Providing Quality Health Care with

CLAS

Culturally and Linguistically Appropriate Services

A Curriculum for Developing Culturally & Linguistically Appropriate Services

Facilitator's Manual

CDPH California Department of Public Health

DHCS California Department of Health Care Services

CalMH California Office of Multicultural Health

UC DAVIS 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

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Ronald W. Chapman, MD, MPH
Director
California Department of Public Health

Toby Douglas
Director
Department of Health Care Services

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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:

- Authors:

  Hendry Ton, MD, MS
  Director of Education, Center for Reducing Health Disparities (CRHD)
  University of California, Davis Health System (UCD)

  Daniel Steinhart
  Project Coordinator, UCD/CRHD

  Sergio Aguilar-Gaxiola, MD, PhD
  Director, UCD/CRHD

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Health organizations are encouraged to use the **Providing Quality Health Care with CLAS Curriculum Tool Kit** 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:

California Department of Public Health
Department of Health Care Services
Office of Multicultural Health
P.O. Box 997413, MS 0022
Sacramento, CA 95899-7413
916-440-7560
omhmail@cdph.ca.gov

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

Welcome to the **Providing Quality Health Care with CLAS curriculum tool kit**. This tool kit was designed to help your organization's leaders develop culturally and linguistically appropriate services that are aligned with your organization's unique mission and goals. Unlike many cultural competence workshops that last only a few hours, this curriculum will take the leaders in your organization through a process that will do more than enhance their awareness and appreciation of the Culturally and Linguistically Appropriate Services (CLAS) standards. It will also build their knowledge and skills to help them make *tangible improvements* to their service area. Most efforts that result in sustainable system change require commitment. The curriculum also requires the participants to allocate time within their busy schedule. People who have participated in this curriculum said they consider it time well spent, and recommend it to their colleagues. Participants report that the tool kit inspired system-wide quality improvements that helped optimize their organization's resources. If you believe that you and your colleagues are ready to commit to an endeavor that *will result* in practical plans aimed at CLAS-compliant improvements in the quality of your service, then please read on.

The ***Providing Quality Health Care with CLAS Facilitator's Manual*** will guide you through the essential steps of preparing and facilitating the curriculum. In addition to this manual, the **Providing Quality Health Care with CLAS tool kit** includes: 1) ***Facilitator's Multimedia Tutorial,*** the companion to this manual; 2) a brief **promotional video** that can be used to introduce the curriculum to potential participants and organizations; 3) a ***Participant Workbook*** that includes necessary worksheets; and 4) a **Resources and Reading** section that lists recommended readings, forms, and Microsoft PowerPoint presentations used in the curriculum. This table below identifies the respective components of tool kit CDs for facilitators and participants.

Table 1	**Providing Quality Care with CLAS Toolkit**
Facilitator's CD	**Participant's CD**
1. Printable *Facilitator's Manual* 2. *Facilitator's Multimedia Tutorial* 3. Resources and Readings 4. Promotional Video	1. Printable Participant Workbook 2. Resources and Readings

Providing Quality Health Care with CLAS utilizes a strength-based approach that entails organizational self-assessment to help participants determine how best to implement these standards, building upon the system's existing infrastructure, mission, and values. Participants will engage in 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., 2004). Rather than having a "cookbook" approach that superimposes a model without attention to the unique challenges and strengths of a particular organization, this strength-based approach can more effectively help leaders to implement these standards creatively.

The curriculum is composed of three phases. The first phase, the **Organizational Culture Assessment**, involves interviewing the participants and other key personnel in the organization to assess the institutional culture, values, and history. This assessment helps the facilitators to customize the curriculum to the participants. The second phase of the curriculum consists of the **Learning Workshops**, divided into four workshop sessions, each lasting 4 hours. In the last phase, the **Follow-up**, participants also will be asked to attend six monthly 1-hour meetings to assist them in ongoing efforts to implement and maintain CLAS programs developed in the workshop sessions.

1. Organizational Culture Assessment
2. Learning Modules:
    a. Workshop Session I: Introduction to the CLAS Standards
    b. Workshop Session II: Quality of Care for Culturally Diverse Patients
    c. Workshop Session III: Getting to Know the CLAS Standards
    d. Workshop Session IV: System Change and CLAS
3. Follow-Up Meetings: Keeping up the Momentum

This manual and the accompanying tutorial will help the facilitator carry out each of the three phases of the curriculum. Also included in this guide is the **Principles of Facilitating Cultural Competence Workshops** appendix that is intended to help the facilitator address some general issues common to cultural competence trainings.

Table 2 Recommended Timeline:

	Wk 1-3	Wk 4	Wk 5	Wk 6	Wk 7	Wk 8	Wk 9	Wk 13	Every 4 wks
Organizational Culture Assessment	■	■							
Workshop Session I			■						
Workshop Session II				■					
Workshop Session III					■				
Workshop Session IV							■		
Follow-up Meetings								■	■

Organizational Culture Assessment

Understanding the culture of the organization that will participate in the curriculum is essential. That comprehension will enable you to gain insight into the organization's readiness for implementing the CLAS standards. You will also better understand the potential obstacles and resources available within the organization to promote change. Moreover, this perspective allows you to identify departments within the organization that may potentially collaborate or have synergistic potential. Finally, the **Organizational Culture Assessment** helps to identify formal and informal champions of CLAS as well as those who may be resistant to CLAS implementation.

PART I: Assessment of Organizational Mission and Roles

Because **Providing Quality Health Care with CLAS** is as much a curriculum about organizational change as it is about CLAS topics, you must understand the organization at its baseline. The following steps have been identified to help facilitators gain a broad systems perspective of the state of the organization, and to develop ideas about how the CLAS standards can potentially benefit the organization.

1. Obtain the mission statement of the organization.
2. Form preliminary thoughts about the relationship between the mission statement and these questions:
    a. What values are reflected in the mission statement?
    b. How might these values be linked to the CLAS standards?
    c. How will you make these links for the participants?
    d. Which organizational values may pose resistance to implementation of the CLAS standards?
    e. How will you approach this potential obstacle with participants?
3. Obtain the organizational chart for the system or organization.
4. For each person or position in the organizational chart, formulate preliminary thoughts about the following questions:
    a. What is the role of this person in the organization?
    b. How does this person or position relate to the other roles depicted in the organizational chart?
    c. How might CLAS standards be applied to his or her department?
    d. What other people or positions might this person need to enhance their CLAS efforts?
    e. What other individuals who are not depicted in the organizational chart should be involved in the curriculum?

PART II: Key Informant Interviews

Key informant interviews are commonly conducted by cultural anthropologists and qualitative researchers to understand the perspectives, viewpoints, and values of a particular group – in other words, its culture. We use this method to do the same. Interviews will help you to understand how the organization works and the particular stand that its key members have on system change and culturally and linguistically appropriate services. The process of conducting interviews also may nurture your development of a one-to-one relationship with potential participants, helping you to facilitate more effectively in the upcoming workshops. Please follow these three guidelines:

1. Schedule 30-minute interviews with each of the people on the organizational chart. While interviewing all the individuals is ideal, time and resources may limit the feasibility of doing so. Strive to interview at least 50% of the individuals, with priority for the organization's top leaders and individuals who are specifically charged with responsibilities that involve cultural competence or linguistic access.
2. During the interviews, identify key people not otherwise depicted in the organizational chart, and schedule interviews with them if possible.
3. Use the **Key Informant Semi-Structured Interview Tool** at the end of this section.

PART III: Selection of Participants

Participants of the curriculum are typically chosen by the organization's leader. Through the **Organizational Culture Assessment**, however, you may identify and suggest other potential participants who will have key roles in implementing CLAS. This curriculum can accommodate up to 30 participants at a time. You should inform the leadership and potential participants about the time commitment involved in attending the program. The **Information for the Participants** handout, found at the end of this section, details the time commitment and selection criteria.

PART IV: Pre-Test

Once selected, the participants should be given the **Participant Pre-Curriculum Survey** (found at the end of this section). The purpose of the survey is to assess participant attitudes, skills, and knowledge about the CLAS standards, and the degree to which they are aware of CLAS-oriented programs in their organization. The survey will highlight various areas on which the facilitators may need to focus. Ideally, the survey should be collected and reviewed one week before the start of **Workshop Session I**. If doing so is difficult, however, the survey may be collected at the start of the first workshop session. At the end of **Workshop Session IV**, the participants also will be given a **Post-Curriculum Survey** to ascertain the influence of the curriculum.

PART V: Participant Groupings

This curriculum predominantly uses the small-group learning format, with typical groups consisting of 4 to 6 individuals. In contrast to larger groups, this format enables greater collaboration, a more sophisticated level of learning, and invokes group process as a powerful mediator to learning. The longer that people work in a small group, the more effectively they learn.

Given that the small groups in this curriculum are time-limited, we have found several strategies to optimize the potential for good group dynamics. An ideal group will have:

1. Cultural competence "champions" balanced with more resistant or skeptical individuals. *The champions will help improve the group's level of engagement, while the more skeptical participants will help promote critical thinking. Both will form a healthy tension between what is ideal and what is realistic. Remember, this curriculum aims for the participants to develop practical implementations of the CLAS standards.*

2. Participants who have had prior opportunities to work together or whose potential collaboration may lead to synergistic impact. *The success of this method depends upon the ability of the groups to work effectively with one another. While the exercises in the curriculum will help to promote effective group process, participants who already have experienced benefits from working together or have commonalities that promote collaboration will help the group process significantly. Information that you obtain from the key informant interviews can be used to identify these relationships.*

3. Participants with overlapping responsibilities, spheres of influence, or goals. *Participants with overlapping responsibilities and goals may be able to pool their resources to develop projects that have broader or more far-reaching implications than if they had developed a project individually. The presence of these participants in the same group allows them more time to explore opportunities to collaborate.*

4. Cultural diversity. *Gender, ethnic, and other sociocultural diversity within each group will promote richer discussion when participants explore issues of cultural competence, language, and health disparities. Participants from diverse cultures also can share experiences that supplement the information given in the didactic components to make the learning experience more realistic.*

PART VI: Involving the Top Leadership

Modifying a system is difficult without support from its top leadership. Implementation of the CLAS standards requires commitment from an organization's top leadership. The first indication of support from the top leader(s) is allocation of time for the organizations' managers and leaders to participate in the curriculum. We encourage top leadership to make a formal presentation to participants about the roles and qualities of a good leader and effective strategies for system change. That introduction gives leaders an opportunity to articulate their own style and perspectives about leadership, thereby clarifying what they need and expect from their managers. The participants also benefit from hearing about these expectations and the strategies that have guided someone who has been successful in the organization. The leader should set aside about 60 minutes in Workshop Session IV to give this talk. **The Leadership Talk** handout at the end of this section describes this activity in more detail.

