., Bazron, B. J., Dennis, K. W., & Issacs, M. R. (1989). *Towards a culturally competent system of care: A monograph on effective services for minority children who are severely emotionally disturbed, volume I*. National Technical Assistance Center for Children's Mental Health, Georgetown University Child Development Center.

Issacs, M. R. (1998). *Towards a culturally competent system of care: The state of the states: responses to cultural competence and diversity in child mental health,* (volume 3). National Technical Assistance Center for Children's Mental Health, Georgetown University Child Development Center.

Isaacs, M. R., & Benjamin, M. P. (1991). *Towards a culturally competent system of care,* (volume II). Washington, DC: National Technical Assistance Center for Children's Mental Health, Center for Child Health and Mental Health Policy, Georgetown University Child Development Center.

*Martinez, E. L., Cummings, L., Davison, L. A., Singer, I. A., DeGuzman, D. S. A., & Regenstein, M. (2003). *Serving diverse communities in hospitals and health systems*. U.S. Department of Health and Human Services Office of Minority Health. Prepared by the National Public Health and Hospital Institute: Washington, DC. Mazade, N. A. Concepts of Transformation. National Association of State Mental Health Program Directors Research Institute, Inc., Alexandria, VA.

*National Association of State Mental Health Program Directors, National Technical Assistance Center for State Mental Health Planning. (2004). Cultural competency: Measurement as a strategy for moving knowledge into practice in state mental health systems.

*Office of Minority Health. (2004). *Physician toolkit and curriculum: Resources to implement cross-cultural clinical practice guidelines for Medicaid practitioners*. Prepared by the University of Massachusetts Medical School, Office of Community Programs for the DHHS OMH.

This is essential reading. The University of Massachusetts Medical School, Office of Community Programs, in a project funded by the DHHS OMH, developed this physician tool kit and curriculum. The tool kit and curriculum, although specifically developed for clinical practitioners, demonstrates an effective mechanism and potential resource for instituting organizational change. It also is a good example of the application of the CLAS standards in curriculum form.

*Paras, M. (2005). *Straight talk: Model hospital policies and procedures on language access*. California Health Care Safety Net Institute & California Association of Public Hospitals and Health Systems. The California Endowment.

*Rosenbaum, S. (2003). Racial and ethnic disparities in health care: Issues in the design, structure, and administration of federal health care financing programs supported. In A. B. D. Smedley & A. R. Nelson (Eds.), *Unequal treatment: Confronting racial and ethnic disparities in health care* (664–698). Washington, DC: National Academics Press.

**Salimbene, Suzanne. (2001). CLAS A-Z: A practical guide for implementing the national standards for culturally and linguistically appropriate services. (CLAS) in Health Care, Inter-Face Intl.*

This is essential reading. The U.S. Department of Health and Human Services (DHHS) Office of Minority Health (OMH) discovered that when the CLAS standards were first published in 2001, numerous requests flooded the OMH seeking assistance and support in implementing the standards. OMH contracted with Dr. Suzanne Salimbene to develop a guide to assist providers and health care organizations to "create a health care environment that would meet the very real needs and expectations of an increasingly diverse patient/consumer population." This report has research- and data-gathering instruments that can be *easily* adapted and applied.

*U.S. Department of Health and Human Services, Office of Minority Health. (2000). Assuring cultural competence in health care: recommendations for national standards and an outcomes-focused research agenda.

*UQIOSC. (2005). CLAS standards implementation tips. QSource/UQIOSC.

Wells, M. (2000). Beyond cultural competence: A model for individual and institutional cultural development. *Journal of Community Health Nursing*, 17(4), 189–199.

All of these articles are indispensable. They offer key insights into different aspects of implementing organizational and systemic change.

Cultural and linguistic competence

*California county profiles: Limited English proficient population. (2006). The California Endowment.

*Cooper, L. A. & Roter, D. (2002). *Patient-provider communication: The effect of race and ethnicity on process and outcomes of health care*. Baltimore, MD: Johns Hopkins University.

*Goode, T. D., Dunne, M. C., & Bronheim, S. M.. (2006). *The evidence base for cultural and linguistic competency in health care*. National Center for Cultural Competence Center for Child and Human Development. Georgetown University: The Commonwealth Fund.

*Kelly, N. (2007). *Telephone interpreting in health care settings: Some commonly asked questions. The ATA Chronicle*.

