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 PublicHealth

DHCS California Department of HealthCareServices

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

UC DAVIS Health System
Center for Reducing Health Disparities

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Introduction

Welcome to the **Providing Quality Health Care with CLAS Curriculum Toolkit**. This toolkit 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 devote time out of their busy schedule. However, those who have participated in this curriculum have found this to be time well spent and would recommend it to their colleagues. The results of their efforts have been system-wide quality improvements that optimally utilize 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 take you through the essential steps of preparing and facilitating the curriculum. In addition to this manual, the **Providing Quality Health Care with CLAS Toolkit** includes: 1) **Multimedia Facilitator's Tutorial** that is the companion to this manual, 2) a brief **Promotional Video** about the curriculum that can be used to introduce the curriculum to potential participants and organizations, 3) a **Participant Workbook** which includes the necessary worksheets used by participants in the curriculum, and 4) a **Resources & Reading** section which provides recommended readings, forms, and PowerPoint Presentations used in the curriculum. The table below graphically illustrates the components of this toolkit:

Providing Quality Care with CLAS Toolkit	
Facilitator's CD	**Participant's CD**
1. Printable Facilitator's Manual 2. Facilitator's Multimedia Tutorial 3. Resources & Readings 4. Promotional Video	1. Printable Participant Workbook 2. Resources & 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 creatively implement these standards.

The curriculum is comprised 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 helps the facilitators to customize the curriculum to the participants. The second phase of the curriculum, the **Learning Workshops**, is the divided into four workshop sessions, each lasting 4 hours. In the last phase, the **Follow-up**, participants will also be asked to attend 6 monthly one 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 carryout 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.

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

It is critical to understand the culture of the organization that will participate in the curriculum. By doing this, you will be able 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 allows for you to identify departments within the organization that may potentially collaborate or have synergistic efforts. 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 on CLAS topics, it is important for you to understand the organization at its baseline. The following steps have been identified to help the facilitators get a broad systems perspective on the state of the organization, and to develop ideas of how the CLAS Standards can potentially benefit the organization.

1. Obtain the mission statement of the organization.
2. You should have preliminary thoughts about the following issues with regard to the mission statement:
    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 address this with participants?
3. Obtain the organizational chart for the system or organization
4. For each person/position in the organizational chart, you should have preliminary thoughts about the following issues:
    a. What is the role of this person in the organization?
    b. How does this person/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/positions might this person need to enhance their CLAS efforts?
    e. Who else should be involved in the curriculum that is not depicted in the organizational chart?

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. This 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. It may also provide an opportunity for you to

develop a one-to-one relationship with potential participants, helping you to facilitate more effectively in the upcoming workshops. Please follow the guidelines below:

1. Schedule 30 minute interviews with the people on the organizational chart. While it is ideal to be able to interview all the individuals, time and resources may limit the feasibility of this. At minimum, it is preferable to interview at least 50% of the individuals with priority for the organization's top leaders and individuals that are specifically charged with responsibilities around cultural competence or linguistic access.
2. During the interviews, key people not otherwise depicted in the organizational chart should be identified and scheduled to interview if possible.
3. The **Key Informant Semi-Structured Interview Tool** is included at the end of this section for your use.

PART III: Selection of Participants

Participants of the curriculum are typically chosen by the organization's leader. However, through the **Organizational Culture Assessment**, 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 prior to the start of **Workshop Session I**. However, if it is difficult to do so, the survey may be collected at the start of the first workshop session. At the end of **Workshop Session IV**, the participants will also be given a **Post-Curriculum Survey** to ascertain the impact of the curriculum.

PART V: Participant Groupings

The majority of this curriculum uses the small group learning format, with typical groups consisting of 4 to 6 individuals. This format has the advantages of allowing for greater collaboration, a more sophisticated level of learning, and invokes group process as a powerful mediator to learning. The longer 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 work together or whose potential collaboration may lead to synergistic impact. *It is important that the groups work effectively with one another. While the exercises in the curriculum will help to promote effective group process, participants who already have positive experiences working together or have commonalities that promote positive 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. *Similar to the above, participants with overlapping responsibilities and goals may be able to pool their resources together to develop projects that have broader or farther implications than if they had developed a project individually. By being in the same group, these participants are allowed 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 can also share experiences that supplement the information given in the didactics to make the learning experience more "real."*

PART VI: INVOLVING THE TOP LEADERSHIP

It is difficult for a system to change 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 time allocated for the organizations' managers and leaders to participate in the curriculum. We also ask that the top leadership formally present to the participants on how to be a good leader and effective strategies for system change. This provides an opportunity for the leader to articulate their own style and perspectives on leadership thereby clarifying what they need and expect from their managers. The participants also benefit from hearing about these expectations and the strategies utilized by 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 provided at the end of this section describes this activity in more detail.

PART VII: IDENTIFYING A MODEL PROGRAM THAT INCORPORATE CLAS

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

1. Demonstrate that it is possible to implement programs compliant with the CLAS standards,
2. Highlight proven strategies and potential pitfalls to consider when implementing CLAS compliant projects, and
3. Inform participants about such programs, as there may be some potential for collaboration.

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 areas that the presenter should speak about is included at the end of this section.

Organizational Culture Assessment Forms:

Key Informant Semi-Structured Interview Tool

Date: _____ Organization: _____ Name: _____

Introduction

1. Prior to meeting with the key informant, the interviewer sends the informant the **Information for the Participants** hand out, which overviews the curriculum.
2. At the start of the meeting have the interviewer introduce themselves, briefly describe the CLAS project and his and her role.
3. Interviewer talks about how the key informant was identified, and if appropriate, who identified them.

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/are working on? 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 feedback/thoughts on it.
   [Interviewer describes 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 thoughts or feedback about this curriculum?

6. Please identify some people who would be ideal participants in this program.

[Interviewer should clarify their roles in the organization and why they are felt 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. Are there other challenges that need to be addressed in order to successfully implement this curriculum?

9. In addition to the people you have identified earlier, are there other people whom you believe would be important for us to speak with?

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

Phone: _____

E-mail:_____

[Interviewer thanks the key informant for their time.]

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 & Human Services, Office of Minority Health. This curriculum helps you do this by building upon your organization's existing infrastructure and mission values. We utilize small group, problem-based discussions which have been shown in many educational contexts to enhance creative problem-solving and to more effectively develop higher-level understanding of topics discussed (Ton et al., 2005). Rather than having a "cookbook" approach that superimposes a model without attention to the unique challenges and strengths of your organization, this strength-based approach can more effectively help you to creatively implement these standards in your organization.

This program has three parts. The first part involves taking an anonymous survey that assesses your level of familiarity and comfort with the CLAS Standards. This will help us to customize the curriculum to your and other participants' learning needs. In the second part of the program, participants will attend four workshop sessions, each lasting 4 hours, in order to develop a quality improvement plan that incorporates one or more of the CLAS standards. You will be given assignments after each session that will take between 30-60 minutes to be completed prior to the next session. The third part of the curriculum involves attending 6 monthly one hour follow-up sessions which will help you to implement and maintain the CLAS quality improvement plan that you develop.

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

Preferred Criteria for Participation:
In order to participate in this program, it is desirable for you to have the following:

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

- Direct services: Clinic Director, Nurse Manager, etc.
- Organizational Supports: Continual Quality Improvement, Human Resources, Staff or Provider Development, etc.
- Language and Community Outreach Services

At the completion of the training, you should be able to:

Knowledge:

1. Define health disparities, cultural competence, and patient centered care;
2. Describe factors that contribute to health disparities;
3. Describe how health disparities impact 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 impacting system change at the organization where you are employed or represent;
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 effect 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 improving quality of care for these communities;
14. Describe the rationale and intent behind each CLAS standard;
15. Describe a model program that effectively implements the CLAS standards;
16. Describe the relevancy of these standards to your department;
17. Describe the qualities and approaches of effective leaders;
18. Describe the strategies used for system change;
19. Describe how CLAS standards can be applied to your service and the organization as a whole;
20. Understand the ways in which your service is related to other participants' services in order to enhance collaboration and pool resources;

Skills:

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 that of communities not specifically discussed;
4. Critically examine the organization's ability to provide care to clients from diverse backgrounds;
5. Assess whether and how your department addresses 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:

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

Providing Quality Health Care with CLAS
Participant Pre-Curriculum Survey
(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 patients limitations when developing care plans
   - [ ] Performing learning needs assessments with patients
   - [ ] Integration of methods to mitigate barriers to learning

4. Racial/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 them
   [ ] 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 what they need to do to get better
   [ ] Cultural beliefs regarding health shared by members of a group
   [ ] All of the above

8. How many CLAS standards are there?
   [ ] 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
   [ ] US Department of Health and Human Services, Office of Minority Health
   [ ] California Department of Public Health
   [ ] 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. There is evidence that cultural factors such as ethnicity, class, religion, spirituality, sexual orientation and racism impact health care decision making.

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

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

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

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 towards CLAS

16. Language barriers have been shown to impact 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, it is important to provide materials/assistance in a 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 delivering 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. It is possible to implement CLAS-based programs.

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

22. It is important that quality improvement efforts include consideration of the CLAS standards.

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

23. A diverse workforce is important to providing quality health care.

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

24. It is important to understand the cultural backgrounds of patients.

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

25. It is important to understand the cultural backgrounds of my co-workers/colleagues.

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

26. It is important to have equity in health care.

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

27. Understanding the patient's experience of their illness is important to providing quality health care.

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

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

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

31. Linguistically appropriate services are important to providing 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. I believe that CLAS-based efforts can improve quality of health care and/or services.

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

35. I believe that 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 the following patient data – Race?

[ ] Yes [ ] No

39. Do you have access to the following patient data – Ethnicity?

[ ] Yes [ ] No

40. Do you have access to the following patient data – Preferred language?

[ ] Yes [ ] No

41. Do you adjust service delivery based on the 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 operationalize one or more of the CLAS standards.

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

Leadership Talk

Presentation Date:
Duration 30-45 minute didactic; 15 minutes for discussion/questions

Purpose:

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

Objectives:

1. Convey an understanding of what 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, in your perspective, what challenges will be faced and what resources will be needed to implement CLAS in the organization.

Model Program Presentation Guide

You have been identified by your organization's leaders as having successfully implemented a culturally and/or linguistically appropriate program. We have found it quite meaningful when the "story" of a successful program is shared with other leaders in an organization. Learning about successful program highlights organizational strengths, reinforces commitment to culturally and linguistically appropriate services and provides a model for others.

We are requesting that you provide a 20 minute presentation on 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 address/overcome challenges?
- How did you know when you had attained your goal?
- What mechanisms were employed to sustain the success of your program or project?

Also, how did the following factors fit, contribute to, and/or challenge your efforts:

1. **Leadership:** Leaders are decision makers who have the ability to influence others and provide direction to an organization to make it more cohesive and effective.
2. **Team:** 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 a series of 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 how staff relate to each other, how they communicate, and how efforts are coordinated.
5. **Data Measurement and Reporting:** This refers to all aspects of data management including what data is measured and how it is collected, stored, processed, updated, and disseminated.
6. **Education and Coaching:** This refers to how knowledge is generated, shared and used. It includes aspects such as implementation assistance and support and may take the form of seminars, staff development, and individual consultations.

Workshop Session I: Introduction to the CLAS Standards

Overview: The first workshop session will prepare the participants and lay the foundation for the rest 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 theirs and other departments. This 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 be able to:

Knowledge:

1. Define health disparities, cultural competence, and patient centered care;
2. Describe factors that contribute to health disparities;
3. Describe how health disparities impact 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 impacting system change at the organization where they work or represent;

Skills:

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

Attitudes:

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

Participant Pre-Curriculum Survey

Prior to the start of this curriculum, you should have asked the participants to complete the **Participant Pre-Curriculum Survey** you can find the survey at the end of the (**Chapter 1: Organizational Culture Assessment**). You can collect the completed surveys prior to the start of this module if they have not been turned in earlier.

Welcome and Check In [5 min]:

Briefly spend some time to welcome the participants to the curriculum. You can start by introducing yourself and any co-facilitator who is also participating, as well as the support staff involved in the training. It is important to acknowledge the commitment of the organization's leadership in allocating time out of their busy schedule to attend this training. You may also want to ask for a show of hands of people who have attended cultural competence trainings in the past. Emphasize to the participants, that while they will become more knowledgeable about the CLAS standards than most people, 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 each participant to first introduce themselves and their title or role in the organization and then ask each to discuss what they know about the origin of their name and the personal and cultural significance of their names. It may be helpful for you to start by explaining 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.

Didactics: Health Disparities and CLAS Presentation [60 min]

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

1. Characterizes the health disparities that exist in the United States for ethnic minorities;
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. Overviews of CLAS standards;
5. And 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 implement 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 to articulate the mission and values of the department that they lead and their own personal experiences around 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 (Figure 1.1 also describes the exercise,) and read the following instructions to the participants: "Please take 30 minutes in your small group to answer and discuss the following questions provided. Also select one person in the group to summarize your group's discussion."