PART VII: Identifying a Model Program that Incorporates CLAS

We have found that many participants are not aware of the programs within their organization that already incorporate elements of the CLAS standards. **Workshop Session III** allocates time for a speaker to present on one of these "model" programs. The purpose of this exercise is to:

1. Demonstrate the practicality of implementing programs compliant with the CLAS standards.
2. Highlight proven strategies and potential pitfalls to consider when implementing CLAS compliant projects.
3. Inform participants about such programs, because potential for collaboration may exist.

You should identify a model program through the **Key Informant Interviews** and schedule time for a representative from that program to speak during the third workshop. A handout detailing the purpose of the presentation and topics about which the presenter should speak is included at the end of this section.

Organizational Culture Assessment:

Key Informant Semi-Structured Interview Tool

Date: _____ Organization: _____ Name: _____

Introduction

1. The interviewer prepares the key informant for their initial meeting by first sending the **Information for the Participants** handout, which presents an overview of the curriculum.
2. The meeting should begin with the interviewer's self-introduction that includes a brief description of the CLAS project and explanation of his and her role.
3. The interviewer describes how the key informant was identified, and if appropriate, who made the nomination.

Questions for key informant

1. Can you describe your role in this organization?

2. How familiar are you with the CLAS standards?
   [Interviewer can briefly describe the CLAS standards or fill in the gaps if key informant is not familiar or partially familiar with them.]

3. Are you aware of any CLAS or cultural competence initiatives that you or others have adopted or are developing? If so, please describe them (including successes and shortcomings of these programs).

4. I would like to take some time to describe CLAS curriculum and get your observations and opinions about it.
   [Interviewer discusses the CLAS curriculum using descriptions and learning objectives at the beginning of each session as a guideline. Be sure to also include time commitment and participant description.]

5. Do you have any observations or opinions about this curriculum?

6. Please identify some people who would be ideal participants in this program. [Interviewer should clarify roles of potential participants in the organization and why they are believed to be ideal]

7. Please also identify people in the leadership who would need to approve of this program in order for it to be successfully implemented.

8. What, if any, additional obstacles must be resolved in order to successfully implement this curriculum?

9. In addition to the people you have identified earlier, can you identify other people with whom you believe we should speak?

May I have your phone number and or e-mail address to contact you as we move forward?

Phone: _____

E-mail:_____

[Interviewer thanks the key informant for time spent talking.]

Providing Quality Health Care with CLAS

Information for Participants

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. This curriculum will help you adapt the CLAS standards by building upon your organization's existing infrastructure and mission values. The small-group, problem-based discussion format what we use has been shown in many educational contexts to enhance creative problem-solving and to effectively help develop high-level understanding of topics discussed (Ton et al., 2005). Rather than having a "cookbook" approach that superimposes a model without attention to impediments and capabilities of your organization, this strength-based approach can help you creatively apply 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 evaluation will help us customize the curriculum to the learning needs of your organization's 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. Following each session, you will be given an assignment that will require 30 to 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 engage 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

To qualify for this program, participants should meet these six recommended requirements:

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 trainings 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 should have acquired new 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 affect 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. Examine your own service in the context of CLAS standards;
7. Describe the factors influencing system change at the organization of which you are an employee or representative;
8. Define the concept of illness narrative;
9. Describe the impact of culture on health care decision making;
10. Describe the impact of language barriers on care;
11. Describe the effects of immigration and acculturation on health status and quality of care;
12. Describe the health status, health disparities, health care barriers, and quality of care experienced by at least two culturally diverse populations;
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 collaboratively implement the CLAS standards.

Providing Quality Health Care with CLAS

Participant Pre-Curriculum Survey
(Facilitator's Answer Key)

** Please Note: This is the facilitator's answer key. The "**preferred"** response is in bold.*

Please select the best answer to define the following:

General knowledge:

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

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

CLAS knowledge

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

CLAS opinion

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

Self-assessment / general knowledge / self-assessment of CLAS knowledge

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

Attitude toward CLAS

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 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 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

CLAS experience

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, 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

Self-assessment of ability to implement CLAS

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

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

Table 3	**Leadership Talk**

Presentation date:
Duration: 30–45 minutes didactic period; 15 minutes for discussion and questions

Purpose:

The purpose of your presentation is to present strategies for effective leadership with the participants. These strategies, based on your experience and perspective, offer participants insight about their leader and the overall organization. This is an opportunity for you to discuss successful strategies or approaches that are particularly relevant to the structure and culture of your organization.

Objectives:

1. Convey an understanding of which qualities make a good leader and why;

2. Discuss the common pitfalls that challenge leaders;

3. Describe strategies for participants to effectively reach their project and larger institutional goals;

4. Describe, from your perspective, which obstacles you anticipate and which resources will be needed to implement CLAS in the organization.

Table 4 Model Program Presentation Guide

You have been recognized by your organization's leaders for your success in implementing a culturally and/or linguistically appropriate program. We have found that other leaders in an organization benefit from hearing the "story" of a successful program. A description of a successful program highlights organizational strengths, reinforces commitment to culturally and linguistically appropriate services, and serves as a model for others.

We are inviting you to make a 20-minute presentation about your program to the leadership group participating in the Providing Quality Health Care with CLAS curriculum.

Please consider including discussion of the these key questions:

- What strategies did you use to capitalize on existing strengths?
- What strategies did you use to address and overcome obstacles?
- How did you know when you had attained your goal?
- What mechanisms did your organization employ to sustain the success of your program or project?

Also consider how your program was influenced – either constructively or detrimentally – by each of these six factors:

1. **Leadership:** Leaders are decision makers who have the ability to influence others and guide an organization to make it more cohesive and effective.
2. **Teamwork:** Group of staff working to implement and sustain a project, program or process.
3. **Models and processes**: "Models" are approaches that have structure or serve as a framework for accomplishing goals. "Processes" are related tasks done in sequence to achieve the goals.
4. **Organizational systems and culture**: "Systems" refers to the organization's processes, policies, forms, and protocols. "Organizational culture" refers to the shared values of an organization, as well as to how staff members relate to each other, how they communicate, and how their activities are coordinated.
5. **Data measurement and reporting:** This designation refers to all aspects of data management, including which data is measured and how it is collected, stored, processed, updated, and disseminated.
6. **Education and coaching:** These terms refer to the 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.

Workshop Session I:

[1] A copy of this PowerPoint presentation is contained in the **Resources and Readings** section of the **Facilitator's and Participant's CD**

Workshop Session I: Introduction to the CLAS Standards

Overview: The first workshop session will prepare the participants and lay the foundation for the remainder of the CLAS curriculum. In this workshop, you will introduce the participants to the CLAS standards, the reasons why these were developed, and the impact of health disparities on the quality of care for patients. You will show them how to assess their own service area or department, and they will describe their service and organizational vision for their particular department. In this way, you, along with the other participants, will learn about the cultural values and goals of each department. With this knowledge, you and the participants will begin the process of customizing CLAS to the particular needs and mission of each service. This process will help the participants increase their understanding of the relationship between their unit and other departments. The process will also increase the potential for collaboration between departments as they begin to understand each other's role with regard to the quality of care for diverse patient populations.

Learning objectives

At the end of **Workshop Session I**, the participants should 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 their own service in the context of the CLAS standards;
7. Describe the factors that influence system change at the organization where they work or represent;

Skills to:

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

Attitudes to:

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

Participant Pre-Curriculum Survey

Before the start of this curriculum, you should have asked the participants to complete the **Participant Pre-Curriculum Survey,** which you can find on page XX in **Chapter 1: Organizational Culture Assessment**. You can collect the completed surveys before the start of this module if they have not been turned in earlier.

Welcome and check-in [5 min]:

Welcome the participants to the session. Introduce yourself and any co-facilitator, as well as the support staff involved in the training. Be sure to acknowledge the commitment of the organization's leaders who have allotted time in their busy schedule to attend this training. You also may want to ask for a show of hands of people who have attended cultural competence training sessions in the past. Emphasize that while participants will become more knowledgeable than most people about the CLAS standards, including cultural competence experts, this course will help them to develop practical strategies and skills for improving quality of service using the CLAS standards.

Small-group exercise: Cultural meanings of names [40 min]

After the welcome, please start the **Cultural Meaning of Names** exercise. Ask all participants to first introduce themselves and their title or role in the organization, and then ask each of them to discuss what they know about the origin of their name and the personal and cultural significance of their names. You may set an example by explaining the origin and meaning of your own name.
This exercise has multiple purposes. It serves as an ice-breaker to facilitate effective small-group interactions. It also emphasizes the relevance of culture to all individuals, helping to include participants who may have, in the past, felt distanced from cultural competence trainings.

Didactic segment: Health disparities and CLAS presentation [60 min]

The small-group exercise is followed by a Microsoft PowerPoint presentation, which you can find in the **Resources and Reading** section of the **Facilitator's CD**. Please take time before the session to review and modify the slides as you see appropriate. The presentation:

1. Characterizes the health disparities that exist for ethnic minorities in the United States;
2. Describes the factors that contribute to these health disparities;
3. Highlights the importance of examining these disparities at the level of the organization;
4. Includes an overview of CLAS standards;
5. Describes the educational approach used by this curriculum.

The presentation should take about 60 minutes to complete.

Break [15 min]

Small-group exercise: Vision statement [40 min]

One of the main goals of this curriculum is to help participants implement CLAS projects that are customized to the participants' organization. Rather than utilizing a "cookbook approach," this curriculum will help participants develop and enact meaningful strategies that are tailored to the needs and strengths of their service. This small-group exercise will lay the foundation of this work by helping the participants articulate the mission and values of the department that they lead and describe their personal experiences related to leadership and change. Please divide the participants into the small groups that you had previously defined in the **Organizational Culture Assessment**.