*Permanente Journal. (2006). Personal stories from ethnographic histories. *The Permanente Journal*, 10(3).

U.S. Department of Health and Human Services. (2001). *Mental health: culture, race, and ethnicity – A supplement to mental health: A report of the surgeon general*. Rockville, MD.

*Wilson-Stronks, A., & Galvez, E. (2007). *Hospitals, language, and culture: A snapshot of the nation*. Exploring cultural and linguistic services in the nation's hospitals: A report of findings. The Joint Commission & The California Endowment.

This cultural and linguistic competence volume series is essential reading. The authors coined the terms "cultural" and "linguistic competence," and their works should be part of the knowledgebase of anyone doing work in cultural and linguistic competence. In short, this is the foundational document for cultural and linguistic competence.

Cultural and linguistic competence education and training

*Addressing language access issues in your practice. (2005). *A toolkit for physicians and their staff members*. The California Academy of Family Physicians and CAFP Foundation. The California Endowment.

A family physician's practical guide to culturally competent care. Retrieved from https://cccm.thinkculturalhealth.org/

This is additional reading. This cultural competence curriculum offers information about various cultural, linguistic, and organizational issues using numerous engaging case studies and critiques by providers and professionals in health care settings. It is a good example of the application of CLAS standards to physician education. The program equips family physicians with awareness, knowledge, and skills to better treat culturally diverse populations. The curriculum is a self-administered training for individuals with an interest in culturally competent care. To train physicians to care for culturally diverse populations, the OMH commissioned the Cultural Competency Curriculum Modules. These modules, encompassed in A Family Physician's Practical Guide to Culturally Competent Care, will equip family physicians and other health care professionals with competencies that will enable them to better treat culturally diverse populations. This site offers CME and CEU credits, contains numerous self–assessment instruments, case studies, audio vignettes, learning points, and pre- and post-tests, as well as opportunities to submit reactions and see what other colleagues think about the training and information.

*American Institutes for Research. (2002). *Teaching cultural competence in health care: A review of current concepts, policies and practices*. Report prepared for the Office of Minority Health. Washington, DC.

This is an excellent resource that examines individual, organizational, and systemic models for cultural and linguistic competence. The models described within the document are accompanied by an expansive list of the methods that organizations have used to codify cultural and linguistic competence into easily understood steps, actions, and strategies.

Center for Disease Control and Prevention. (2007). *General considerations regarding health education & risk reduction activities*. Department of Human and Health Services. Retrieved from http://www.cdc.gov/hiv/resources/guidelines/herrg/gen-con_community.htm

The HIV prevention community planning process requires an assessment of HIV prevention needs based on a variety of sources and various assessment strategies. This assessment serves as the basis for the development of a comprehensive HIV prevention plan. In addition, more targeted needs assessment may be required for effective health education program planning for health departments and non-governmental organizations (NGOs). Tailored needs assessments enable the program planner to make informed decisions about the adequacy, availability, and effectiveness of specific services that are available to the target audience.

Culhane-Pera, K., Reif, C., et al. (1997). A curriculum for multicultural education in family medicine. *Family Medicine,* 29(10), 719-723.

This concise article, for additional reading, describes a multicultural curriculum in the St. Paul Family Practice residency program (Minnesota). The three broad goals of the program were to help residents gain insight into how culture affects a practitioner's personal and professional life, how culture might influence patients' perspectives, and how communication skills are to be developed. Researchers adapted Bennet's developmental model of intercultural sensitivity into five developmental levels of cultural competence in medicine. The program utilized lectures, case discussions, community presentations, videotapes, role plays with simulated patients, and one-on-one faculty-resident evaluation of residents' videotaped clinical encounters. Evaluation showed that residents believed the letter was most helpful. In a self assessment, residents' knowledge and skills increased significantly, as did their level of "cultural competence." Residents' and faculty members' assessments of ending levels of competence correlated closely. The authors have done educators a commendable service in presenting participants' positive *and* negative comments, as well as the obstacles that program planners' faced in overcoming past participants' resistance to learning about the cultural dimensions of clinical practice.

*Gilbert, J. M. (Ed.). (2003). *Principles and recommended standards for cultural competence education of health care professionals*. The California Endowment.

*Gilbert, J. M. (Ed.). (2003). *Resources in cultural competence education for health care professionals*. The California Endowment.