Figure 1.1 Vision Statement Exercise

Name:

My role/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 work together?
- What values would your service embody?

B. Discuss and get feedback on 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]

Now let us move onto the **Process of Change Challenge**. 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. Team
3. Models and Processes
4. Organizational Systems and Culture
5. Data Measurement and Reporting
6. Education and Coaching

It is helpful to review the report "Contributing to Sustaining and Spreading Learning Collaborative Improvements" to further understand what each domain entails prior to today's session. This report is provided in the **Resources & Readings** section of the **Facilitator's CD**.

We will utilize these six domains as a framework for the participants to discuss the factors needed to develop and sustain programs in their organization. This exercise provides a conceptual framework for them 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 to Figure 1.2 **The Process of Change Challenge**, and ask the participant to refer to the same handout found in the **Workshop Session I** chapter of the **Participant Workbook.** 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 being addressed by at least one group. Please ask each group to address the following questions with regard to their particular domain:

1. How does this domain influence the implementation and sustainability of new programs/projects?
2. Describe strategies that ensure that this domain is developed or supported.
3. What contributions can you make to this area? What are the barriers that keep you from doing so?
4. What resources are required to strengthen this domain in your system?
5. As a group, please be prepared to present one example of how you have seen this domain be effectively applied or developed.

6. Are there other domains not mentioned that your group feels is 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 efforts. You may also decide to put forth the following discussion question to get the participants to think about their own role as agents of change in their system:

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

Figure 1.2 Process of Change Challenge

Domains Critical to System Change:*

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

2. **Team:** Group of staff working to implement and sustain a program.

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

4. **Organizational Systems and Culture**: Systems refer to the organization's processes, polices, forms and protocols. Organizational culture refers to the shared values of an organization as well as how staff relate to each other, how they communicate, and how efforts are coordinated.

5. **Data Measurement and Reporting:** This refers to all aspects of data management including what data is measured and how it is collected, stored, processed, updated, and disseminated.

6. **Education and Coaching:** This refers to how knowledge is generated, shared and used. It includes aspects such as 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/projects?
B. Describe strategies that ensure this domain is developed or supported.
C. What contributions can you make to this area? What are the barriers that keep you from doing so?
D. What resources are required to strengthen this domain in your system?
E. As a group, please be prepared to present one example of how you have seen this domain be effectively applied or developed.
F. Are there other domains not mentioned that your group feels is important to system change?
Report Back to Large Group

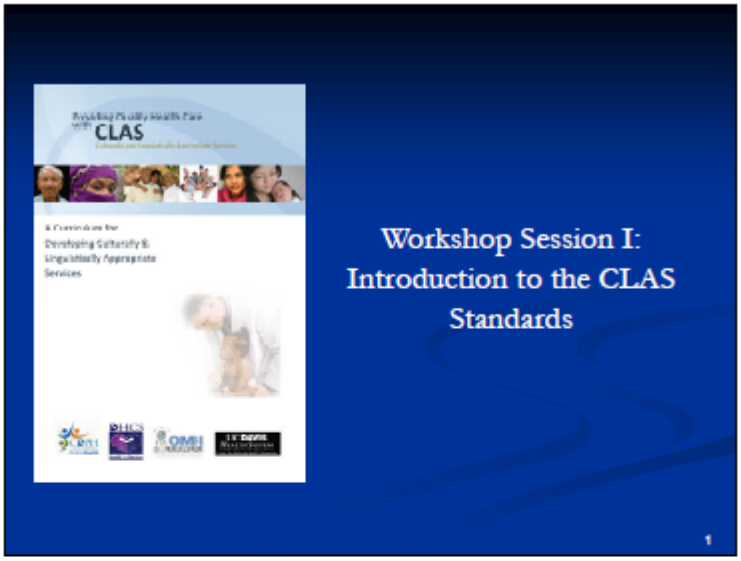
* Judge, K.H., Zahn, D., Lustbader, N.J., Thomas, S., Ramjohn, D., & Chin, M. (2007). *Factors Contributing to Sustaining and Spreading Learning Collaborative Improvements.* Primary Care Development Corporation.

Closing Statements and Assignment of Homework (20 min)

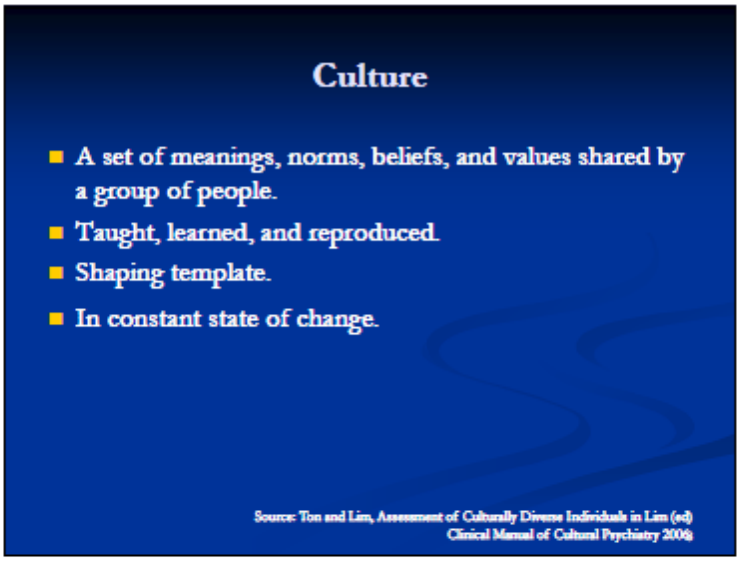
Prior to ending the session, please assign the following two intersession assignments. The first assignment, the illness narrative is intended to help them to better consider the client experiences and perspectives on illness, which will be the topic of focus at the next session. They should refer to the **Illness Narrative** form found at the end of **Workshop Session I** in the **Participant Workbook**. Please let the participants know that they should come to the next session prepared to discuss an experience that they or a close friend/relative had of receiving or being in treatment. They can use the worksheet to jot down notes but you should let them know 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 to characterize the culturally and linguistically appropriate elements of their respective departments. A copy of this can also be found in the **Workshop Session I** of the **Participant Workbook**.

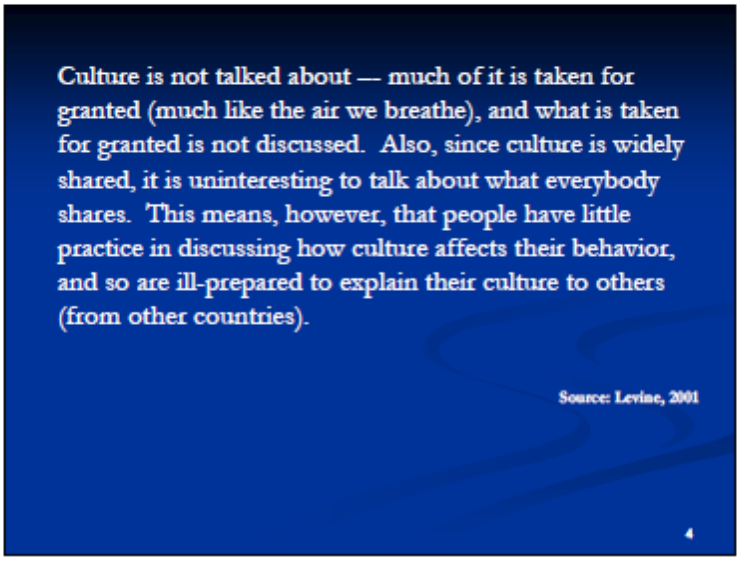
Workshop Session I Forms:

[1] A copy of PowerPoint Presentation can be located in the **Resources & Readings** section of the **Facilitator's & Participant's CD**

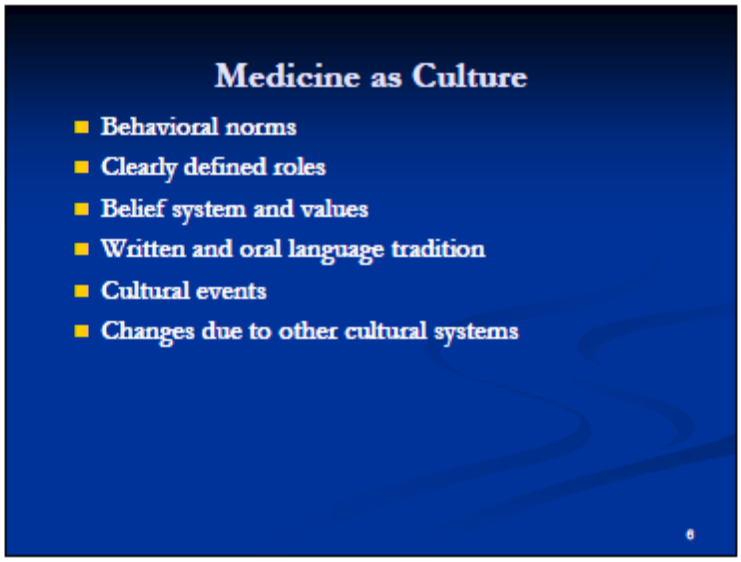

CLAS
Workshop Session I:
Introduction to the CLAS
Standards
1


Acknowledgment
The Providing Quality HealthCare with CLAS Curriculum Toolkit, a project of the Office of Multicultural Health, California Department of Public Health and California Department of Health Care Services, was developed in partnership with the University of California Davis, Center for Reducing Health Disparities to educate providers and health care institutions about the Culturally and Linguistically Appropriate Services Standards which address the important need for cultural and linguistic competency in health care delivery. Funding for the development of the curriculum was provided by the U.S. Department of Health and Human Services, Office of Minority Health State Partnership Grant Program (Grant No. STTMPO51006-01-00)
2

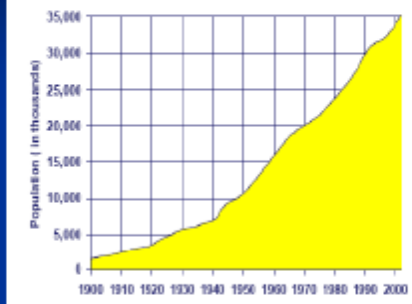

Culture
A set of meanings, norms, beliefs, and values shared by a group of people.
Taught, learned, and reproduced.
Shaping template.
In constant state of change.
Source: Tan and Lim, Assessment of Culturally Diverse Individuals in Lim (ed) Clinical Manual of Cultural Psychiatry 2006


Culture is not talked about — much of it is taken for granted (much like the air we breathe), and what is taken for granted is not discussed. Also, since culture is widely shared, it is uninteresting to talk about what everybody shares. This means, however, that people have little practice in discussing how culture affects their behavior, and so are ill-prepared to explain their culture to others (from other countries).
Source: Levine, 2001
4


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
Source: Ton and Lim, Assessment of Culturally Diverse Individuals in Lim (ed) Clinical Manual of Cultural Psychiatry 2006.
5


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
6

California's Population, 1990-2000



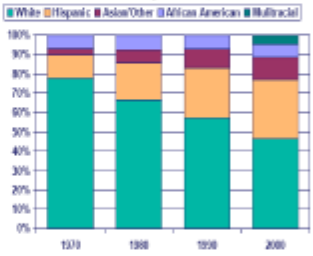
Source: California Department of Finance

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

7

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

8

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

9

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, etc.
- 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

10

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

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

Source: Gornick et al., 1996

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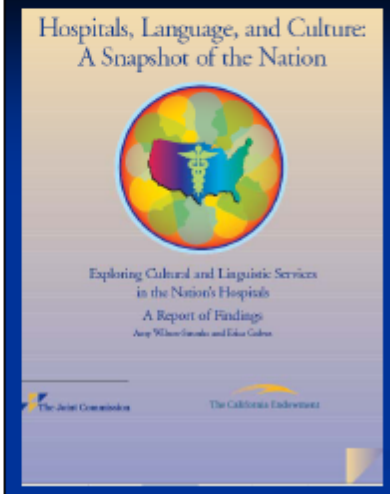
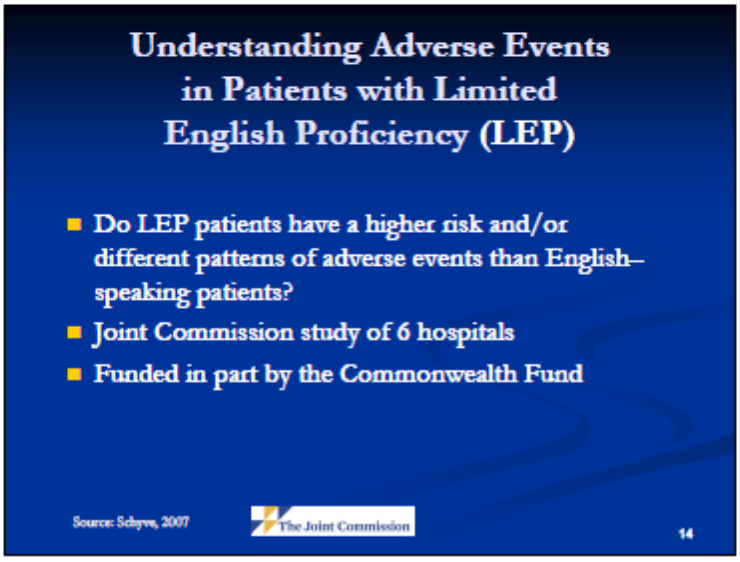