Please ask the participants to refer to the **Vision Statement Exercise** found in the **Workshop Session I** chapter of their workbook which is Table 1. Then read the following instructions to the participants: "Please take 30 minutes in your small group to answer and discuss the following questions. Also select one person in the group to summarize your group's discussion." The **Vision Statement Exercise** is Worksheet 1 in the Facilitator Manual.

Worksheet 1	**Vision Statement Exercise**
Name:	
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 would your service contribute to the overall organization and your clients? ■ Ideally, how would your staff members work together? ■ What values would your service embody?	
B. Discuss and solicit reactions to your vision statement as a group.	
Notes:	
C. Discuss how your service might relate to that of others in the group.	
Notes:	

After allowing for 30 minutes of small-group discussion, please ask the representatives from each group to summarize their discussion.

You can then close this part of the workshop with a summary of what the participants just discussed, including common themes, and themes that relate to CLAS standards. After this exercise, the participants should have a better sense of the other departments in their organization, and some initial thoughts about possibilities for collaboration.

Process of change challenge [45 min]

A research project conducted by the Primary Care Development Corporation identified six domains critical to system change and sustainability (Judge et al., 2007). These domains are:

1. Leadership
2. Teamwork
3. Models and processes
4. Organizational systems and culture
5. Data measurement and reporting
6. Education and coaching

You may find that reviewing the report "Contributing to Sustaining and Spreading Learning Collaborative Improvements" before today's session can help you further understand what each domain entails. This report is included in the **Resources and Readings** section of the **Facilitator's CD**.

We will use these six domains as a framework for the participants to discuss the factors needed to develop and sustain programs in their organization. This exercise presents a conceptual framework for participants to develop effective CLAS quality improvement plans in the subsequent sessions.

At this point, the participants are still in the same small groups. Please refer them to Table 4, **The Process of Change Challenge**, and ask the participants to refer to the same handout found in the **Workshop Session I** chapter of the **Participant Workbook** as Table 4**.** Ask each group to select one or more of the Six Domains of Change on which to focus. Please make sure that each domain is addressed by at least one group. Ask each group to consider their own domains when considering the following questions:

1. How does this domain influence the implementation and sustainability of new programs and projects?
2. What are your strategies to ensure development or support of this domain?
3. What contributions can you make to this area? What are the barriers that prevent you from doing so?
4. What resources are required to strengthen this domain in your system?
5. Can your group present one example of how you have seen this domain be effectively applied or developed?
6. Can your group identify other domains not mentioned that you consider important to system change?

Please allow 30 minutes for the participants to discuss these points. Afterwards, the group should select a different speaker to report back to the large group. You should give each group a few minutes to present. In the last 15 minutes of this exercise, please summarize the common themes, as well as any comments that you feel are particularly striking or relevant to CLAS-related activities. To prompt the participants to think about their own role as agents of change in their system, you may wish to put forth the following discussion question:

Given what you know of existing health disparities and what you've told us of your service and experience as a leader, how feasible would implementation of the CLAS standards be in your department? And in the organization as a whole?

Table 4	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:** 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 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 determination of which data is measured, and how it is collected, stored, processed, updated, and disseminated.

6. **Education and coaching:** These terms refer to the 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 one example of how you have seen this domain be effectively applied or developed?
F. Can your group identify other domains not mentioned that you consider important to system change?
Report back to 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.

Closing statements and assignment of homework (20 min)

Before ending the session, please assign the following two intersession assignments. The first assignment, the illness narrative, is intended to help participants to better consider the client experiences and perspectives on illness, which will be the topic of focus at the next session. They should refer to the **Illness Narrative** form found at the end of **Workshop Session I** in the **Participant Workbook,** which is Table 3. In the Faciliator Manual this is labeled as Table 5. Please advise participants that they should come to the next session prepared to discuss their experience – or that of a close friend or relative – in receiving treatment. Tell them they can use the worksheet to jot down notes, but mention that these will not be collected. The second assignment – the **Assessment by Leadership Survey,** adapted from Suzanne Salimbene's CLAS A to Z – will help participants characterize the culturally and linguistically appropriate elements of their respective departments. A copy of the Assessment by Leadership Survey also can be found in the **Workshop Session I** section of the **Participant Workbook**.

Table 5	**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 often are 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?

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 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.

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 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 preference 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 language competency in that language.

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

b. If **Yes**, these staff are compensated for use of this skill.

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.

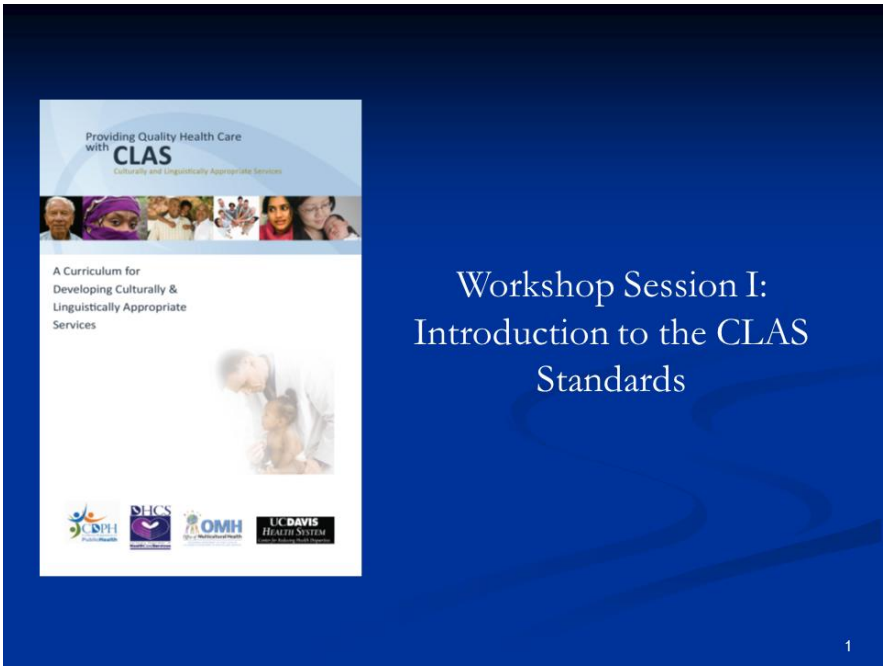
Yes ___ No ___ Don't know ___

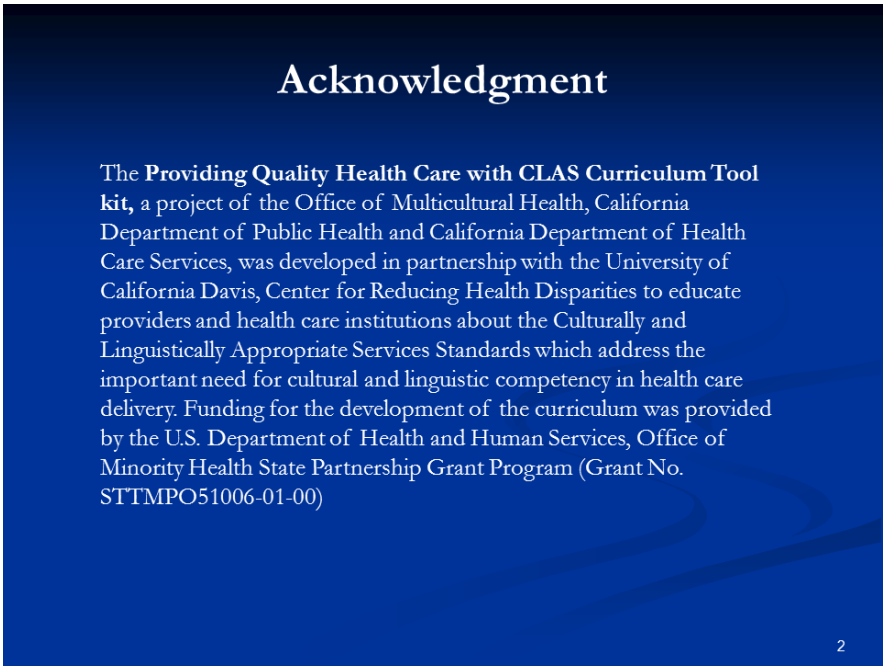
38. List all other measures which the department *already has taken* as a means of ensuring a culturally and linguistically competent work environment (e.g., training and development, performance review criteria).

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 I
Slides





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

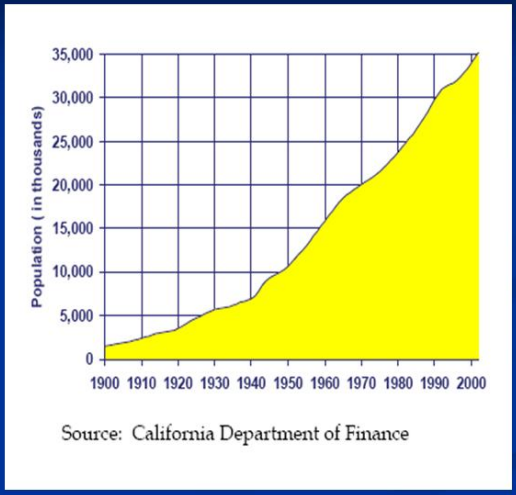
4

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

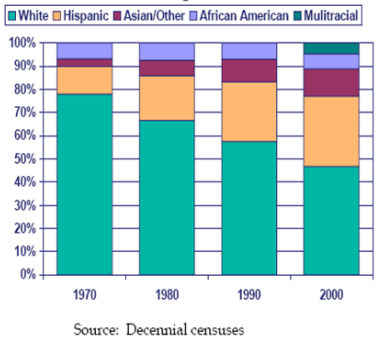


Source: Johnson, California's Demographic Future, Public Policy Institute of California, 2003