Green, A., Betancourt, J., & Carillo, J. E. (2003). Worlds apart facilitator's guide. *Worlds apart: A four-part series on cross-cultural health care*. Boston, MA: Fanlight Production.

*Henry J. Kaiser Family Foundation. (2003). *Compendium of cultural competence initiatives in health care*. Prepared by: Courtney Rees, Intern, and Sonia Ruiz, Policy Analyst, The Henry J. Kaiser Family Foundation, with contributions from Marsha Lillie-Blanton, Vice President, and Osula Rushing, Policy Analyst, The Henry J. Kaiser Family Foundation.

This must–read report presents a comprehensive presentation of health care initiatives that have demonstrated success in improving culturally and linguistically competent services and supports. Retrieved from http://www.kff.org/minorityhealth/index.cfm.

Kai, J., et al. (1999). Learning to value ethnic diversity – What, why, how? *Medical Education*, 33, 616-623.

*National Initiative for Children's Health Care Quality. (2005). Improving cultural competency in children's health care. Cambridge, MA.: NICHQ.

Orlando Regional Health Care, Education & Development. (2004). Providing culturally competent care: Self-learning packet. Retrieved from http://www.orhs.org/classes/nursing/Cultcomp04.pdf

This vitally important document portrays a health care system's attempt to implement a self-learning tool based on improving cultural and linguistic competence for providers and staff members. The self-learning packet is intended to introduce health care professionals to effective methods for providing culturally appropriate, responsive, and sensitive care.

Papadopoulos, I. & Lees, S. (2001). Developing culturally competent researchers. *Issues and innovations in nursing education*.

*Pond, A. N. S. (2005). *Second language and cultural competency training for continuing medical education (CME) credit*. The California Endowment.

*Roat, C. E. (2003). *Health care interpreter training in the state of California*. Including an Analysis of trends and a compendium of training programs health care interpreter training in the state of California. The California Endowment.

*Thom, N. (2008). Using telephone interpreters to communicate with patients. *Nursing Times*, 104(46), 28–29.

Ton, H., Hilty, D. M., & Wilkes, M. S. (2005). *Teaching in small groups*. In Hilty, D. M., & Roberts, L. (Eds.), Survival guide for early career faculty in psychiatry & behavioral sciences. American Psychiatric Publishing Inc.

U.S. Department of Health and Human Services, Health Resources and Services Administration, Bureau of Health Professions, Division of Health Careers Diversity and Development. (2005). Transforming the face of health professions through cultural and linguistic competence education. Retrieved from http://www.hrsa.gov/culturalcompetence/curriculumguide/default.htm

Measuring cultural and linguistic competence

*Beach, M. C., Saha, S., & Cooper, L. A. (2006). The commonwealth fund. Retrieved from http://www.cmwf.rg/publications/publications_show.htm?doc_id=413721.

*Board on Neuroscience and Behavioral Health. (2002). *Speaking of health: Assessing health communication strategies for diverse populations*. *Behavioral changes in 21st century: Improving the health of diverse populations*. Washington, DC: National Academies Press.

Edberg, M. C., Wong, F. Y., Woo, V., & Doong, T. (2003). Elimination of health disparities in racial/ethnic minority communities: Developing data indicators to assess the progress of community-based efforts. *Evaluation and Program Planning,* 26, 11–19.

*Fortier J. P., & Bishop, D. (2003). *Setting the agenda for research on cultural competence in health care: Final report*. C. Brach. (Ed.). Rockville, MD: U.S. Department of Health and Human Services Office of Minority Health and Agency for Health Care Research and Quality.

This excellent report lends insights into past efforts and future trends in creating more culturally and linguistically competent individuals, organizations, and systems.

Inglehart, M., et al. (1997). Cultural audits: Introduction, process and results. *Journal of Dental Education,* 61(3), 283–288.

Kairys, J. A., & Like, R. C. (2006). Caring for diverse populations: Do academic family medicine practices have CLAS? *Family Medicine*, 38,196–205.

This essential article describes strategies to measure whether culturally and linguistically appropriate services are evident in family medicine practices. The researchers found major challenges in the family medicine practices in their study, including major frustrations relating to the care of diverse populations

*Mason, J. L., & Williams-Murphy, T. (1995). *Cultural competence self-assessment questionnaire: A manual for users*. Multicultural Initiative Project Research and Training Center on Family Support and Children's Mental Health Portland, Oregon: Portland State University Graduate School of Social Work, Regional Research Institute for Human Services.