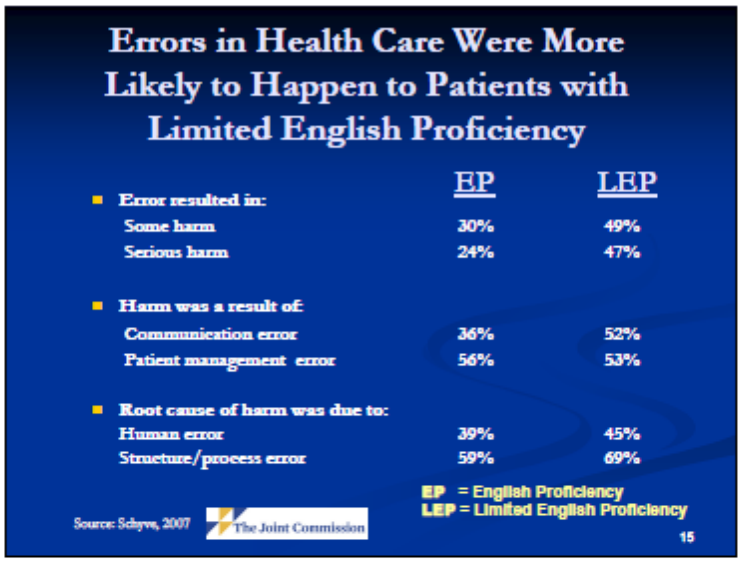
Language, Cultural Competency, and Health Literacy in Health Care

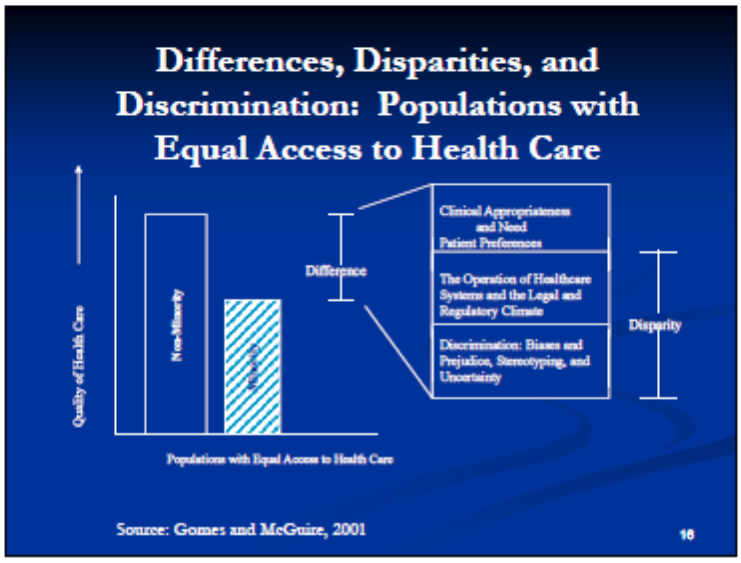
Paul M. Schyve, MD
Senior Vice President
The Joint Commission

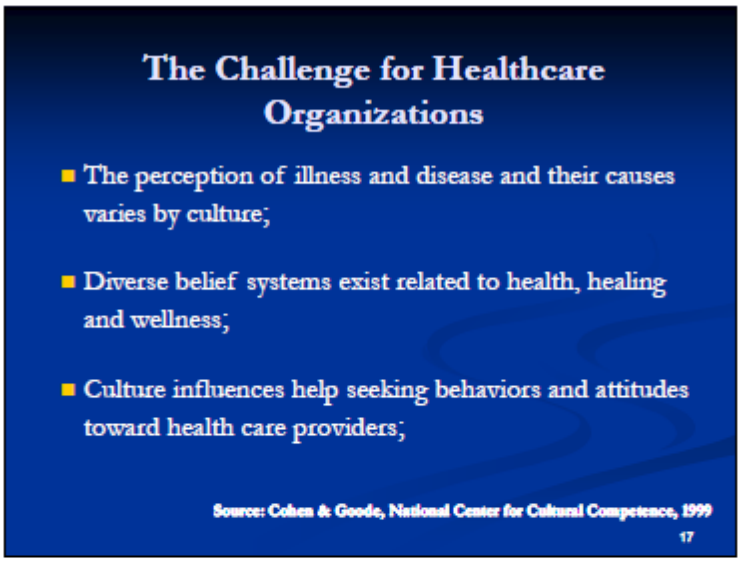
12


The Communication Triad
Language
- In California 12.5 million (40%) speak a language other than English
- Over 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
13


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
14


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
15

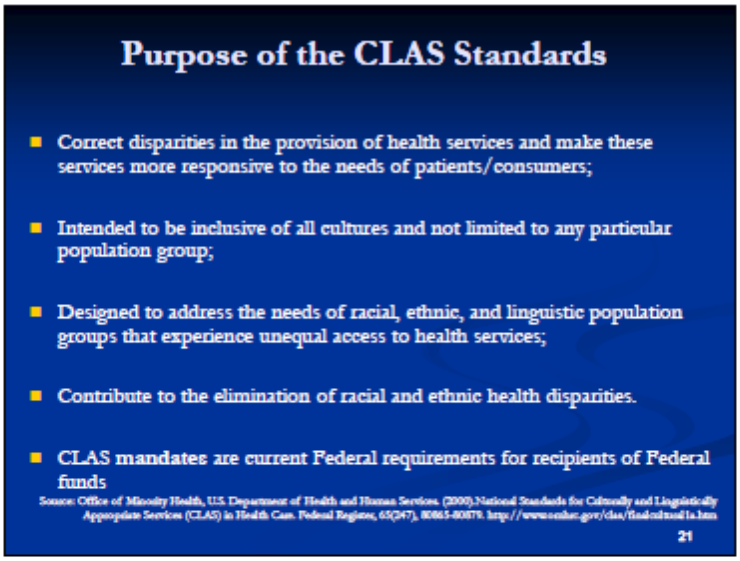

Differences, Disparities, and Discrimination: Populations with Equal Access to Health Care
Quality of Health Care
Non-Minority
Minority
Difference
Clinical Appropriateness and Need
Patient Preferences
The Operation of Healthcare Systems and the Legal and Regulatory Climate
Discrimination: Biases and Prejudice, Stereotyping, and Uncertainty
Disparity
Populations with Equal Access to Health Care
Source: Gomes and McGuire, 2001
16


The Challenge for Healthcare 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
17

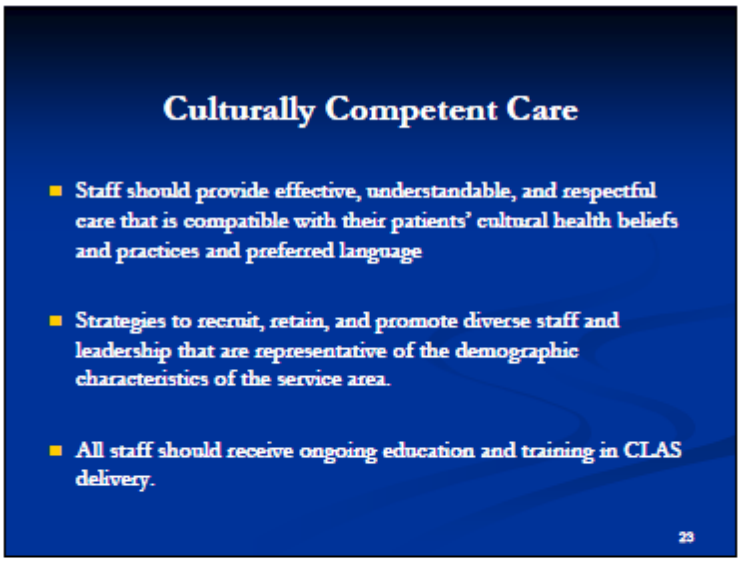

The Challenge for Healthcare Organizations
Individual preferences affect traditional and non-traditional approaches to health care;
Patients must overcome personal experiences of biases within health care systems, and;
Health care providers from culturally and linguistically diverse groups are under-represented in the current service delivery system.
Source: Cohen & Goode, National Center for Cultural Competence, 1999
18

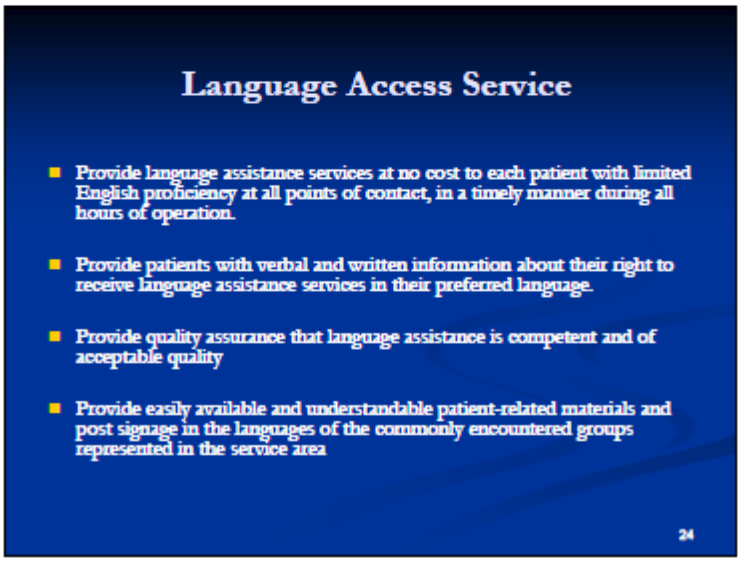

National Standards for Culturally and Linguistically Appropriate Services in Health Care
FINAL REPORT
March 2001
Washington, D.C.
Source: Federal Register: December 22, 2000, Volume 65, Number 247, pages 80865-80879
www.omhrc.gov/CLAS
19


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 which define key concepts and issues, and 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/finalculturall.htm
20


Purpose of the CLAS Standards
Correct disparities in the provision of health services and make these services more responsive to the needs of patients/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/finalculturall a.htm
21


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
22

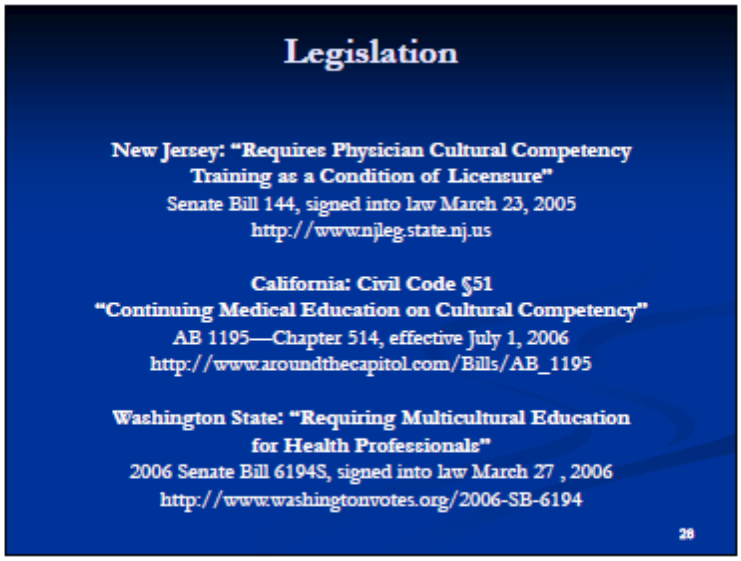

Culturally Competent Care
Staff should provide effective, understandable, and respectful care that is compatible with their patients' cultural health beliefs and practices and preferred language
Strategies to recruit, retain, and promote diverse staff and leadership that are representative of the demographic characteristics of the service area.
All staff should receive ongoing education and training in CLAS delivery.
23