6

California's Population by Race and Ethnicity

Figure 2
Racial/Ethnic Composition of
California's Population, 1970-2000



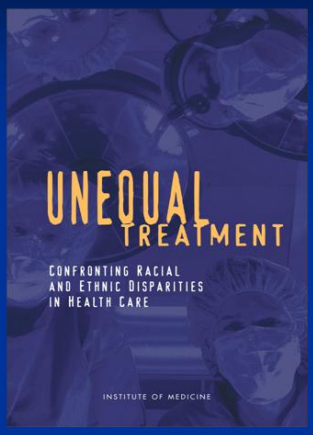
Source: Decennial censuses

- 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

8

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

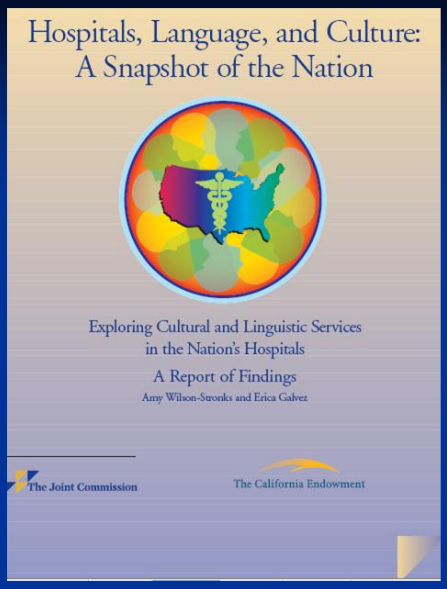
9

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

10



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

12

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

The Joint Commission

13

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%

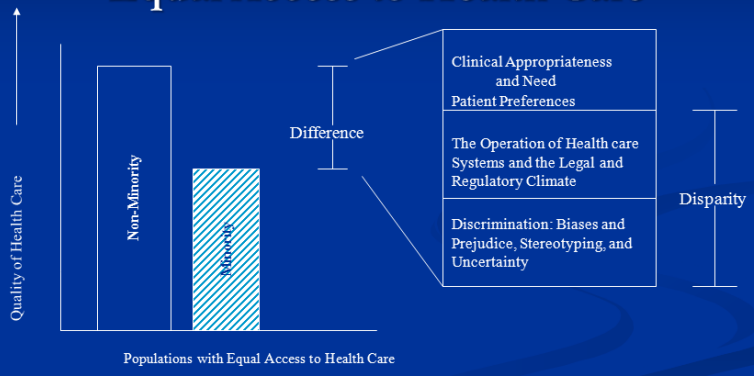
EP = English Proficiency
LEP = Limited English Proficiency

Source: Schyve, 2007

The Joint Commission

14

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



Source: Gomes and McGuire, 2001

15

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

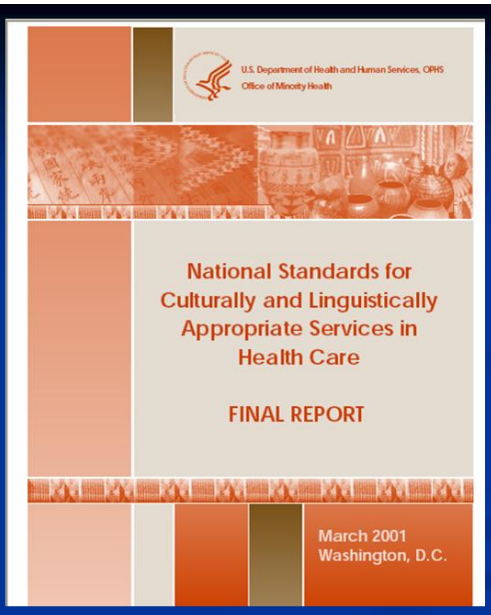
16

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

17



Source: Federal Register: December 22, 2000, Volume 65, Number 247, pages 80865-80879 www.omhrc.gov/CLAS 18

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/finalculturall1a.htm

19

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/finalculturall1a.htm

20

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

21

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.

22

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.

23

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.

24

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

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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

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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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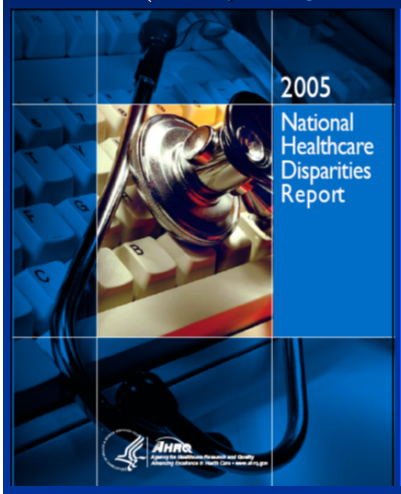
The National Healthcare Disparities 2005 Report

(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

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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.

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Curricular Approach

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

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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

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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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California Office of Multicultural Health
California Department of Public Health and
Department of Health Care Services

Laura Hardcastle

David Bodick, MPH

Mallika Rajapaksa, PhD

Carol Gomez

Center For Reducing Health Disparities
University of California, Davis

Sergio Aguilar-Gaxiola, MD, PhD
Director

Hendry Ton, MD, MS
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Marbella Sala
Executive Operations Manager

Lina Mendez, PhD
Project Coordinator

Kimberly Reynolds
Administrative Staff

Daniel Steinhart
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Roberto Ramos, MS
Project Coordinator

Mai See Yang, MS
Project Coordinator

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Workshop Session II:

[2] A copy of the PowerPoint presentation can be located in the Resources and Readings section of the Facilitator's and Participant's CD

Workshop Session II: Quality of Care for Culturally Diverse Patients

Overview: In this workshop session, the participants will examine the difficulties of obtaining quality health care services from the perspective of individual patients. They will have the opportunity to describe their own experiences with health care and discuss the audio recordings of two patients from culturally diverse backgrounds. Collectively the cases will highlight the impact of issues such as communication, decision-making, health beliefs, racism, and socioeconomics on quality of care. The participants also will identify systems and organizational factors that mitigate the impact of these issues. For homework, the small groups will prepare a presentation on one or more of the CLAS standards for the following session.

Learning objectives

At the end of Workshop Session II, the participants should 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 effects 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-group and discussion formats;
3. Critically examine the 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.

Welcome and Check-In [10 min]

The welcome and check-in is an important part of every session. It helps the participant attain an appropriate mindset for the work of the day and gives you insight about the issues that the participants may raise during the session. You can start with general questions. Consider checking how the previous session went for the participants; doing so may help you make necessary adjustments in facilitating the current session. To close the check-in and make a transition to the next topic, you may wish to ask how the participants felt about completing the **Assessment by Leadership Survey.**

Discussion of assessment by leadership survey [20 min]

The **Assessment by Leadership Survey**, from Suzanne Salimbene's CLAS A to Z was assigned to help participants begin thinking about how compliant their system is with the CLAS standards. Take the opportunity to check in with the participants about how much effort was taken to complete the questionnaire. Did they have the resources they needed in order to complete it? What feelings or insights do they have about their system after they completed the survey? Some participants may express frustration or demoralization when trying to complete the survey because they did not have the answers to the questions asked, or because they observed a large lack of CLAS compliance in their system. You may wish to acknowledge their frustration, but also ask the participants what they wish to do with this knowledge.

Illness narratives exercise [50 min]

This is the first of two activities today that attempts to bring the patient experience closer to home for the participants. An illness narrative is defined as an individual's story about illness experienced and how it affected his or her life. 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 often are used in cross-cultural and client-centered settings to better understand the experiences and perspectives of clients.

Because the narrative can be very personal, it is important to assure the participants that their notes will not be collected. Rather, the participants will pair up and discuss their illness experiences. You should ask each participant to listen respectfully and with empathy to their partner's story –his is a foundation of cultural sensitivity.

Instructions for the participants:

- Please pair up with another participant.
- Take turns discussing your illness experience [15 minutes *each*]
- Please listen respectfully and with empathy to their partner's story – this is a foundation of cultural sensitivity.
- Listen from both the standpoint of a potential patient and a systems leader.

As the facilitator, consider sharing your own illness narrative, in case a participant remains without a partner. Alternatively, you can ask that participant join a pair to share their illness

narrative. If you do not share your narrative, you may spend time observing the dyads for nonverbal communication to ensure that active discussion is taking place, though it is important to avoid listening to the content of their discussions.

Large-group discussion of illness narrative [20 min]

- Discuss people's responses to the experiences.
- What did you learn? What struck you?
- Determine how your viewpoint as a patient contrasts with that of a systems leader.
    - What were the differences?
    - What were the similarities?
- What were the reasons that led to pursuing medical treatment?
- How easy was it to get medical treatment? Please describe the process.
- What was the experience during the treatment?
- What were the hospital's or clinic's strengths and weaknesses, from a patient's perspective?
- Do you think that your (or your friend's or family member's) treatment was influenced by race, ethnicity, gender, class, education level, or occupation? If so, how?

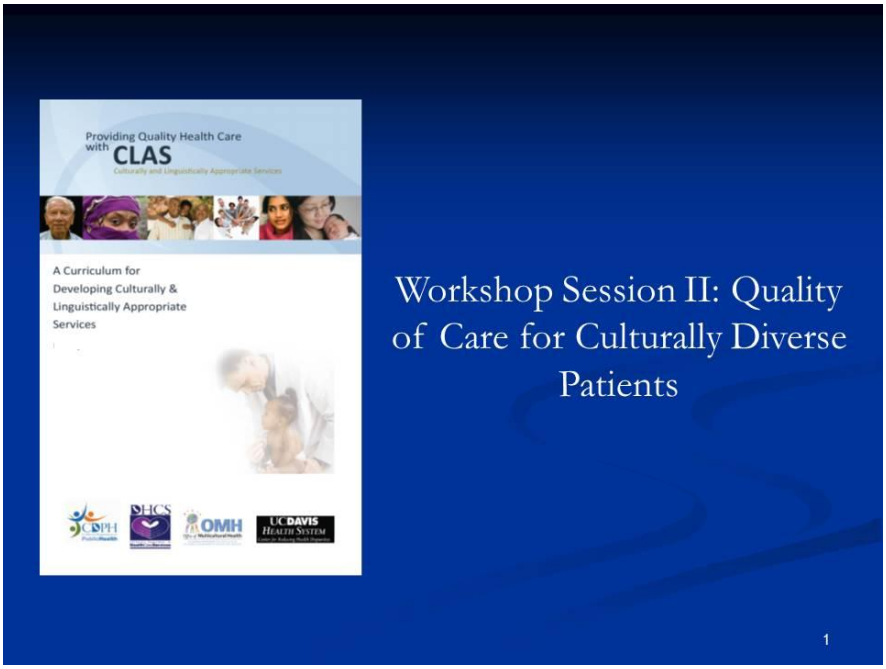
The facilitator summarizes the discussion, attempting to link experiences to CLAS standards.