Siegel, C., Davis-Chambers, E., Haugland, G., Bank, R., Aponte, C. & McCombs, H. (2000). Performance measures of cultural competency in mental health organizations. *Administration and Policy in Mental Health*, 28(2), 91–106.

This must-read article offers a comprehensive framework for measuring and evaluating cultural and linguistic competence. Although its focus is on mental health organizations, it can easily apply to health care organizations and/or systems.

*Speaking of health: Assessing health communication strategies for diverse population. Committee on Communication for Behavior Change in the 21st Century: Improving the Health of Diverse Populations Board on Neuroscience and Behavioral Health. (2003). Washington, DC: The National Academies Press.

U.S. Department of Health and Human Services, Health Resources and Services Administration. (2002). *Indicators of cultural competence in health care delivery organizations: An organizational cultural competence assessment profile*. Prepared by The Lewin Group, Inc., Linkins, K. W., McIntosh, S., Bell, J., & Chong, U.

Health disparities

*Byrd, M. W. & Clayton, L. A. (2003). Racial and ethnic disparities in health care: A background and history. In B. D. Smedley & A. R. Nelson (Eds.), *Unequal treatment: Confronting racial and ethnic disparities in health care* (444-527). Washington, DC: National Academics Press.

*California Department of Health Services. (2003). *Multicultural health disparities: California 1990–1999*. Center for Health Statistics, Office of Health Information and Research.

*California Endowment. (2003). *Unequal treatment, unequal health: What data tell us about health gaps in California*. Retrieved from http://www.calendow.org/reference/publications/pdf/disparities/TCE1029-2003_Unequal_Treatm.pdf

Casalino, L. P., Elster, A., Eisenberg, A., Lewis, E., Montgomery, J., & Ramos, D. (2007). Will pay-for-performance and quality reporting affect health care disparities? *Health Affairs*, 26(3), 405–414.

*Faden, R. & Powers, M. (2003). Racial and ethnic disparities in health care: An ethical analysis of when and how they matter. In B. D. Smedley & A. R. Nelson (Eds.), *Unequal treatment: Confronting racial and ethnic disparities in health care* (722–738). Washington, DC: National Academics Press.

Fiscella, K, Franks P., et al. (2000). Inequality in quality: Addressing socioeconomic, racial and ethnic disparities in health care. *Journal of the American Medical Association,* 283, 2579–2584.

These reports explain the unique health needs of culturally diverse communities in California.

*Geiger, H. J. (2003). Racial and ethnic disparities in diagnosis and treatment: A review of the evidence and a consideration of causes. In B. D. Smedley & A. R. Nelson (Eds.), *Unequal treatment: Confronting racial and ethnic disparities in health care* (417–454). Washington, D. C.: National Academics Press.

*Good, M. J. D. V., James, C., & Becker, A. E. (2003). The culture of medicine and racial, ethnic, and class disparities in health care. In B. D. Smedley & A. R. Nelson (Eds.), *Unequal treatment: Confronting racial and ethnic disparities in health care* (594–625). Washington, DC: National Academics Press.

Horowitz, C., et al. (2001). Approaches to eliminating socio-cultural disparities in health. *Minority Health Today*, 2(2)33–43.

This essential article presents three areas of focus targeting: (1) health care providers (i.e. via cultural competence training; (2) individual patients and communities; and (3) health systems and policies, and laws, and present opportunities to increase research and evaluation efforts.

*Institute of Medicine. (2002). Shaping for the future for health. *Unequal treatment: What health care administrators need to know about radical and ethnic disparities in health care*. Washington, DC: National Academies Press.

*Institute of Medicine. (2002). Shaping for the future for health. *Unequal treatment: What health care consumers need to know about radical and ethnic disparities in health care*. Washington, DC: National Academies Press.

*Institute of Medicine. (2002). Shaping for future for health. *Unequal treatment: What health care providers need to know about radical and ethnic disparities in health care*. Washington, DC: National Academies Press.

*Institute of Medicine. (2003). *Unequal treatment: Confronting racial and ethnic disparities in health care*. Committee on Understanding and Eliminating Racial and Ethnic Disparities in Health Care. Washington, DC: National Academies Press.

This consequential report presents clear and compelling evidence of health disparities for racially and ethnically diverse populations. It defines the issue with clarity and details the potential causes for health disparities and their effects on racial and ethnic minority populations.