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
24

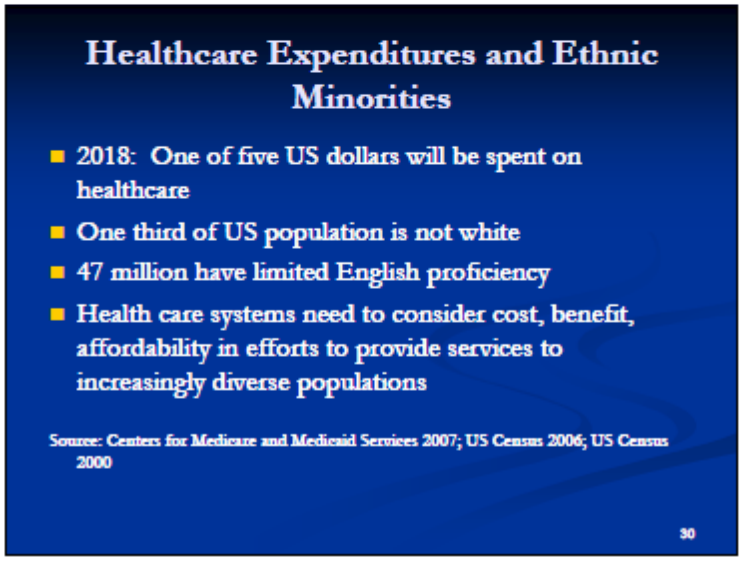

Organizational Support
Written Strategic Plan that outlines clear goals, policies, operational plans, and management accountability/oversight mechanisms to provide culturally and linguistically appropriate services.
Organizational Self-Assessments of CLAS-related activities and are encouraged to integrate 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/ethnicity, and spoken and written language are collected in health records, 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.
25

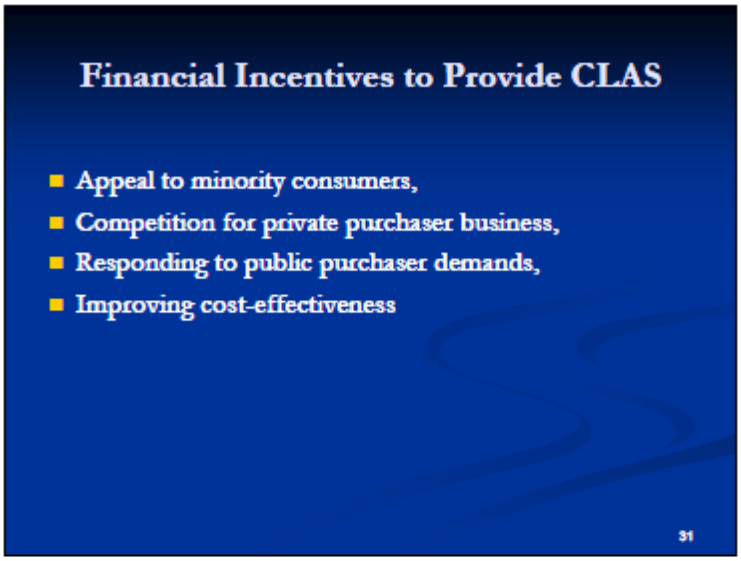

Organizational Support
Community Partnerships should be developed utilizing a variety of formal and informal mechanisms to facilitate community and patient involvement in designing and implementing CLAS-related activities.
Grievance Processes should be culturally and linguistically sensitive and capable 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 their communities about the availability of this information.
26


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/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.
27

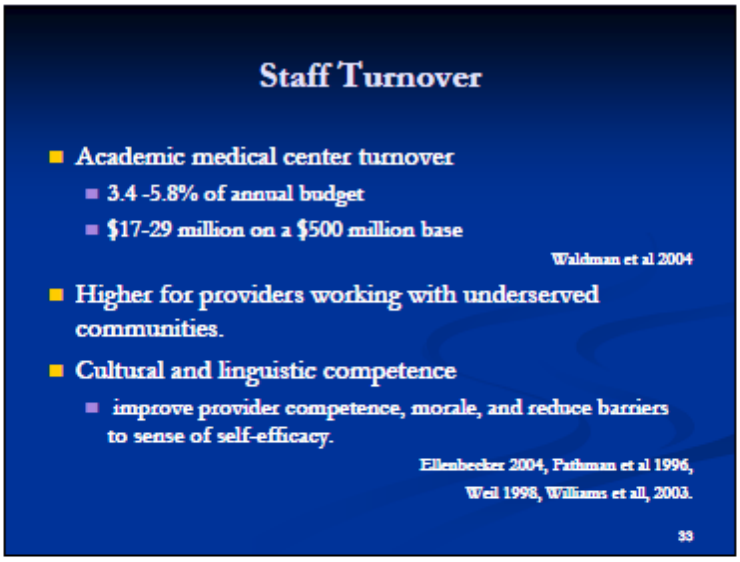

Legislation
New Jersey: "Requires Physician Cultural Competency Training as a Condition of Licensure"
Senate Bill 144, signed into law March 23, 2005
http://www.njleg.state.nj.us
California: Civil Code §51
"Continuing Medical Education on Cultural Competency"
AB 1195—Chapter 514, effective July 1, 2006
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
28

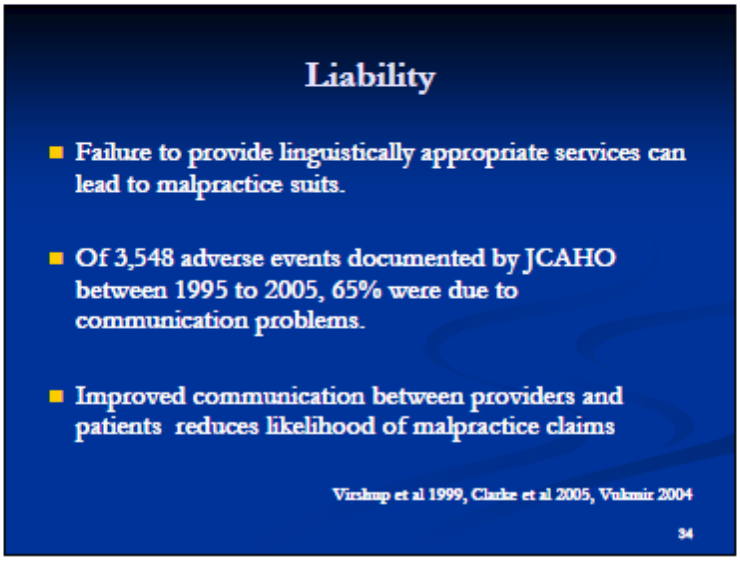

Business Case
29

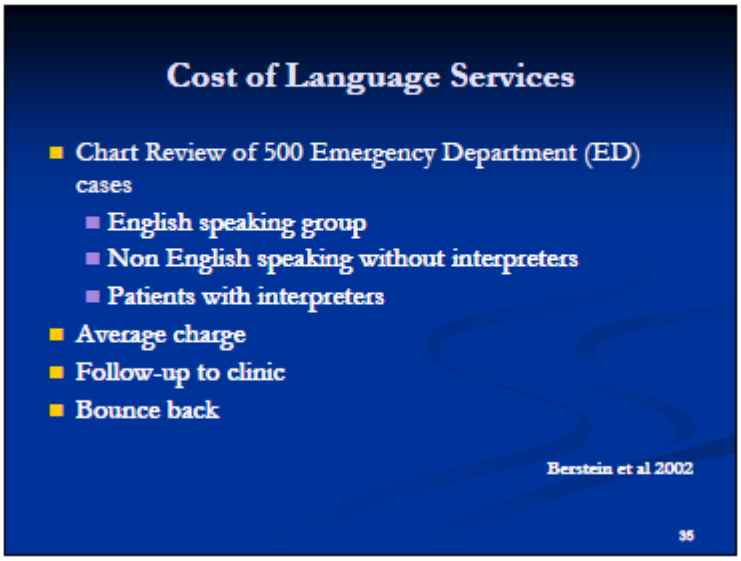

Healthcare Expenditures and Ethnic Minorities
2018: One of five US dollars will be spent on healthcare
One third of US population is not white
47 million have limited English proficiency
Health care systems need to consider cost, benefit, affordability in efforts to provide services to increasingly diverse populations
Source: Centers for Medicare and Medicaid Services 2007; US Census 2006; US Census 2000
30


Financial Incentives to Provide CLAS
Appeal to minority consumers,
Competition for private purchaser business,
Responding to public purchaser demands,
Improving cost-effectiveness
31


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: Selig Center for Economic Growth, 2007
32


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.
Ellenbecker 2004, Pathman et al 1996, Weil 1998, Williams et all, 2003.
33


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
Virshup et al 1999, Clarke et al 2005, Vukmir 2004
34


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
35


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
36

Cost of Language Services

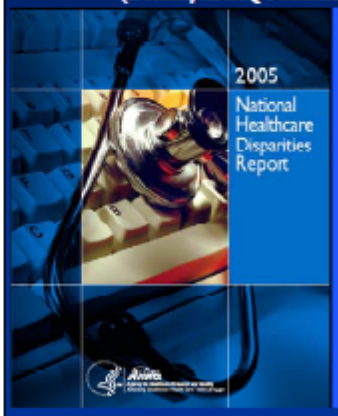
"Use of trained interpreters was associated with increased intensity of ED services, reduced return rate, increased clinic utilization, and lower 30-day charges, without any simultaneous increase in length of stay or cost of visit."

Berstein et al 2002

37

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:

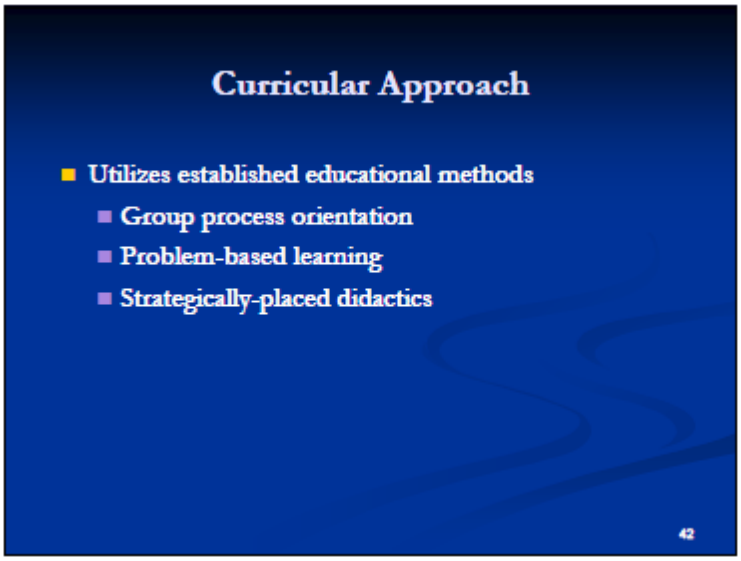
- Health care continues to improve at a modest pace
- Disparities narrowing for many, except for Hispanics
- Disparity has widened in both access to and in quality of care measures

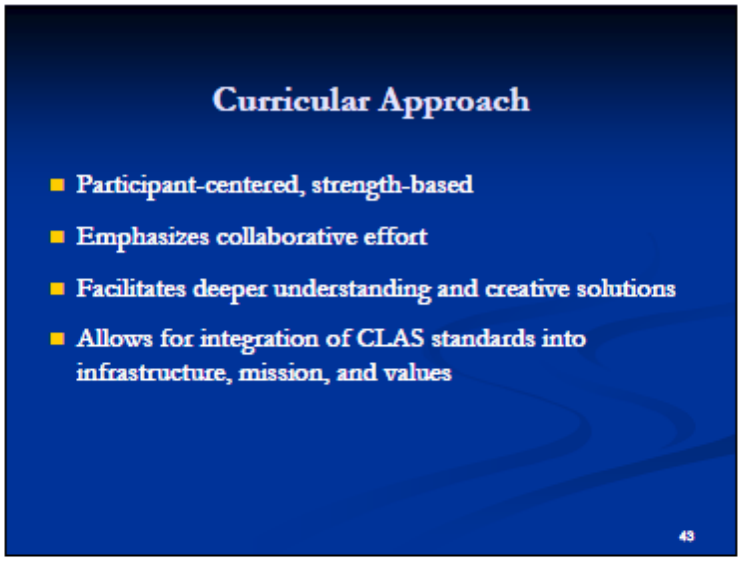
38

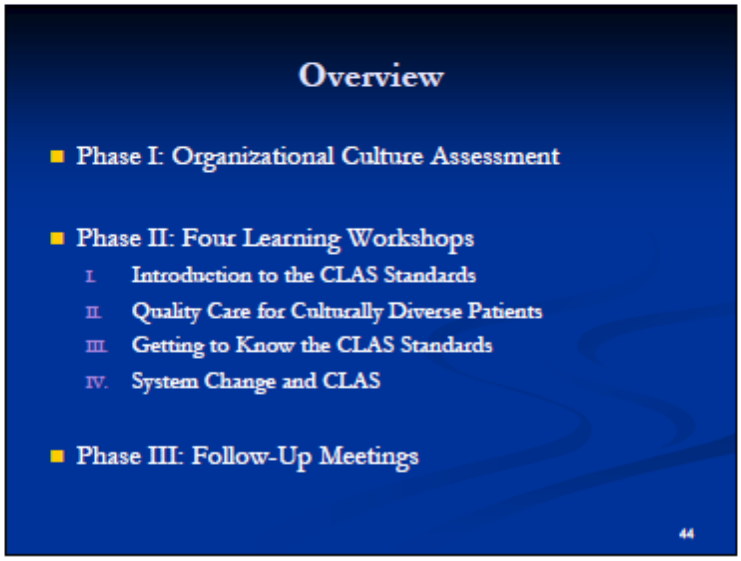

OMH State Partnership Grant Program to Improve Minority Health
Purpose:
A national strategy to facilitate the improvement of minority health and elimination of health disparities through the development of partnerships with established states and territorial offices of minority health.
39