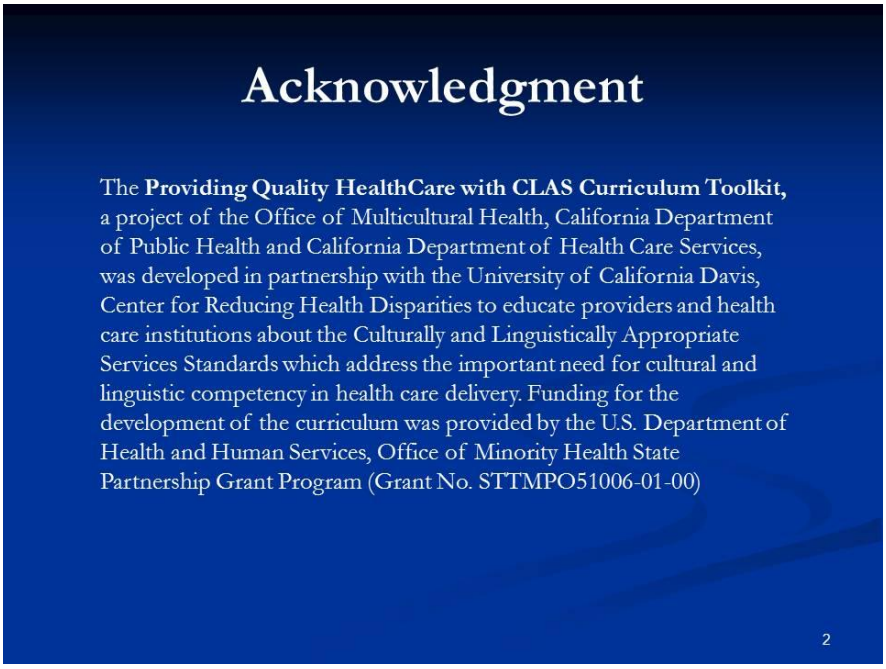
Break [15 min]

Personal stories and CLAS exercise [90 min total]

This section of the curriculum explores how health care and public health systems which are not CLAS-compliant can negatively impact individuals and families from culturally diverse communities. Participants will discuss the interactions between these patients and their health care providers by listening to the *Personal Narrative* series found in the Power Point presentation titled *CLAS Workshop Session II*. The audio clips portray two culturally diverse individuals as they attempt to navigate their way through a western health care and public health systems.

Workshop Session II
Slides





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

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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?

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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]

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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]

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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)

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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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Carol Gomez

Center For Reducing Health Disparities
University of California, Davis

Sergio Aguilar-Gaxiola, MD, PhD
Director

Hendry Ton, MD, MS
Director of Education

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Executive Operations Manager

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Kimberly Reynolds
Administrative Staff

Daniel Steinhart
Project Coordinator

Roberto Ramos, MS
Project Coordinator

Mai See Yang, MS
Project Coordinator

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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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Personal Stories and CLAS Exercise [90 min]

Small Group Case Discussion [50 min]

Please ask the participants to form their small groups. They will go over case scenarios that are meant to personalize health and public health care issues that are commonly encountered by people from diverse communities. The two cases will illustrate the experiences of a Latina woman and a Vietnamese woman. While these cases are fictional, the scenarios are inspired by real life experiences.

Start the PowerPoint presentation entitled "CLAS Workshop Session II: Quality Care for Culturally Diverse Patients. This is included in the **Facilitator's CD.** After reviewing the acknowledgement on slide 2, proceed to slide 3 and read the following to the participants:

During the next 40 minutes we will play several audio recordings from the PowerPoint presentation depicting two case scenarios that characterize key challenges in health care and public health experienced by people from culturally diverse backgrounds. While these cases are fictional, the scenarios depicted are from real life experiences. Try closing your eyes and picture these individuals and their experiences as you hear them speak.

Case #1 Tuyet Nguyen [20 minutes]

Proceed to slide 4 and read the following to the participants:

The first person we will hear from is Tuyet Nguyen who is a 62-year-old widow Vietnamese woman with poorly controlled hypertension.

Proceed to slide 5 and click on "Scenario #1" to hear an audio recording of Ms. Nguyen's narrative.

THE SCRIPT IS PROVIDED FOR THE FACILITATOR BELOW:

Scenario # 1: I live here with my son and his family. We moved to America 20 years ago, but sometimes it feels like just yesterday. There is a lot of loneliness in my life. My son and daughter-in-law both work all day and the children are mostly at school. I spend the day waiting for them to come home. I cannot speak or read English very well. I don't take walks too far outside my house because I'm afraid to get lost. Who can I ask for help if I get lost? Who could understand me? I have a new doctor who is white. She tells me to come see her more regularly. I am embarrassed to tell her that I cannot drive and do not know how to take the bus, so I just nod my head. I feel ashamed to lie to her, but I feel more ashamed to tell her the truth.

After the audio clip, please proceed to slide 6 and ask the participants to discuss the following items in their small groups for 5 minutes:

1. What thoughts, feelings and images came up for you as you listened to Ms. Nguyen?
2. Can you relate to Ms. Nguyen's challenges? Please elaborate.
3. What are the potential factors that impact Ms. Nguyen's health?
4. What is the impact of her limited English proficiency on her life?

Please proceed to slide 7 and click on "Scenario #2" for Ms. Nguyen's ongoing narrative.

THE SCRIPT IS PROVIDED FOR THE FACILITATOR BELOW:

Scenario #2: My son was able to hire someone to drive me to the doctor. He charges $34, but I am glad he is Vietnamese and I can talk to him in the car. I thought he was going to come in to interpret for me, but he said he had to drive someone else. I had a hard time understanding the doctor and I know she is frustrated. I am embarrassed that I don't understand so I nod when she asks me questions. I don't want to disrespect her by complaining or not responding. I think she wants me to bring my family next time to interpret. I don't think I can ask them. I am already so much of a burden to them. But I nod and say "yes." She gives me a prescription for medicine. I don't know what it says.

After the audio clip, proceed to slide 8 and ask the participants to discuss the following questions in their small groups for 5 minutes:

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

THE SCRIPT IS PROVIDED FOR THE FACILITATOR BELOW:

Scenario #3: I show my prescription to my son when he gets home. He says that this is too much medication for me. He says that I get "high blood pressure" when I have headaches or feel stressed. I agree with him. He tells me to take the medicine when I have headaches or stress only. Taking too much medicine would cause my body to become too "hot," and make me sicker. I'm glad my children take care of me.

After the audio clip, proceed to slide 10 and ask the participants to discuss the following items in their small groups for 5 minutes:

1. What thoughts, feelings, or images come up for you?
2. How does her son's understanding of hypertension compare to your understanding of it?
3. How often do doctors and their patients agree on the importance of symptoms, causes of symptoms, and treatment?

4. How can you use the CLAS standards to help you address these issues?

Case #2 [20 minutes]

Please proceed to slide 11 and read the following to the participants:

Jimena López is a 32-year-old Mexican American woman who immigrated to the United States 4 years ago.

Proceed to slide 12 and click on the "Scenario #1" to hear an audio recording of Ms. Lopez's narrative.

THE SCRIPT IS PROVIDED FOR THE FACILITATOR BELOW:

Scenario #1: My pastor told me last week that the public health department is having a health fair at our church. I decided to take my children and go. I see a lot of my friends there, and we had a good time. I see a young woman at one of the booths that is for the H1N1 shot. I feel sorry for her because there is no one going to her booth. I appreciate what the public health people are doing for our community, but many of my friends and family don't want to take the shot because it makes them sick. Last year my brother had the shot and got sick for five days. I decide to avoid getting information from this booth.

After the audio clip, proceed to slide 13 and ask the participants to discuss the following items in their small groups for 5 minutes:

1. What feelings, thoughts, or images come to mind as you listen to Ms. López?
2. How well does your public health department outreach to culturally diverse communities? How can outreach be improved using the CLAS standards?
3. What do you think about Ms. López's concerns about the flu shot? How would you address these concerns using the CLAS standards?

Proceed to slide 14 and click on the "Scenario #2" for Ms. Lopez's narrative.

THE SCRIPT IS PROVIDED FOR THE FACILITATOR BELOW:

Scenario #2: It is now several months later that I have heard the news about people becoming very sick with H1N1. Some of my relatives have gotten the shot and are fine, so I decide to go get one also. I work in a small restaurant. I wash the dishes and clean the restaurant. It is hard work, but I am so glad that I have a job. The owners are very nice people. I used to live by their parents when I was in Mexico. They pay me for every hour I work, but they don't have enough money to give me health insurance. I feed my family from my pay, and I send the rest home to my parents. One day, I will have enough money to bring them over too. I want to get the shot but I cannot because I don't know how to drive. My cousin drops me off to work every day. I can take the bus across town to get to the free clinic where they have a Spanish interpreter, but this would take 4 hours. I would lose a half day's pay. I think I cannot afford that.

After the audio clip, proceed to slide 15 and ask the participants to discuss the following items in their small groups for 5 minutes:

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

Proceed to slide 16 and click on the "Scenario #3" for Ms. López's narrative.

THE SCRIPT IS PROVIDED FOR THE FACILITATOR BELOW:

Scenario #3: Many customers have stopped coming to the restaurant. People walking outside give us bad looks. Last week, someone broke one of the windows from the restaurant. The owner says that many people are afraid to come in because they are afraid to associate with Mexicans. They blame us for the H1N1. Yesterday the owner told me that he is running out of money because customers have stopped coming and cannot keep me. I can see that it is very hard for him so I tell him I am willing to work for half pay, but he says he can't do that. I don't know what to do, I have children and bills to pay.