*Joe, J. R. (2003). The rationing of health care and health disparity for the American Indians/Alaska natives. In B. D. Smedley & A. R. Nelson (Eds.), *Unequal treatment:*

Confronting racial and ethnic disparities in health care (528–551). Washington, DC: National Academies Press.

Key Facts: Race, Ethnicity & Medical Care. (2007).

*Mead, H, Cartwright-Smith, L., Jones, K., Ramos, C., & Siegel, B. (2008). *Racial and ethnic disparities in U.S. health care: A chartbook. Washington*, DC: The George Washington University School of Public Health and Health Services, Maya Angelou Research Center on Minority Health, Wake Forest University School of Medicine.

*Multicultural Health Series. (2005). The Institute of Cultural Affairs, 1996. Kaiser Permanente & The California Endowment.

*Murray-Garcia, J. L. (2002). Multicultural health 2002: An annotated bibliography. The California Endowment. Retrieved from http://www.calendow.org/reference/publications/pdf/disparities/TCE0222-2002_Multicultural.pdf

This important document identifies numerous research sources for multicultural health topics.

*Perez, T. E. (2003). The civil rights dimension of racial and ethnic disparities in health status. In B. D. Smedley & A. R. Nelson (Eds.), *Unequal treatment: Confronting racial and ethnic disparities in health care* (626–663). Washington, DC: National Academies Press.

*PolicyLink Report. (2002). Reducing health disparities through a focus on communities. Retrieved from http://www.calendow.org/reference/publications/pdf/disparities/TCE1106-2002_Reducing_Healt.pdf

*Rice, T. (2003). The impact of cost containment efforts on racial and ethnic disparities in health care: A conceptualization. In B. D. Smedley & A. R. Nelson (Eds.), *Unequal treatment: Confronting racial and ethnic disparities in health care* (699–721). Washington, DC: National Academies Press.

Smedley, B. D., Stith, A. Y. & Nelson, A. R. (Eds.). (2003). *Unequal treatment: Confronting racial and ethnic disparities in health care*. Washington, DC: The National Academies Press.

Smith, D. B. (1998). Addressing racial inequalities in health care: Civil rights monitoring and report cards. *Journal of Health, Politics, Policy and Law*, 23(1) 75-105.

This is an important detailed review of the history of civil rights monitoring of health care institutions in America. It provides a base for a historical record for understanding a root cause of health care disparities, in the context of race, ethnicity, and difference.

Williams, D. (2000). Understanding and addressing racial disparities in health care. *Minority Health Today*, 2(1), 30–39.

This must-read article makes an interesting argument that disparities constitute an enduring part of racism in this country.

*U.S. Department of Health and Human Services, Agency for Health Care Research and Quality. (2005). *National health care disparities report*. Rockville, MD: Agency for Health Care and Quality Research. AHRQ Publication No. 06-0017. Retrieved from http://www.ahrq.gov/qual/nhdr05/nhdr05.htm

This consequential report contains the most current information on health care disparities in the U.S. It also presents useful information that could benefit researchers, administrators, practitioners, consumers, and family members in understanding health care disparities and how to address them.

Quality of care

*Beach, M. C., Cooper, L. A., Robinson, K. A., Price, E. G., Gary, T. L., Jenckes, M. W., Gozu, A., Smarth, C., Feuerstein, C. J., Bass, E. B., & Powe, N. R. (2004). *Strategies for improving minority health care quality, evidence report/technology assessment, No. 90*. Prepared by John Hopkins University Evidence-based Practice Center, Baltimore, MD: Health care Research and Quality.

This must-read report helps define both quality of care for culturally diverse populations and innovative strategies for improving health care quality specifically for racial and ethnic minorities.

Institute of Medicine. (2001). *Crossing the quality chasm: A new health system for the twenty-first century*. Washington: National Academy Press.

This significant report delineates the most prominent issues in health care quality, as well as concise suggestions and recommendations on how to improve outcomes in quality of care. Although it is not focused on racial and ethnic minority populations, its impact inspired, in part, the IOM's later report, "Unequal Treatment."

System change

Dignan, L. & Carr, M. (1981). *Introduction to program planning: A basic text for community health education*. Philadelphia: Lea & Febiger.

This model focuses on community analysis, defining and verifying the problem; establishing program goals; defining and assessing behaviors; developing a program plan

including methods and activities; and designing a program evaluation for various program levels.