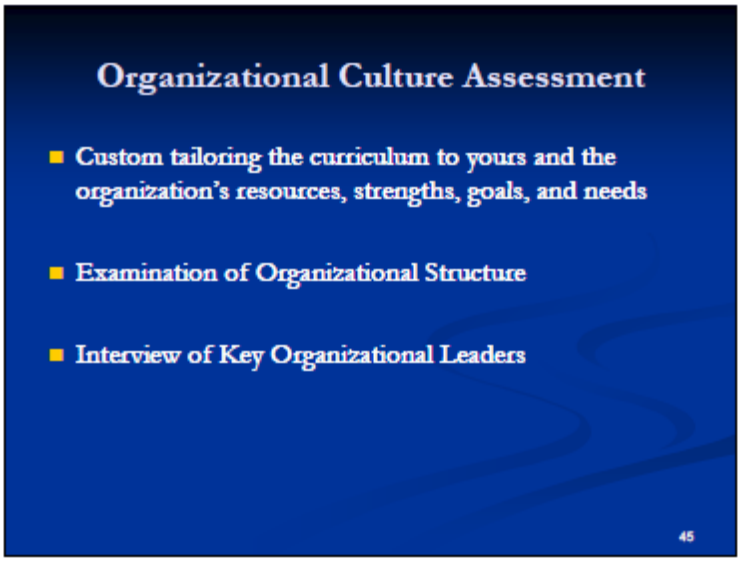

OMH State Partnership Grant Program to Improve Minority Health
A Partnership between:
U.S. Department of Health and Human Service, Office of Minority Health
California Department of Public Health and Department of Health Care Services, Office of Multicultural Health
UC Davis Center for Reducing Health Disparities
40

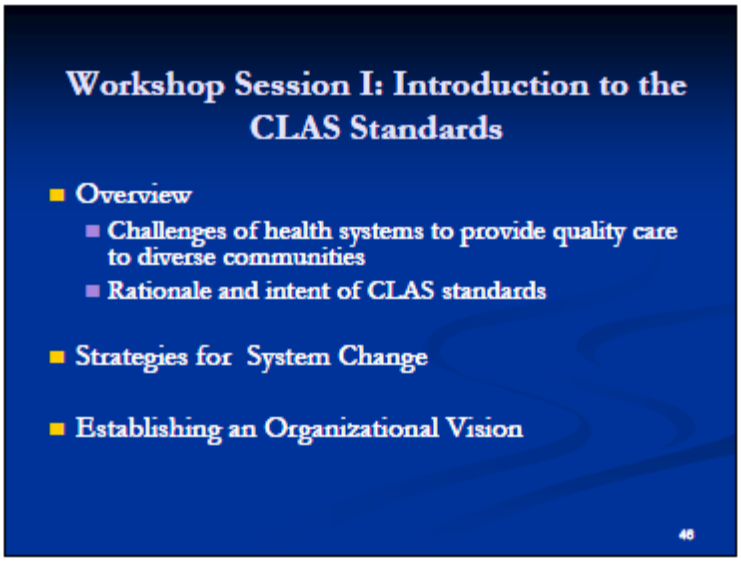

Cultural Competency Toolkit/Curriculum Development Project
Primary Goals:
Develop, implement, and evaluate a training curriculum for health service agencies and organizations based on the Culturally and Linguistically Appropriate Services (CLAS) standards
Disseminate and provide technical assistance in an effort to improve health service outcomes for minority populations
41


Curricular Approach
Utilizes established educational methods
Group process orientation
Problem-based learning
Strategically-placed didactics
42

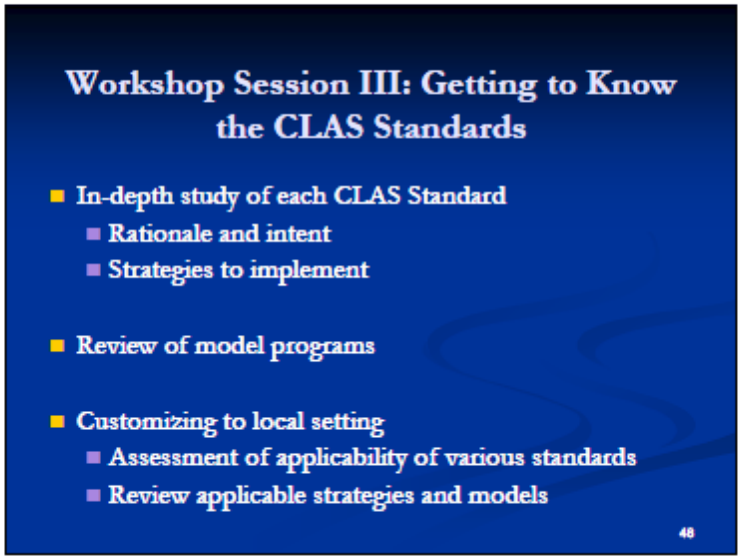

Curricular Approach
Participant-centered, strength-based
Emphasizes collaborative effort
Facilitates deeper understanding and creative solutions
Allows for integration of CLAS standards into infrastructure, mission, and values
43

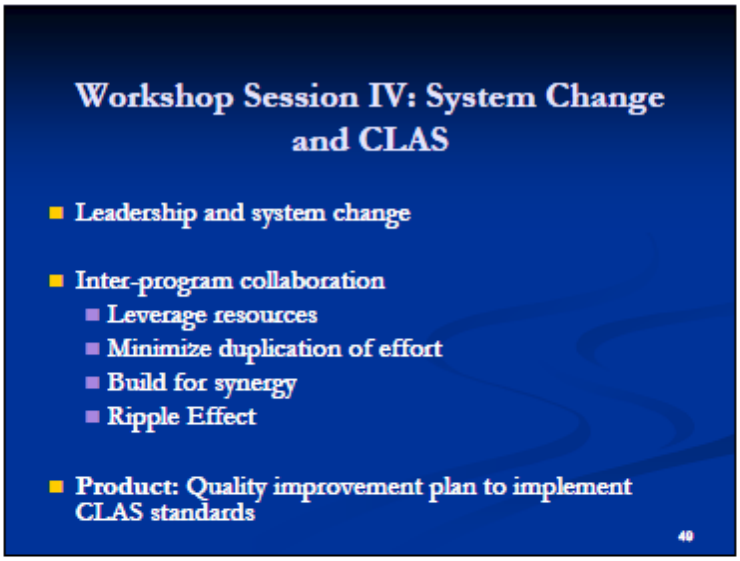

Overview
Phase I: Organizational Culture Assessment
Phase II: Four Learning Workshops
I. Introduction to the CLAS Standards
II. Quality Care for Culturally Diverse Patients
III. Getting to Know the CLAS Standards
IV. System Change and CLAS
Phase III: Follow-Up Meetings
44


Organizational Culture Assessment
Custom tailoring the curriculum to yours and the organization's resources, strengths, goals, and needs
Examination of Organizational Structure
Interview of Key Organizational Leaders
45

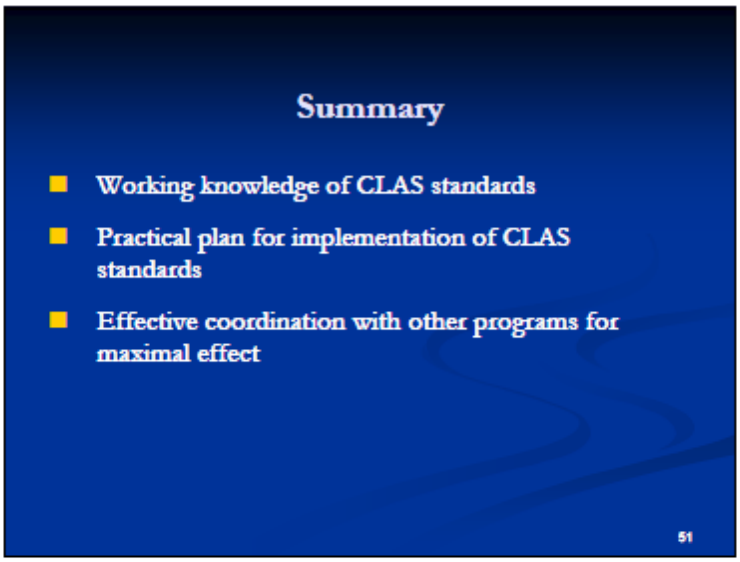

Workshop Session I: Introduction to the CLAS Standards
Overview
Challenges of health systems to provide quality care to diverse communities
Rationale and intent of CLAS standards
Strategies for System Change
Establishing an Organizational Vision
46


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
47


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
48


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
40


Follow Up: Monthly Meetings
Continue forward momentum
Ongoing plan development
Troubleshoot challenges
Share successful strategies
50


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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Office of Multicultural Health
Laura Hardcastle
Chief
David Bodick, MPH
Health Education Consultant Specialist III
Carol Gomez
Analyst
Center For Reducing Health Disparities
Sergio Aguilar-Gaxiola, MD, PhD
Director
Hendry Ton, MD, MS
Director of Education
Marbella Sala
Executive Operations Manager
Mai See Yang, MS
Project Coordinator 2008-2009
Kimberly Reynolds
Administrative Staff
Daniel Steinhart
Project Coordinator 2006-2008
Roberto Ramos, MS
Project Coordinator 2005-2006
52

Vision Statement Exercise

Name:

My role/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 work together?
- What values would your service embody?

B. Discuss and get feedback on your vision statement as a group

Notes:

C. Discuss how your service might relate to that of others in the group

Notes:

Process of Change Challenge

Domains Critical to System Change:*

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

2. **Team:** Group of staff working to implement and sustain a program.

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

4. **Organizational Systems and Culture**: Systems refer to the organization's processes, polices, forms and protocols. Organizational culture refers to the shared values of an organization as well as how staff relate to each other, how they communicate, and how efforts are coordinated.

5. **Data Measurement and Reporting:** This refers to all aspects of data management including what data is measured and how it is collected, stored, processed, updated, and disseminated.

6. **Education and Coaching:** This refers to how knowledge is generated, shared and used. It includes aspects such as 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/projects?
B. Describe strategies that ensure that this domain is developed or supported.
C. What contributions can you make to this area? What are the barriers that keep you from doing so?
D. What resources are required to strengthen this domain in your system?
E. As a group, please be prepared to present one example of how you have seen this domain be effectively applied or developed.
F. Are there other domains not mentioned that your group feels is 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.

Assessment by Leadership

(Adapted from Suzanne Salimbene: CLAS A-Z: A Practical Guide for Implementing the National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health Care, Inter-Face Intl. 2001)

Please answer the following questions for your organization:

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

Top Priority ___ Priority ___ Lesser 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 3 specific measures that you have already taken to "walk the talk" to demonstrate to clients, staff and the community, your commitment to culturally and linguistically appropriate services:

a._____

b._____

c._____

4. Is there a specific person or program assigned 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. List the **telephone** services (scheduling, hours/location, etc.) your department currently has for limited or non-English speaking callers in the first column and the language(s) for which these services are available in the second column.

Service	**Language**

10. In your organization or department what training/instruction do the telephone operators/reception staff receive to help them appropriately handle calls from limited or non-English speaking persons?

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

	Excellent	Above Average	Average	Poor	Don't Know
Physicians					
Nurses					
Licensed Staff					
Medical Assistants					
Clerical					
Outreach/Health Educators					

12. a. All staff are given written guidelines regarding working with clients/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 taking an accurate history/physical/intake on culturally and linguistically diverse clients.

Yes ___ No ___ Don't Know ___

b. These strategies are consistently followed.

Yes ___ No ___ Don't Know ___

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

Yes ___ No ___ Don't Know ___

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

Yes ___ No ___ Don't Know ___

c. Above information is made available through: _____

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

Yes ___ No ___ Don't Know ___

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

Yes ___ No ___ Don't Know ___

17. a. Staff are made aware of treatments, education/information, interventions, etc. 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. Consideration is given to **the impact of** artwork, decorations, and wall color preference etc. to cultural/ethnic communities served when furnishing space.

Yes ___ No ___ Don't Know ___

19. In waiting areas, there is 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 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.

Yes ___ No ___ Don't Know ___

22. Forms, signs, education materials, satisfaction surveys, etc. are offered in the native language of each client/community served.

Yes ___ No ___ Don't Know ___

23. Only trained medical interpreters are used when providing care to limited or non-English speaking clients.

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 tested/assessed for language competency/fluency 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 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, etc.

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, etc.