After the audio clip, proceed to slide 17 and ask the participants to discuss the following items in their small groups for 5 minutes:

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

Break [10 min]

Large Group Discussion [20 min]
Please instruct the participants to gather back into the large group format. Ask the group how the dyadic discussions went for them. Briefly review each of the case scenarios and invite volunteers to highlight how they discussed the issues in their small groups.

Demographic and Health Disparities Presentation [20 min]:
After the large group discussion, please continue with the PowerPoint presentation starting with slide #18: Demographics and Health Disparities. This presentation will inform the participants epidemiologic and health disparities faced by the two cultural communities (Asian and Pacific Islander and Latino) from which the fictional patients come.

Closing discussion [20 min]

As this session comes to a close, the participants should start to relate these individual experiences of illness and health care back to their organization. To help them make these connections, you can ask the following questions:

If these individuals and families were to receive services at your organization, how well would their issues be addressed?

What are the strengths and weaknesses of this organization in culturally and linguistically appropriate care?

Intersession assignment: CLAS standard group presentation [25 min]

Before adjourning for the day, each group will select one or more of the CLAS standards to present for the next workshop. All 14 standards should be covered by the participants as a whole. Reading each standard aloud and asking the groups to volunteer to take responsibility for each of them may be the best approach. Allow 15 minutes at the conclusion of the meeting for the members of each group to coordinate their schedules. Table 6 describes the presentation exercise. A copy of this exercise also is contained in the **Workshop Session II** of the **Participant Workbook** as Table 4.

Table 6	CLAS Standards Exercise

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 the following considerations in mind 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 is relevant to your service and to the organization as a whole?**
4. **Describe one or more strategies to implement this standard in your service area or the organization as a whole.**

When answering question 4, please consider the following:

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

b) What resources would be required and how would they be accessed?

c) What challenges would be faced?

d) How might you measure progress and success of implementation?

Notes:

Workshop Session III forms:

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, the participants will know more than many cultural competence trainers in the field about the CLAS standards and ways to implement them. They also will have the opportunity to learn about an existing program in the organization that incorporates one or more of the CLAS standards, including the resources used and obstacles faced during its implementation. At the end of the session, participants will be asked to develop a quality improvement plan related to the CLAS standards, using the knowledge that they have gained in this and the prior two sessions.

Learning objectives

At the end of **Workshop Session III**, the participants should 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 their respective departments;

Skills to:

1. Assess whether and how their respective 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.

Welcome and check-In [10 min]

The welcome and check-in segment is an important part of every session. It helps the participants ease into an appropriate mindset for the work of the day, and gives you as the facilitator a sense of the issues that the participants may bring into the session today. You can start with general questions. Consider checking how the previous session went for the participants, in order to make adjustments in how the current session will be facilitated. It will also be helpful to ask how working on the CLAS presentations went for the participants in general.

CLAS group presentations [140 min]

The core exercise in this workshop is the **CLAS Group Presentations**. The participants were responsible, in their groups, for researching one or more of the CLAS standards using the National Standards for Culturally and Linguistically Appropriate Services in Health Care: Final Report. The purpose of this exercise is to actively engage the participants in learning the CLAS standards by doing the research themselves. Because the participants have prepared and delivered their presentation, their efforts become accountable to and acknowledged by the rest of their peers. They become more proficient at articulating the standards to others in succinct and usable terms. This format, with the frequent change of presenters and diverse styles of presentation, should also keep the participants' attention focused in what might otherwise have been a dry didactic session. Please give the members of each group 10 minutes to present and answer questions about each standard they were assigned.

Large-group discussion [10 min]

After the small group presentations, the participants should be familiar with the CLAS standards, their intent and rationale, and implementation strategies. You should ask the participants, when all have reconvened in the large group, what impediments they might face when implementing the CLAS standards in their organization, and how they might overcome these difficulties.

Break [10 min]

The model program presentation [35 min]

As stated earlier in this manual, we have found that many participants were not aware of the programs within their organization that already incorporate elements of the CLAS standards. In the first phase of the curriculum, **The Organizational Culture Assessment**, you were asked to identify, through the **Key Informant Interviews**, a program within the organization that carried out one or more of the CLAS standards. You were assigned to ask a representative of that program to prepare a 20-minute presentation. The purpose of this exercise is to:

1. Demonstrate the possibility of implementing programs compliant with CLAS standards.
2. Highlight proven strategies and potential pitfalls to consider when implementing CLAS compliant projects.
3. Inform participants about such organizations, to discover any potential for collaboration.

Table 7 is included here as a reminder of the responsibilities of the guest presenter in his or her presentation. After the 20-minute formal presentation, you should allow for a 15-minute question-and-answer period.

Table 7 Model Program Presentation Guide

You have been recognized by your organizational leaders for successfully implementing a culturally and/or linguistically appropriate program. We have found that relating the "story" of a successful program to other leaders in an organization can be motivational. Learning about successful programs highlights organizational strengths, reinforces commitment to culturally and linguistically appropriate services, and provides a model for others. We are asking you to deliver a 20-minute presentation about your program to the leadership group participating in the Providing Quality Health Care with CLAS Curriculum.

In preparing, please consider the following:

- What strategies did you use to capitalize on existing strengths?
- What strategies did you use to approach and overcome obstacles?
- How did you know when you had attained your goal?
- What mechanisms did your organization employ to sustain the success of your program or project?

Also, explain how the following factors fit and contribute to and/or impede your efforts.

- **Leadership:** Leaders are decision makers who have the ability to influence others and guide an organization to make it more cohesive and effective.
- **Team:** Group of staff members working to implement and sustain a project, program or process.
- **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.
- **Organizational systems and culture**: "Systems" refers 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.
- **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.

- **Education and coaching:** These terms refer to the 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.

CLAS implementation strategy: Large-group discussion [35 min]

At this point, the participants have undergone nearly 12 hours of training, and should be familiar with the health disparities and unequal treatment experienced by many consumers in the community. They have shared and witnessed true-life stories of those affected by these inequities. The participants have researched and taught themselves about the CLAS standards, their rationale, and ways that these standards can be implemented in their organization. Most recently, they witnessed a "proof of concept" demonstration illustrating how a CLAS standard has been applied to the organization. Now they are ready to embark on developing their own **CLAS quality improvement plan**, individually, or more likely, in groups. Their task is to identify an area in their department or organization in need of improvement, and – using one or more of the CLAS standards as the foundation – develop a plan to respond to this need. They will be asked to do this during the next two weeks, before the fourth workshop session.

Please ask the participants to refer to the **CLAS Quality Improvement Plan Worksheet** found in their workbook, and review with them each component of the worksheet**.** As managers, many participants will be familiar with these components, diminishing the time you may need to spend in discussion. If participants find that they are having difficulty identifying a project, they may complete the optional **CLAS Standards Feasibility Worksheet**, which will help them to systematically review each of the CLAS standards that they might apply to their department. After they have completed a draft of their quality improvement plan, they should refer to the **CLAS Quality Improvement Plan Evaluation Checklist** and assess to what degree their plan addresses the components of the CLAS standard they are using. These two forms also can be found in the **Participant Workbook** in the **Workshop Session III** chapter. You will need to determine a date in the week before **Workshop Session IV** for the participants to submit their **CLAS quality improvement plan** for your review.

The participants' plans must be aligned with the organizational mission, and they should synergize with other CLAS projects to optimize chances of meaningful implementation. To assist, you should ask the participants in the large-group format to discuss the following questions:

- Which standards are top priorities?
- Which standards are most practical or feasible to address?
- Does the organization want to try for a broad approach (i.e., addressing all 14 standards) or a focused approach (examining selected key standards thoroughly).
- Are you aware of existing resources, programs, or efforts that can be used to address one or more of the standards?

At the end of the discussion, the facilitator should ask each of the participants to commit to a standard to be addressed (individually or as a group) in the quality improvement plan.

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 can also be various laws and regulations. Who is responsible for acquiring/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 AIM statement? How will you measure such improvements? 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 8 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 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 deterrents:

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 hindrances in implementation:

Ideas to overcome hindrances:

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 impediments in implementation:

Ideas to overcome impediments:

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 obstacles in implementation:

Ideas to overcome obstacles:

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 hindrances to implementation:

Ideas to overcome hindrances:

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 obstacles to implementation:

Ideas to overcome obstacles:

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 not applicable?

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

*Why would it be unfeasible?

Anticipated impediments to implementation:

Ideas to overcome impediments:

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 hindrances to implementation:

Ideas to overcome hindrances:

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 obstacles to implementation:

Ideas to overcome obstacles:

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 impediments to implementation:

Ideas to overcome impediments:

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 objectively, quantitatively measure the relevance of individual participant project plans to target 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 worksheet entitled CLAS Quality Improvement Plan Evaluation Checklist.

Table 9 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 preventative 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 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 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 to 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:

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 the participants in this session. The participants will be given the opportunity to reflect on how they can be effective leaders and agents for system change. They will also discuss their **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 participants' plans will help to comprehensively implement CLAS at the level of the entire organization. At the end of the session, the participants will be asked to fill out the **Post-Curriculum Survey** and the **Participant Satisfaction Survey**. This session concludes the 16-hour workshop phase. As the facilitator, you will coordinate with the participants to determine a follow-up meeting time one month later to help them further develop and implement their **CLAS quality improvement plans**.

Learning objectives

At the end of **Workshop Session IV**, the participants 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 CLAS standards can be applied to their service and to the organization as a whole;
4. Understand the ways in which their service is related to other participants' services, in order to enhance collaboration and pool resources;

Skills to:

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

Attitudes to:

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

Facilitator preparation for Workshop Session IV:

At the end of **Workshop Session III**, you and the participants had agreed upon a time to turn in the **CLAS quality improvement plans** for review. After receiving them, you should review each plan, looking for:

1. The degree to which the plan addresses the CLAS standards;
2. The impact it has on culturally and linguistically appropriate services; and
3. The practicality of implementation.