Dreachslin, J. (1999). Diversity leadership and organizational transformation: Performance indicators for health service organizations. *Journal of Health Care Management*, 44(6), 427–439.

*Hernandez, M. & Hodges, S. (2003). Crafting logic models for systems of care: Ideas into action. *Making children's mental health services successful series,* (Vol. 1). Tampa, FL: University of South Florida, The Louis de la Parte Florida Mental Health Institute, Department of Child & Family Studies.

*Judge, K. H., Zahn, D., Lustbader, N. J., Thomas, S., Ramjohn, D. & Chin, M. (2007). Factors contributing to sustaining and spreading learning collaborative improvements. Primary Care Development Corporation.

Lehman, W. E. K., Greener, J. M., & Simpson, D. D. (2002). Assessing organizational readiness for change. *Journal of Substance Abuse Treatment*, 22, 197–209.

*Nelson, E. C., Batalden, P. B., Godfrey, M. M., Headrick, L. A., Huber, T. P., Mohr, J. J., & Wasson, J. H. (2001). Microsystems in health care: The essential building blocks of high performing systems. Executive Summary for Health Care Leaders.

Petersen, D. J. & Alexander, G. R. (2001). Needs assessment in public health: A practical guide for students and professionals. *Health Education Research*, 17(2):273.

The book offers a step-by-step guide through the process, and uses case examples that are realistic and that will seem familiar to professionals working in the "trenches."

*World Health Organization (WHO). (2000). *Needs assessment: Workbook 3*. Geneva, Switzerland: World Health Organization. Retrieved from http://www.emcdda.europa.eu/attachements.cfm/att_5865_EN_3_needs_assessment.pdf

This workbook (Workbook 3) describes step-by-step methods for implementing evaluations. These steps span the start of the study, collecting, analyzing, and reporting the data, and putting the results into action in your treatment program.

Workforce development

Carlisle D., Gardner J., & Lin, H. (1998). The entry of underrepresented minority students into U.S. medical schools: An evaluation of recent trends. *American Journal of Public Health*, 88, 1314–1318.

This is an important article because it provides evidence of the underrepresentation of culturally diverse students in U.S. medical schools. Specifically, the article describes the decrease in diverse student enrollment in medical schools following passage of

Proposition 209 (California) and the Hopwood decision (Southern states). The authors found a nearly 10% decline in enrollment at medical schools versus an almost 2% decline at private medical schools.

Coffman, J. & Spetz, J. (1999). Maintaining an adequate supply of RNs in California. *Journal of Nursing Scholarship*, 31, 389–393.

This is an important article because it documents evidence of the underrepresentation of culturally diverse registered nurses (RNs) in California. Investigators determined that in to keep up with California's population growth, the state would need to need to add more than 40,000 RNs by 2010, and 74,000 by 2020. The report stated that Hispanics were the most underrepresented group, constituting only 4% of RNs in California, even though they make up more than 30% of the general population.

Cohen, J. J. (1997). Finishing the bridge to diversity. *Academic Medicine,* 72, 103–109.

Dower, C., McRee, T., Grumbach, K., et al. (2001). *The practice of medicine in California: A profile of the physician workforce*. San Francisco, CA: California Workforce Initiative at the UCSF Center for the Health Professions.

Fang, D., et al. (2000). Racial and ethnic disparities in faculty promotion in academic medicine. *Journal of the American Medical Association,* 284, 1085–1092.

Hayes-Bautista, D., Hsu, P., et al. (2000). Latino physician supply in California: Sources, locations, and projections. *Academic Medicine*, 75, 727–736.

Johnson, J., Jayaderappa, R., et al. (1998). Extending the pipeline for minority physicians: A comprehensive program for minority faculty development. *Academic Medicine,* 73, 237–244.

These are important articles because they report compelling arguments and strategies for increasing the cultural diversity of this nation's physician workforce.

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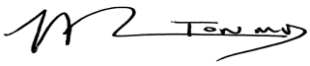
Message to the Facilitators and Participants

This tool kit has greatly benefitted from the valuable observations of the participants who trained in this curriculum. We are grateful for their involvement and appreciative of their time and insights. Their contributions have helped to make refinements that resulted in this version of the tool kit. We hope that this tool kit will help other health care organizations to develop and deliver culturally and linguistically appropriate services that will reduce health disparities and improve the quality of care for all patients.



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