Yes ___ No ___ Don't Know ___

32. Trainings on the cultural beliefs of the specific communities and/or clients served is required of all staff.

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(s) (e.g. religious/cultural beliefs, proper etiquette such as forms of address and "rules of touching," specific health/illness beliefs and practices, etc.)

1	2	3	4
5	6	7	8

34. How long is the training(s) (In hours): _____ **Don't Know ___**

35. How many times per year is the training(s) offered: _____ **Don't Know ___**

36. The Department has specific teambuilding efforts to improve the communication and teamwork between 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 which should be made available to their members.

Yes ___ No ___ Don't Know ___

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

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

Fully competent ___ Excellent ___ Adequate ___ Poor ___

Illness Narrative

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

Assignment: Please come to the next session prepared to discuss an experience that you or a close friend/relative had of receiving or being 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. How easy was it to get treatment?
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 treatment provided was influenced by any socio-cultural factors such as race, ethnicity, gender, language, sexual orientation, age, class, education level, etc.?
   If so, how?

Workshop Session II: Quality of Care for Culturally Diverse Patients

Overview: In this workshop session, the participants will examine the challenges 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 video vignettes 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 will also identify systems and organizational factors that mediate 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 be able to:

Knowledge

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

Skills

1. Be able to use concepts learned above to better understand the health status and needs of communities not specifically discussed in this session;
2. Be able to operate collaboratively in small group and discussion formats;
3. Be able to critically examine the organization's ability to provide care to clients from diverse backgrounds;

Attitudes

1. Appreciate the importance of understanding the illness experience from a client's perspective;
2. Appreciate the positive impact that culturally and linguistically appropriate care can have on 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 get into an appropriate mindset for the work of the day and gives you sense of the issues that the participants may bring into the session. You can start with general questions. It is also helpful to

check in with how the last session went for the participants, in order to make changes to how the current session should be facilitated. To close the check-in and 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 the participants start to think 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. It may be helpful 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 the experience of their illness and how it impacted their lives. As with stories, most narratives have a beginning, middle, and end that are defined and held together by common themes that unfold in relation to time. Illness narratives are often used in cross cultural and client-centered settings to better understand the experiences and perspectives of clients.

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 that each participant to listen respectfully and with empathy to their partner's story—this 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 both from the standpoint of a potential patient and systems leader

As the facilitator, you should consider sharing your own illness narrative, in case there is participant left without a partner. Alternatively, you can have 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 there is active discussion, though it is important not to listen in on 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?
- Contrast your viewpoint as a patient vs. a systems leader
    - What were the differences?
    - What were the similarities?
- What were the reasons that lead 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/family's) treatment was influenced by race/ethnicity, gender, class, education level, occupation? If so, how?

Facilitator summarizes the discussion, attempting to link experiences to CLAS standards.

Break [15 min]

Patient Narratives

This section of the curriculum addresses western medicine and how it can conflict with the beliefs and values of patients and their families from diverse ethnic populations.

Participants can experience the interactions between these patients and their healthcare providers by viewing the "Worlds Apart" video series. The videos feature patients and their families as they attempt to navigate their way through the western health care system. The "Worlds Apart" video is available from Fanlight Productions. Please see the disclaimer statement in the beginning of the curriculum page__ for ordering information.

As an alternative to viewing the videos a substitute exercise can be found in Appendix A (page 134). This exercise also exposes the participants to the beliefs and values of an ethnic population and their experience with the western medical culture.

"Worlds Apart" Exercises [80 min total]

This exercise uses **Worlds Apart: A four-Part-Series on Cross Cultural Health Care**. by Maren Grainger-Monsen, MD, and Julia Haslett (Fanlight Productions 2003). This video documentary contains four trigger videos about real life patients from culturally diverse backgrounds experiencing cultural misunderstandings that significantly affect their health care. The videos can be used to trigger discussions about language and cultural issues commonly encountered in the health care setting. While these vignettes illustrate issues in clinical medicine, all bring up issues related to institutional cultural barriers, language barriers, and cultural misunderstandings and miscommunications. The facilitator should obtain and view the

video and review the accompanying **Worlds Apart Facilitator's Guide** by Alexander Green, MD, Joseph Betancourt, MD MPH, and J. Emilio Carrillo, MD MPH (2003). A copy is provided in the **Facilitator's CD**. The video is not provided with this curriculum toolkit but it can be ordered from the following link: http://www.fanlight.com/catalog/films/912_wa.php.

Included in the **Facilitator's CD** is the **Session II Presentation** PowerPoint that can be used to introduce the two of the four cases (Justina Chitsena and Robert Phillips) and to provide didactical information about health challenges experienced by Asian Americans and African Americans. You can opt to use this presentation to complement the viewing and discussion of the vignettes.

Alternatively you can choose the two vignettes that have the most relevance to the participants, and use the format suggested in the **Worlds Apart Facilitator's Guide**, disregarding the PowerPoint presentation included in this toolkit.

This part of the workshop consists of three steps:

1. View two of the four videos [30min]

2. Worlds Apart: Small Group Exercise [30 min]
   After viewing the 2 vignettes, the participants should return to the small groups that they had formed in **Workshop Session I** to start the exercise described in Table 2.1.

Table 2.1 Worlds Apart Small Group Exercise

As a group, choose one of the case vignettes to explore the following issues:

1. Discuss what went well and what did not, from the perspective of the organization;

2. Discuss how well the organization lived up to the CLAS standards;

3. Describe at least 6 things the health care system should have done to ensure high quality care for that patient.

Be sure to cover each of the three CLAS domains:

I. Culturally Competent Care **II. Language Access** **III. Organizational Support**

3. Afterwards each group should select a representative to summarize their discussion to the larger group in last 20 minutes

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 when it comes to culturally and linguistically appropriate care?

Intersession Assignment: CLAS Standard Group Presentation [25min]

Before adjourning for the day, each group will select one or more of the CLAS standards to present for the next workshop. All fourteen standards should be covered by the participants as a whole. It may work best to read out each standard and ask the groups to volunteer to take responsibility for each of them. You should allow for 15 minutes at the conclusion of the meeting for the members of each group to coordinate their schedules. Table 2.2 describes the presentation exercise. A copy of this exercise is also provided in the **Workshop Session II** of the **Participant Workbook**.

Table 2.2 CLAS Standards Group Presentation

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

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

Be sure to address the following four objectives:

1. **Describe what the standard(s) means in plain language.**
2. **Provide the rationale for the standard(s).**
3. **How is this standard(s) relevant to your service and the organization as a**

whole?

4. Describe one or more strategies to implement this standard(s) in your service area or the organization as a whole.

When answering question 4, please consider the following:

Who are the stakeholders and how do you engage them?

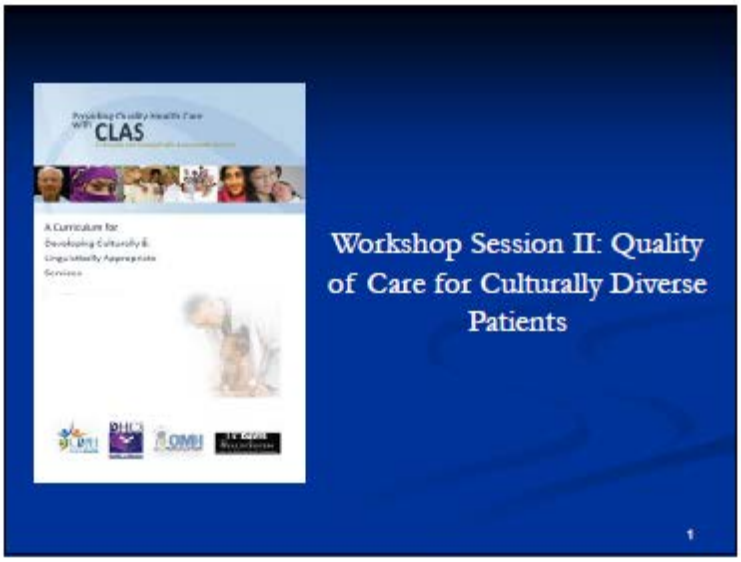
What resources would be required and how would they be accessed?

What challenges would be faced?

How might you measure progress/success of implementation?

Workshop Session II Forms:

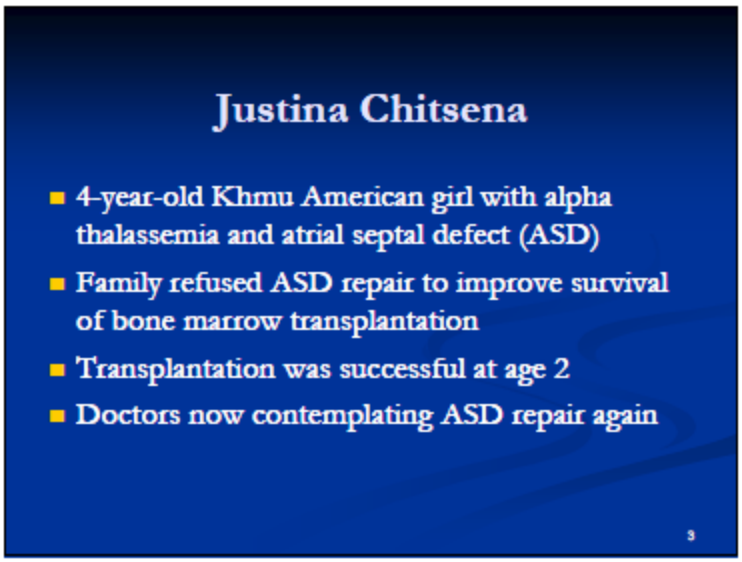
[2] A copy of PowerPoint Presentation can be located in the Resources & Readings section of the Facilitator's & Participant's CD

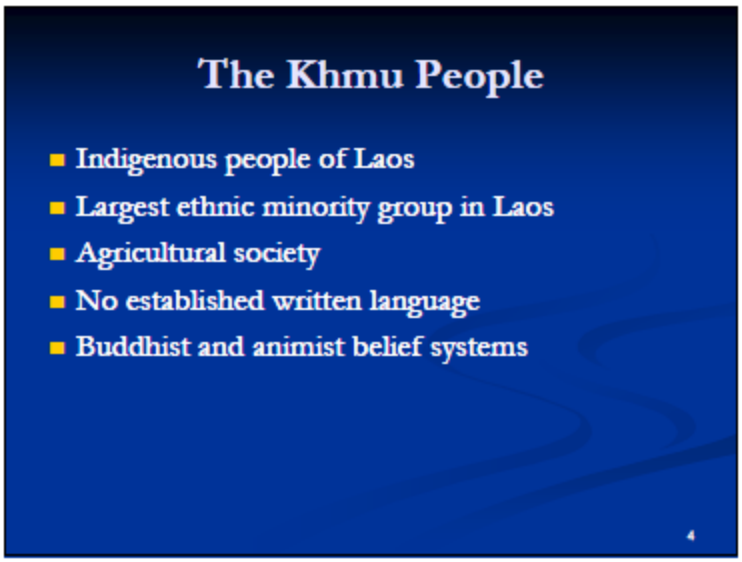


Acknowledgment

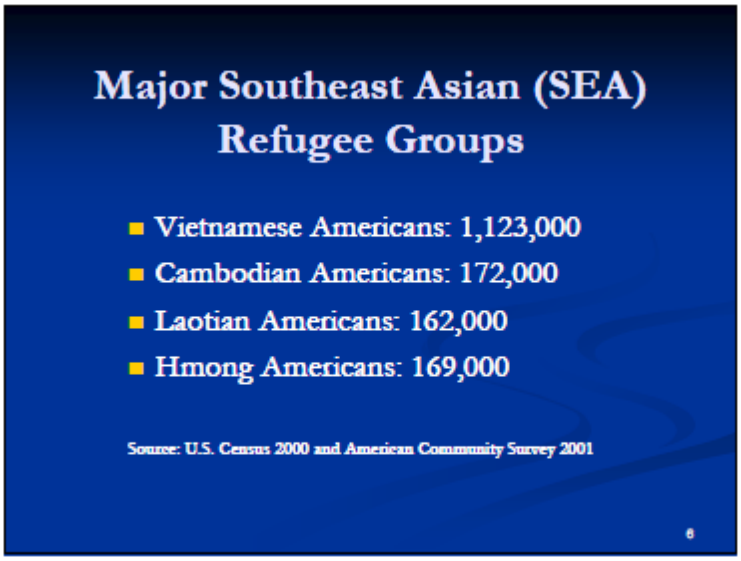
The Providing Quality HealthCare with CLAS Curriculum Toolkit, a project of the Office of Multicultural Health, California Department of Public Health and California Department of Health Care Services, was developed in partnership with the University of California Davis, Center for Reducing Health Disparities to educate providers and health care institutions about the Culturally and Linguistically Appropriate Services Standards which address the important need for cultural and linguistic competency in health care delivery. Funding for the development of the curriculum was provided by the U.S. Department of Health and Human Services, Office of Minority Health State Partnership Grant Program (Grant No. 5TTMPO51006-01-00)