For the third factor, you may benefit from involvement an experienced manager if you have limited management experience. You should consider using the **CLAS Quality Improvement Plan Evaluation Checklist** included in the prior chapter to help assess the degree to which the plan addresses its targeted standard. Written comments about these three factors should be prepared for each of the plans. After all the plans have been reviewed, you will need to consider them collectively with regard to the following:

Collaboration and coordination

1. Which plans are complementary?
2. Which plans utilize similar resources?
3. Does potential for collaboration between plans exist?

Addressing the needs of the organization

1. Collectively, do the plans address the predominant concerns about CLAS identified in the key informant interviews or discussions in the prior sessions? If not, these concerns should be mentioned to the participants in Session IV.
2. Collectively, do the plans address the three major domains of the CLAS standards: cultural competence, language access services, and organization supports?

You will need to divide the participants into groups in advance according to the similarity or degree of overlap of their plans. In **Workshop Session IV**, the participants from each group will discuss how they can coordinate their individual plans to optimize their impact on the organization. You should consider grouping the participants according to:

1. Domains of CLAS: cultural competence, language access services, organization supports.
2. Degree to which the aims and goals of the CLAS quality improvement plans overlap or complement each other.
3. Degree to which resources or expertise are shared or are complementary.

Individuals identified in the **key informant interviews** who are not participants of the curriculum, including the presenter of the "model program," may be invited to join a group if they have a particular expertise or resources relevant to the respective group.

Welcome and check-in [20 min]

The welcome and check-in is an important part of every session. It helps the participant attain an appropriate mindset for the work of the day and gives you a sense of the issues that the participants may bring into the session today. You can start with general questions. Also, take time to ask the participants how satisfied they were with the process of developing their **CLAS quality improvement plan** before moving ahead to the **Leadership and Process of Change** talk.

Didactic segment: Leadership and process of change [60 min]

The top level of leadership must explicitly support the participants' efforts toward CLAS standards implementation. This component of the workshop helps to establish this support formally. During the **organizational culture assessment** phase, you should have asked the top leader to commit an hour of his or her time to present on how to be an effective leader and agent of system change. This talk gives the leader an opportunity to formally articulate his or her own style and perspectives on leadership, thereby clarifying what is needed and expected from their managers (the participants). The participants also benefit from understanding these expectations, and from hearing about the strategies utilized by someone who has been successful in the organization. The talk should address the following questions:

1. What qualities makes a good leader, and why?

2. What are the common pitfalls that leaders encounter?

3. What are effective strategies for participants to effectively reach their project and larger institutional goals?

4. What obstacles are participants likely to face, and what resources will be needed to implement CLAS standards in the organization?

Break [10 min]

Discussion of quality improvement plans [90 min]

You should ask the participants to divide into the groups predetermined during your review of the quality improvement plans. These groups should be asked to devote 60 minutes to completion of the following activities:

1. Review the plan of each participant in the small group and discuss suggestions and feedback.

2. Discuss the strengths and merits of each plan, as well as impediments that may interfere with implementation of the plan.
3. Discuss the potential overlaps, opportunities to share resources, and ways to collaborate and mutually support each others' projects.
4. Finalize **CLAS quality improvement plans** based on these discussions.

Afterwards, participants in each group should summarize their plans and describe how they can collaborate to implement these plans to the large group. You should allow 30 minutes to complete this segment.

Conclusion [20 min]

This concludes the second **Learning Workshops** phase of the curriculum. By now, the participants should have a working plan on how to implement one or more aspects of the CLAS curriculum in their system. They should be congratulated for dedicating their time and energy to participating in the curriculum, and for their commitment to improving culturally and linguistically appropriate services in their organization. You also should emphasize to the participants that they now know more about the CLAS standards than many cultural competency trainers, particularly with regard to strategies to realistically implement CLAS. In order to close this part of the curriculum, you should ask the participants about their success in absorbing principals taught in the workshop and in completing the exercises. Other questions that help promote reflection and conclusion of the curriculum are:

1. What was the most demanding part of the curriculum? What was most rewarding?
2. What surprised you most about this experience? About the organization? About yourself?
3. How could this experience be improved for future participants?
4. You've devoted over 16 hours focusing on this learning activity. What do you take away from this experience?

You should remind the participants that they will be asked to attend monthly one-hour meetings to discuss and support their implementation of the CLAS quality improvement projects. In the last five minutes of the concluding segment, you should spend some time to thank the participants for their hard work; the organization's top leadership assigning a high priority to participation in this experience; and the speakers, co-facilitators (if any), and assistants who helped to support the running of the curriculum.

Curriculum evaluation [40 min]

Before the participants leave the session, they should be asked to fill out the **Participant Satisfactory Survey** and the **Post-Curriculum Survey**. Copies are found in the **Participant Workbook** at the end of the **Workshop IV** chapter, though it will be more practical for them to receive handout copies if they wish to keep their workbooks. It should take them 30 to 40

minutes in total to complete. The **Participant Satisfaction Survey** will help to assess the quality of each module, the facilitation, speakers, and logistical support. These reactions will help you determine how the teaching of the curriculum can be improved. To complement this, the **Post-Curriculum Survey** ascertains the impact of the curriculum on the participants through self-assessment of their knowledge, skills, and attitudes around various components of the CLAS standards. These results can be compared with the **Pre-Curriculum Survey** to determine changes in knowledge, skills, and attitudes.

Providing Quality Health Care with CLAS

Participant Post-Curriculum Survey
(Facilitator's Answer Key)

** Please Note: This is the facilitator's answer key. The "**preferred"** response is in bold.*

Please select the best answer to define the following:

General knowledge:

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

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

CLAS knowledge

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?

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

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

CLAS opinion

12. Evidence has shown 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

Self-assessment / general knowledge / self-assessment of CLAS knowledge

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

Attitude toward CLAS

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 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 of their 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

CLAS experience

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, 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

Self-assessment of ability to implement CLAS

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.

	Excellent	Good	Fair	Poor
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				
	Excellent	Good	Fair	Poor
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				
	Excellent	Good	Fair	Poor
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				
	Excellent	Good	Fair	Poor
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				

	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		

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

Facilitator #2 Evaluation				
	Excellent	Good	Fair	Poor
Facilitator name:				
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				
	Excellent	Good	Fair	Poor
Facilitator name:				
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	
Room accommodations:					
Catering:					
Comments:					

Logistics and Planning					
	Excellent	Good	Fair	Poor	
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 Sessions:

Follow-up Meetings: Maintaining the Momentum

Overview: The purpose of the follow-up meetings is to help the participants follow through on the implementation of their CLAS quality improvement plans. The meetings should be held with the same groups that were formed at in Session IV. This means it is likely that you will need to meet with more than one group each month.

Learning objectives

At the end of the **Follow-up Meetings**, the participants should have acquired the followingknowledge, skills and attitudes.

Knowledge to:

1. Describe the key accomplishments and difficulties that they have encountered in implementing their quality improvement plan;
2. Describe the key accomplishments and difficulties that other members of their 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 their commitment toward implementing their quality improvement plan;
5. Maintain their 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 their own plan.

Project updates [30 min]

In the first half of the meeting, you should ask each participant to update the group on the progress of their project. As part of the update, the participants should identify at least one key accomplishment and one key obstacle that the other members can help to troubleshoot. The other participants should offer reactions that are both constructive and supportive. Afterwards, the participant who is giving the update should be asked to identify, realistically, the next step(s) they wish to take for the upcoming month. You or, ideally, an assistant should take notes on the **CLAS QI Project Update Worksheet** (found at the end of this chapter) for each project update.

One copy should be given to the participant sometime after this session but before the next. You also can use a copy as a point of reference at the next meeting.

Facilitator's summary [10 min]

After the updates, you should conclude the meeting by summarizing the collective experience of the group in their work toward implementing their **CLAS quality improvement plans**. Consider including in your summary reference to these elements:

- Themes that cross projects
- Interactions between project participants and their departments
- Major obstacles and successes that the group as a whole has experienced
- Solutions discussed and next steps for each project

CLAS QI Project Update Worksheet

Date:

Session number:

Project name:

Project participants:

Interval accomplishments:

Interval obstacles:

Group responses:

Identified next steps:

Appendix A: Principles of Facilitating Cultural Competence Workshops

Overview: This module is intended to be used to train individuals who will be facilitating the **Providing Quality Health Care with CLAS** curriculum. It emphasizes the importance of becoming familiar with the culture of the participants in order to make the learning experience more relevant to them. The module will also review strategies to facilitate small-group discussions, which is a primary modality used in this curriculum.

Learning objectives

Upon the completion of this session participants will have acquired the following knowledge, skills, and attitudes.

Knowledge to:

1. Describe the strengths and weaknesses of various facilitator roles;
2. Characterize the Meyers-Briggs Dichotomies as they pertain to learning styles;
3. Describe the qualities that make a good group facilitator;

Skills to:

1. Be able to assess the qualities of your participants that may influence their involvement in the training;
2. Be able to align participants' values and beliefs with the objectives of the training;
3. Be able to utilize various facilitating styles to enhance group learning;
4. Be able to plan and adjust a workshop(s) to the learning styles of the participants;

Attitudes to:

1. Gain confidence as a group facilitator;
2. Increase one's appreciation of a customized, culturally competent approach-toward CLAS training.

Introduction

The **Providing Quality Health Care with CLAS** curriculum is not meant to be "one-size-fits–all" training. One of the prime tenets of cultural competence is appreciation of people's beliefs, perspectives, and values. Likewise, conducting any sort of workshop requires understanding of the perspectives, background, and needs of the collective audience in order to establish the context in which you will be doing the training. In essence, this guide will help you conduct this cultural competence and CLAS training utilizing a *culturally competent process.* This module will help you improve your ability to understand and anticipate:

1. Potential impediments to facilitating the group
2. How to align CLAS values with the values already inherent in the group
3. How to better fit case examples and discussion points to the level of the audience
4. How to enhance empathy and connectedness to the group

Preparatory work

A. Who is your audience?

Checklist:

- How would you characterize the participants?
- What types of roles and responsibilities do they have in the department, organization, or the community?
- What are some of the difficulties they face in their work?
- What have been their collective accomplishments?
- Describe some of principal values that drive people's work?
- What are their goals?