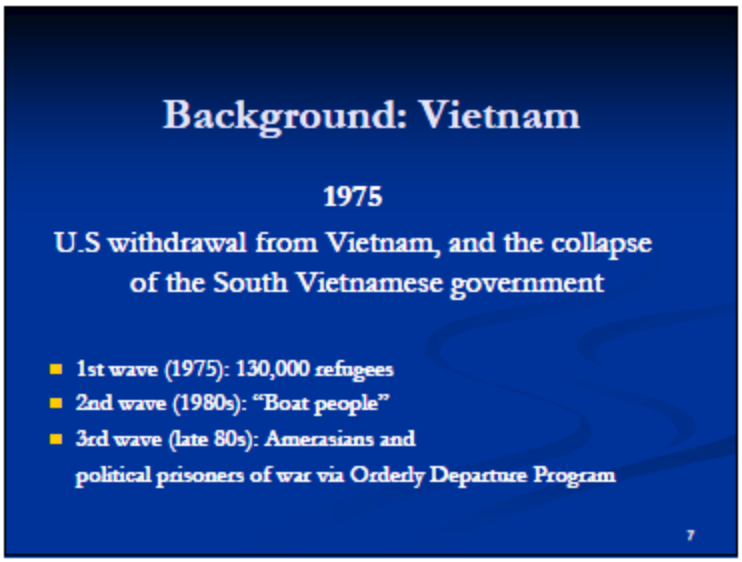
2


Justina Chitsena
4-year-old Khmu American girl with alpha thalassemia and atrial septal defect (ASD)
Family refused ASD repair to improve survival of bone marrow transplantation
Transplantation was successful at age 2
Doctors now contemplating ASD repair again
3


The Khmu People
Indigenous people of Laos
Largest ethnic minority group in Laos
Agricultural society
No established written language
Buddhist and animist belief systems
4


Show Worlds Apart Video: Justina Chitsena
5

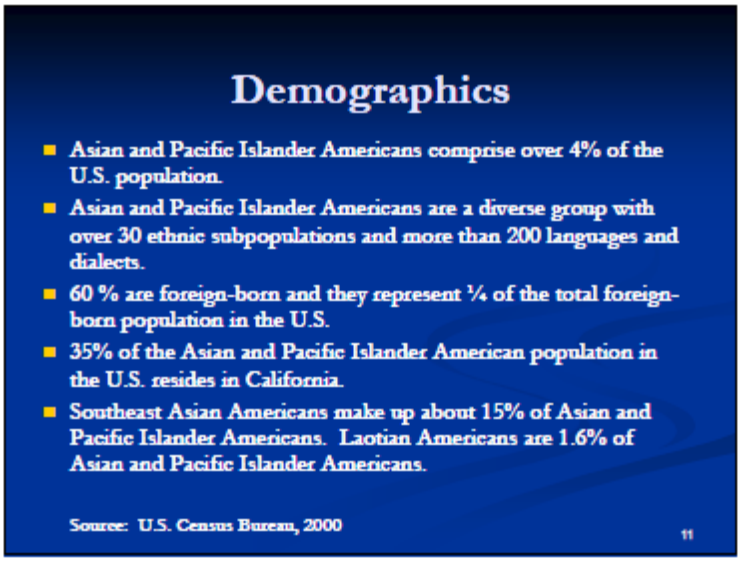

Major Southeast Asian (SEA) Refugee Groups
Vietnamese Americans: 1,123,000
Cambodian Americans: 172,000
Laotian Americans: 162,000
Hmong Americans: 169,000
Source: U.S. Census 2000 and American Community Survey 2001
6

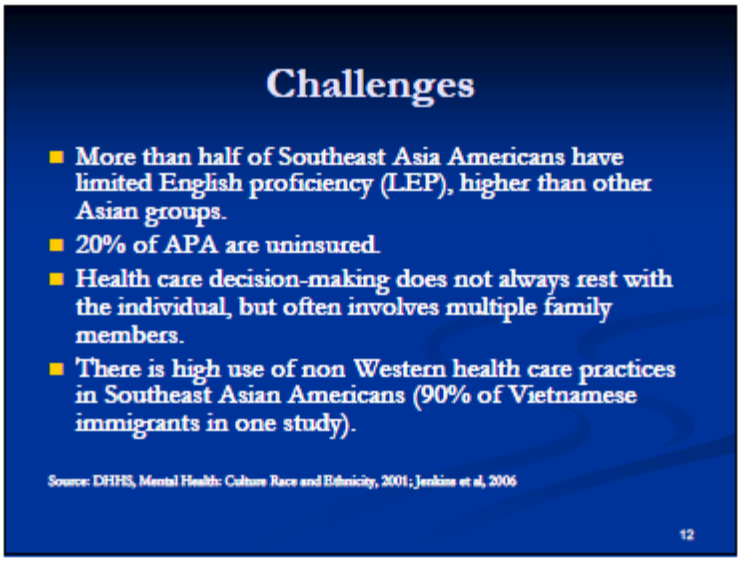

Background: Vietnam
1975
U.S withdrawal from Vietnam, and the collapse of the South Vietnamese government
1st wave (1975): 130,000 refugees
2nd wave (1980s): "Boat people"
3rd wave (late 80s): Amerasians and political prisoners of war via Orderly Departure Program
7

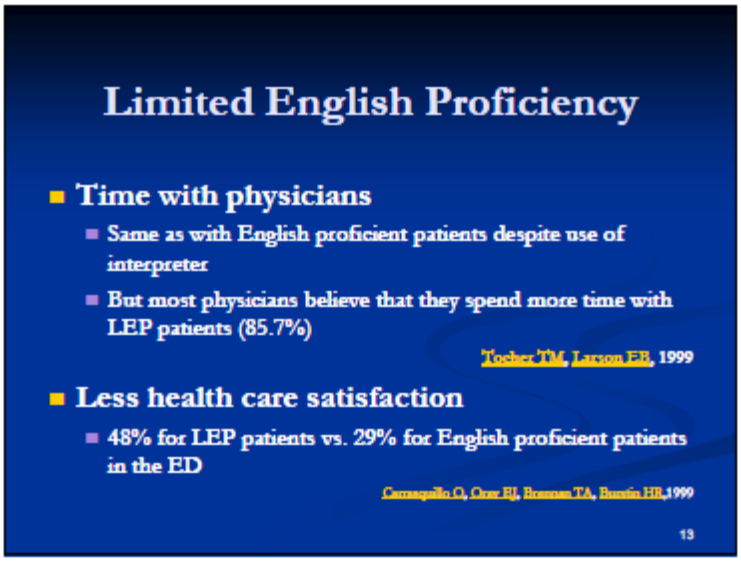

Background: Laos
As US forces withdraw, Pathet Lao gain control of Laos.
300,000 escape to Thailand.
-Half are Hmong, persecuted by new government.
8

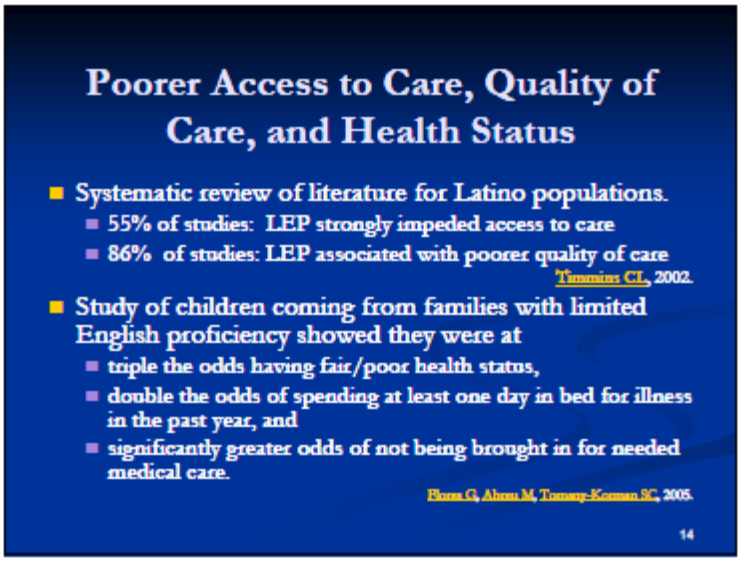

Background: Cambodia
1975-1979
Khmer Rouge reigns in Cambodia
Systematic extermination of 1,000,000 Cambodians
1978
Vietnam invades Cambodia
100,000 survivors flee to Thailand
9

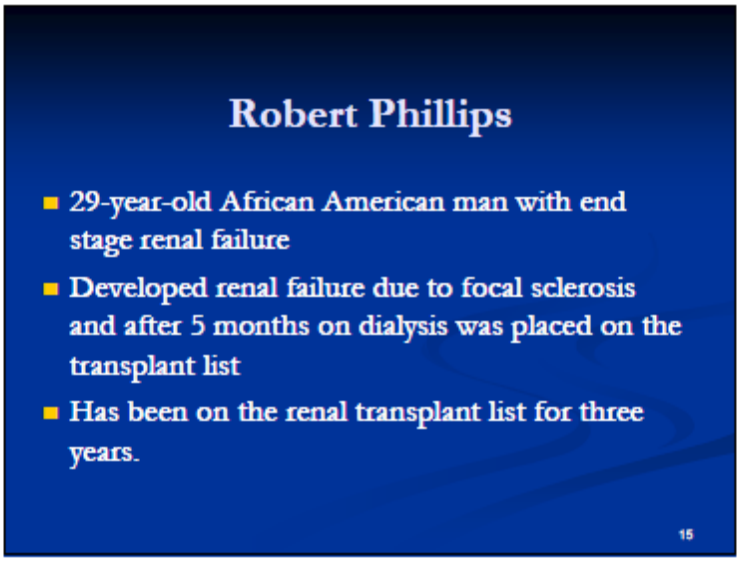

Background: Resettlement
United States Immigration Policy:
Dispersal of Southeast Asian refugees to avoid formation of ethnic enclaves and lessen impact of large number of refugees on existing communities
10

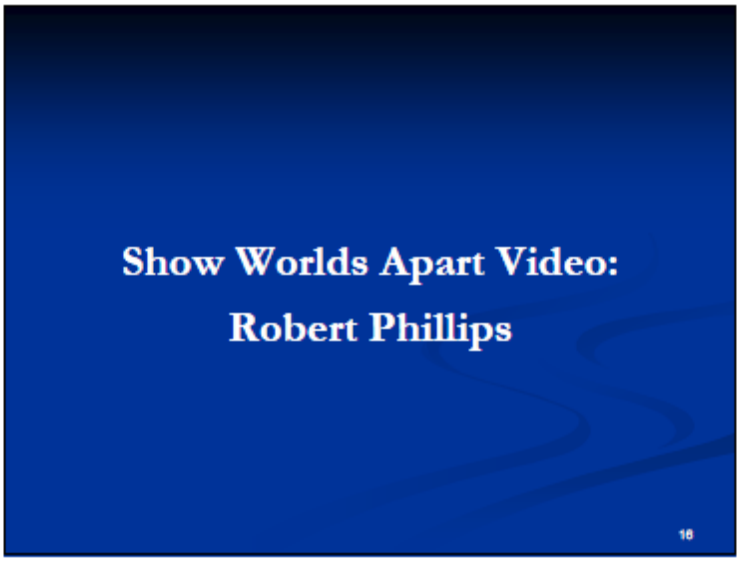

Demographics
Asian and Pacific Islander Americans comprise over 4% of the U.S. population.
Asian and Pacific Islander Americans are a diverse group with over 30 ethnic subpopulations and more than 200 languages and dialects.
60 % are foreign-born and they represent ¼ of the total foreign-born population in the U.S.
35% of the Asian and Pacific Islander American population in the U.S. resides in California.
Southeast Asian Americans make up about 15% of Asian and Pacific Islander Americans. Laotian Americans are 1.6% of Asian and Pacific Islander Americans.
Source: U.S. Census Bureau, 2000
11

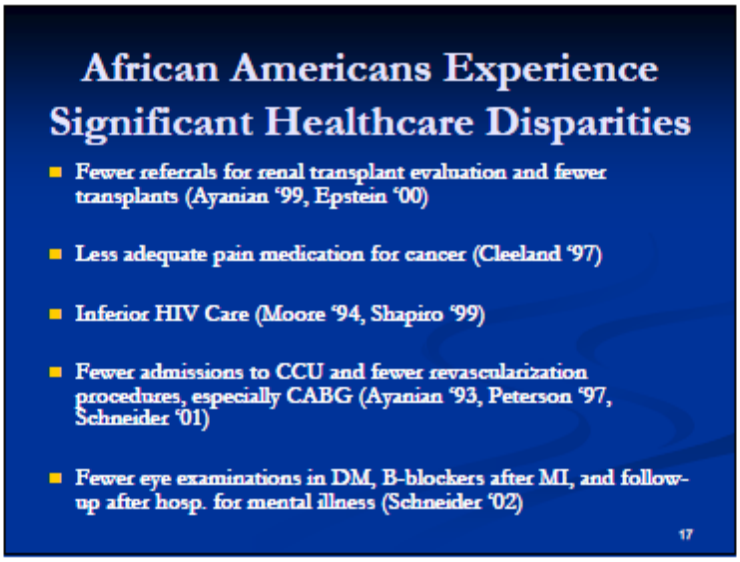

Challenges
More than half of Southeast Asia Americans have limited English proficiency (LEP), higher than other Asian groups.
20% of APA are uninsured.
Health care decision-making does not always rest with the individual, but often involves multiple family members.
There is high use of non Western health care practices in Southeast Asian Americans (90% of Vietnamese immigrants in one study).
Source: DHHS, Mental Health: Culture Race and Ethnicity, 2001; Jenkins et al, 2006
12