B. What are the beliefs and attitudes of your audience toward the CLAS standards?

Checklist:

- How important is cultural competence to the participants' work?
- What might the participants believe is the process to becoming culturally competent?
- What, if any, have been the participants' prior experiences with CLAS standards or cultural competence trainings?
- Characterize the good and bad experiences with these trainings.
- What might the participants see as the role, if any, of the CLAS standards training?
- What are the impediments to implementing the CLAS standards in their work?
- How do participants envision the sustainability of projects to implement and maintain CLAS standards?

In the workshop

C. Facilitator-participant dynamics

Facilitating CLAS standards workshops can be demanding. Participants may regard the facilitator with skepticism, believing that he or she has unrealistic expectations, or lacks true understanding of the participants' work context. The facilitator may be subjected to cynical attitudes or minimal engagement as a result of resistance to discussing racism, unequal treatment and other emotionally sensitive topics; defensiveness that discredits their "need" of CLAS standards training; and/or frustration with the constraints of the system in which they work. As a result, CLAS standards/ and cultural competence trainers often face resistance that is more emotionally difficult than trainers of other areas. It is unlikely that a single approach will be able to overcome these attitudes. Moreover, the different interpersonal and learning styles of the participants place further importance on a multimodal approach.

Potential trainer roles	Advantages	Disadvantages
Expert Answers questions directly, uses didactical format or anecdotes. Requires good knowledge of learning materials. Titles and honorifics help.	▪ Seen as having legitimate (but not necessarily relevant) knowledge. ▪ Aligned with most academic learning format. ▪ May rapidly convey superficial information	▪ Poor engagement strategy ▪ May impede discussion ▪ Poorly able to address resistance ▪ Material may be seen as not applicable or relevant ▪ Does not promote problem-solving
Facilitator Asks questions rather than answers, coaches and cheerleads. Good knowledge helps to identify or highlight relevant questions. (See appendix for further details)	▪ Improves group engagement ▪ Enhances discussion ▪ Promotes problem solving	▪ May be seen as "soft" and vague ▪ Will have difficulty conveying information rapidly ▪ May not provide comfortable learning environment for some learners (see Myers-Briggs)
Skeptic Voices his or her own distressful experiences or concerns about CLAS standards trainings	▪ Can help reduce defensiveness of participants ▪ Can provide safety for skeptics to voice their opinion	▪ May stretch believability ▪ May alienate those who are advocates ▪ Why are you a trainer?
Comedian: Uses humor, pokes fun (usually at self)	▪ May add some lightness to emotionally charged topic ▪ Can be used to improve group engagement and cohesion ▪ Helps to engage people who feel that they are at the training on coercive basis (**à** la Traffic School Comedy)	▪ May derail the discussion ▪ May anger CLAS standards/cultural competence advocates ▪ May offend some participants

Reflection exercise:

- What is the role that you most and least often assume?
- Can you imagine yourself in the other roles?
- Can you identify other roles that you consider productive (or counterproductive) to CLAS standards training?
- Discuss how you might use the two least comfortable roles in the next training workshop.

D. Learning styles

Significant diversity exists in the way people learn. Divergence in learning styles is attributable to many factors, including the type of information and experiences that people regard as useful; how people tend to process the information; and how they prefer to organize their learning experiences. For example, one learner may find experiential exercises and discussions appealing, whereas another learner may prefer didactic instruction and spending time at home digesting the information. The facilitator is responsible for recognizing the particular style of each learner, to facilitate a learning context that is consistent with that learning style, and to also challenge each participant to adapt to other learning contexts. The table below summarizes learning styles using the Myers-Briggs Dichotomies. Please take some time to reflect upon the questions following as well.

Table 10 Myers-Briggs Dichotomies (as they pertain to learning context)

Extraversion	**Introversion**
Describes a person's general orientation towards self and other and how they draw their energy	
▪ Outwardly focused ▪ Focuses on other people and things when making decisions ▪ Becomes energized from social relationship	▪ Inwardly focused ▪ Focuses on one's own thoughts and feelings when making decisions ▪ Becomes energized from inwardly focused activities
Sensing	**Intuition**
Describes what kinds of information are most relevant	
▪ Information received from the five senses	▪ Prefers information received from intuition, subconscious, intangible, insights
Thinking	**Feeling**
Describes how a person prefers to make decisions	
▪ Decides with their head ▪ Uses logic –"if this, then that"	▪ Decides with their heart ▪ Uses value –this is better, this is worse
Judging	**Perceiving**
Describes one's preference for how experience is organized	
▪ Prefers organized and planned activities	▪ Preference for spontaneity and flexibility

Brightman, H. J.: (2006). *On Learning Styles*. Georgia State University Master Teacher Program. Retrieved August 13, 2009, from http://www2.gsu.edu/~dschjb/wwwmbti.html.

Reflection exercise

- How would you characterize your preferred domains?
- Does this reflect on how you conduct trainings?
- When conducting training, which domains are the most difficult for you to engage?
- Characterize a strategy to engage participants from each of the eight Myers-Briggs Dichotomies.
- Characterize a strategy to engage participants from each of these eight domains.

Appendix B: 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 support 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 C: Recommended 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, video 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. 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.

This indispensable report comprehensively reviews the literature on organizational change strategies in cultural and linguistic competence. Additionally, it presents a framework for evaluating cultural and linguistic competence through the introduction of consistent themes across the application of cultural and linguistic competence in health care settings.

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.

*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 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 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.

Contributors

UC Davis Health System Center for Reducing Health Disparities

Marbella Sala
Executive Operations Manager

Lina R. Méndez, PhD
Project Coordinator

Mai See Yang, MS
Project Coordinator

Kimberly Reynolds
Administrative Staff

Roberto Ramos, MS
Project Coordinator

California Department of Public Health
Department of Health Care Services
Office of Multicultural Health

Laura Hardcastle, Chief

David Bodick, MPH
Health Education Consultant

Mallika Rajapaksa, PhD
Research Scientist

Carol Gomez
Analyst

University of California Davis Extension Enterprise Group

Mary Anne Porter
Enterprise Group

Kristen Hoard
Online Learning Group

Joe Najera
Online Learning Group

John Loring
Online Learning Group

Rita Smith Simms
Online Learning Group

Denise Malloy
Online Learning Group

Amy Ryan
Education Unit/Online Learning & Education

Susan Catron
Director, Education, Health & Policy Programs

Internal Advisory Committee

Jesse Joad, MD, MS
Professor of Pediatrics and Associate Dean of Diversity and Faculty Development
University of California, Davis, Health System

Cindy Oropeza
Manager
Equal Opportunity and Diversity
University of California, Davis, Health System

Gregg Servis, MDiv
Director
Faculty Development and Diversity
University of California, Davis, Health System

External Advisory Committee

Ijeoma Achara-Abrahams, PsyD
Director of Strategic Planning
Department of Behavioral Health and Mental Health Retardation Services
Philadelphia Alliance

Renato D. Alarcon, MD, MPH
Professor
Department of Psychiatry and Psychology
Mayo Clinic College of Medicine

Carolyn Castillo-Pierson, JD
Executive Director
Yolo County Family Resource Center

José Cintron, PhD
Professor of Education
California State University, Sacramento

External Advisory Committee (continued):

Marya Endriga, PhD
Professor of Psychology
California State University, Sacramento

Peter J. Guarnaccia, PhD
Professor and Medical Anthropologist
Institute for Human Research/CSHP
Rutgers College

Tawara Goode, MA
Director
National Center for Cultural Competence
Georgetown University Center for Child and Human Development

Rachel Guerrero, LCSW
Former Chief
Office of Multicultural Services
California Department of Mental Health

Mario Hernandez, PhD
Professor and Chair
Department of Child and Family Studies

Louis de la Parte Florida Mental Health Institute
University of South Florida.

DJ Ida, PhD
Executive Director
National Asian American Pacific Islander Mental Health Association

Mareasa Isaacs, PhD
Director
National Alliance of Multi-Ethnic Behavioral Health Associations

Kenneth J. Martinez, PsyD
Mental Health Resource Specialist
American Institutes for Research

Matthew Mock, PhD
Former Director
Center for Multicultural Development
California Institute for Mental Health

Guadalupe Pacheco, MSW
Special Assistant to the Deputy Assistant Secretary for Minority Health
U.S. Department of Health and Human Services
Office of Minority Health

Annelle B. Primm, MD, MPH
Director
Minority and National Affairs
American Psychiatric Association

William A. Vega, PhD
Professor
Department of Family Medicine
David Geffen School of Medicine at UCLA

Participant Organizations

California Department of Alcohol and Drug Program

Behavioral Health Service
San Joaquin County, CA

Public Health Service
San Joaquin County, CA

University of California, Davis, Health System Dean's Office and Departments of Family Medicine, Pediatrics, Human Resources, Public Affairs, Patient Relations, Dean's Office, and Medical Interpreting

With special appreciation to:

Claire Pomeroy, MD, MBA
Vice Chancellor for Human Health Sciences, UC Davis
Dean, UC Davis School of Medicine

Elizabeth Miller, MD, PhD
Assistant Professor of Pediatrics

Erik Fernandez y Garcia, MD
Assistant Professor of Pediatrics

Renée Zito
Former Director
California Department of Alcohol and Drug Program

Michael Cunningham
Former Deputy Director
California Department of Alcohol and Drug Program

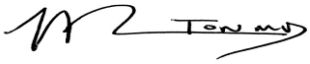
Bill Mitchell
Director
Public Health Service
San Joaquin County, CA

Vic Singh
Director
Behavioral Health Service
San Joaquin County, CA

William M. Sribney, MS
Third Way Statistics

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 develop and deliver culturally and linguistically appropriate services that will reduce health disparities and improve the quality of care for all patients.



Hendry Ton, MD, MS

Sergio Aguilar-Gaxiola, MD, PhD

EDMUND G. BROWN Jr.
Governor
State of California

Diana S. Dooley
Secretary
Health and Human Services Agency

Ronald W. Chapman, MD, MPH
Director
California Department of Public Health

Toby Douglas
Director
Department of Health Care Services

California Department of Public Health
Department of Health Care Services
P.O. Box 997413, MS 0022
Sacramento, CA 95899-7413
(916) 440-7560
omhmail@cdph.ca.gov