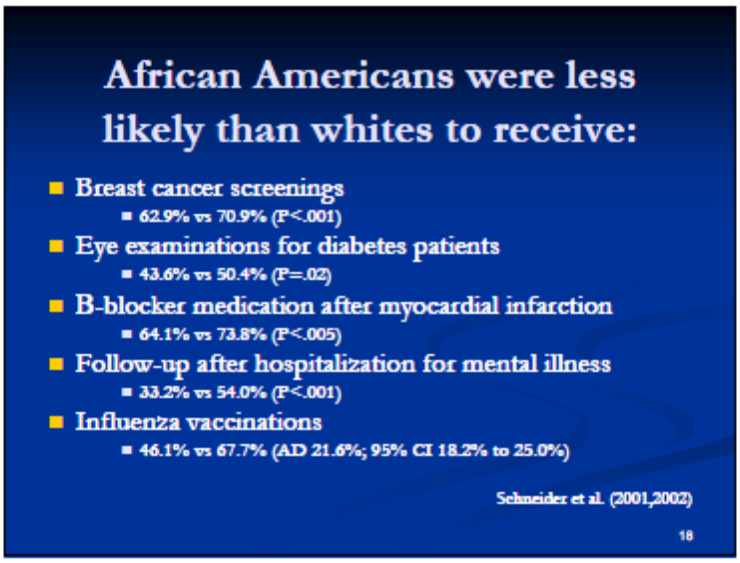

Limited English Proficiency
Time with physicians
Same as with English proficient patients despite use of interpreter
But most physicians believe that they spend more time with LEP patients (85.7%)
Tocher TM, Larson EB, 1999
Less health care satisfaction
48% for LEP patients vs. 29% for English proficient patients in the ED
Carmagallo O, Crow RJ, Brennan TA, Burstin HR,1999
13

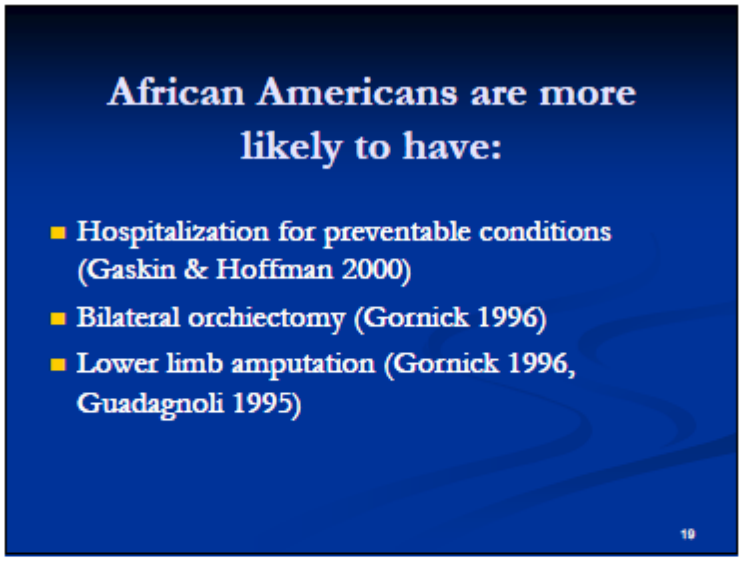

Poorer Access to Care, Quality of Care, and Health Status
Systematic review of literature for Latino populations.
55% of studies: LEP strongly impeded access to care
86% of studies: LEP associated with poorer quality of care
Timmins CL, 2002.
Study of children coming from families with limited English 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.
14


Robert Phillips
29-year-old African American man with end stage renal failure
Developed renal failure due to focal sclerosis and after 5 months on dialysis was placed on the transplant list
Has been on the renal transplant list for three years.
15


Show Worlds Apart Video:
Robert Phillips
16


African Americans Experience Significant Healthcare Disparities
Fewer referrals for renal transplant evaluation and fewer transplants (Ayanian '99, Epstein '00)
Less adequate pain medication for cancer (Cleeland '97)
Inferior HIV Care (Moore '94, Shapiro '99)
Fewer admissions to CCU and fewer revascularization procedures, especially CABG (Ayanian '93, Peterson '97, Schneider '01)
Fewer eye examinations in DM, B-blockers after MI, and follow-up after hosp. for mental illness (Schneider '02)
17

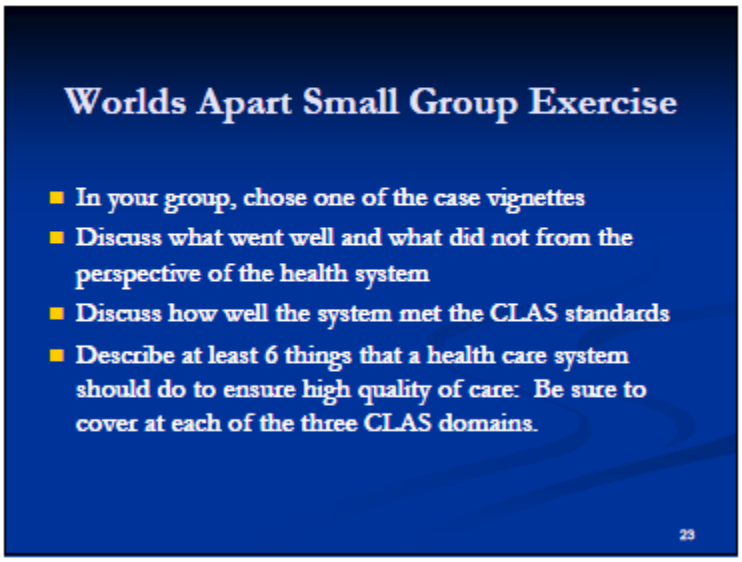

African Americans were less likely than whites to receive:
Breast cancer screenings
62.9% vs 70.9% (P<.001)
Eye examinations for diabetes patients
43.6% vs 50.4% (P=.02)
B-blocker medication after myocardial infarction
64.1% vs 73.8% (P<.005)
Follow-up after hospitalization for mental illness
33.2% vs 54.0% (P<.001)
Influenza vaccinations
46.1% vs 67.7% (AD 21.6%; 95% CI 18.2% to 25.0%)
Schneider et al. (2001,2002)
18


African Americans are more likely to have:
Hospitalization for preventable conditions (Gaskin & Hoffman 2000)
Bilateral orchiectomy (Gornick 1996)
Lower limb amputation (Gornick 1996, Guadagnoli 1995)
19


Who You Are Influences What You Think
Do you think the average African American is better off, worse off, or just as well off as the average white American in terms of access to health care?
Worse Off: White Americans 35% African Americans 61%
How much discrimination do African Americans face in our society today?
A Lot: White Americans 20% African Americans 48%
The Washington Post, the Henry J. Kaiser Family Foundation and Harvard University Racial Attitudes Survey (April 2001)
20


Who You Are Influences What You Think
Do you feel that African Americans have more, less, or about the same opportunities in life as white Americans have?
Less Opportunities: White Americans 27%
African Americans 74%
The Washington Post, the Henry J. Kaiser Family Foundation and Harvard University Racial Attitudes Survey (April 2001)
21


Unfair Treatment
29% of physicians
25% of White physicians
33% of Asian physicians
52% of Latino physicians
77% of African American physicians
… believe that the health care system treats people unfairly based on their racial or ethnic background "very" or "somewhat often."
The Washington Post, The Henry J. Kaiser Family Foundation and Harvard University Racial Attitudes Survey (April 2001)
22


Worlds Apart Small Group Exercise
In your group, chose one of the case vignettes
Discuss what went well and what did not from the perspective of the health system
Discuss how well the system met the CLAS standards
Describe at least 6 things that a health care system should do to ensure high quality of care: Be sure to cover at each of the three CLAS domains.
23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Project Coordinator 2008-2009
Kimberly Reynolds
Administrative Staff
Daniel Steinhart
Project Coordinator 2006-2008
Roberto Ramos, MS
Project Coordinator 2005-2006
24

Worlds Apart: Small Group Exercise

As a group, chose one of the case vignettes to explore the following issues:

1. **Discuss what went well and what did not from the perspective of the organization.**

2. **Discuss how well the organization lived up to the CLAS standards**

3. **Describe at least 6 things that the health care system should have done to ensure high quality care for that patient.**
   [Be sure to cover each of the three CLAS domains].

NOTES:

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). Please be prepared to lead a 10 minute presentation/discussion of each of your assigned standards at the next session.

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

Be sure to address the following four objectives:

1. **Describe what the standard(s) mean in plain language.**
2. **Provide the rationale for the standard.**
3. **How is this standard relevant to your service and 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:

Who are the stakeholders and how do you engage them?

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

What challenges would be faced?

How might you measure progress/success of implementation?

Notes:

Workshop Session III: Getting to Know the CLAS Standards

Overview: This module provides 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 about the CLAS standards and ways to implement them than many cultural competence trainers in the field! They will also 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 challenges faced during its implementation. At the end of the session, the participants will be asked to develop a quality improvement plan that addresses 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 be able to:

Knowledge:

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

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

1. Appreciate that there are effective and practical ways to implement these standards.

Welcome and Check-In [10 minutes]

As we have stated before, the welcome and check-in is an important part of every session. It helps the participants to get 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. Again, you can start with general questions. It is also helpful to check in with how the last session went for the participants, in order to make changes to how the current session is to 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. By preparing and delivering their presentation, the

participants' 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 in what might otherwise have been a dry didactic. Please give 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 now be familiar with the CLAS standards, their intent and rationale, and implementation strategies. You should ask the participants, when they have all convened back to the large group, what challenges they might face when implementing the CLAS standards in their organization, and how they might overcome these challenges.

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 tasked with finding, through the **Key Informant Interviews**, a program within the organization that carried out one or more of the CLAS standards and then to ask a representative of that program to prepare a 20 minute presentation. The purpose of this exercise is to:

1. Demonstrate that it is possible to implement programs compliant with CLAS standards,
2. Highlight proven strategies and potential pitfalls to consider when implementing CLAS compliant projects, and
3. Inform participants about such organizations, as there may be some potential for collaboration.

Figure 3.1 is included here as a reminder of what the guest presenter is responsible for in his or her presentation. After the 20 minute formal presentation, you should allow for a 15 minute Q&A.

Figure 3.1 Model Program Presentation Guide

You have been identified by your organizational leaders as having successfully implemented a culturally and/or linguistically appropriate program. We have found it quite meaningful when the "story" of a successful program is shared with other leaders in an organization. Learning about successful programs highlights organizational strengths, reinforces commitment to culturally and linguistically appropriate services and provides a model for others. We are requesting that you provide a 20 minute presentation on 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 address/overcome challenges?
- How did you know when you had attained your goal?
- What mechanisms were employed to sustain the success of your program or project?

Also, how did the following factors fit and contribute to and/or challenge your efforts:

- **Leadership:** Leaders are decision makers who have the ability to influence others and provide direction to an organization to make it more cohesive and effective.
- **Team:** Group of staff 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" are 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 how staff relate to each other, how they communicate, and how efforts are coordinated.
- **Data Measurement and Reporting:** This refers to all aspects of data management including what data is measured and how it is collected, stored, processed, updated, and disseminated.
- **Education and Coaching:** This refers to how knowledge is generated, shared and used. It includes aspects such as 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 had 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. Finally, they have just seen a "proof of concept" of 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 a need in their department or organization that they wish to improve upon, and using one or more of the CLAS standards as the foundation, develop a plan to address this need. They will be tasked to do this in the next two weeks prior to 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 will be familiar with these components, and so you may not need to take much time to do this. 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 can also be found in the **Participant Workbook** in the **Workshop Session III** chapter. You will need to determine a date in the week prior to **Workshop Session IV** for the participants to submit their **CLAS Quality Improvement Plan** for your review.

It is important that the participants' plans are aligned with the organizational mission and that they synergize with other CLAS projects for optimal chance of meaningful implementation. To assist with this, you should ask the participants in the large group format, to discuss the following questions prior to ending the workshop.

- 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 (addressed a few key standards very well).
- Are there 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 get a commitment from each of the participants as to which standard they will address (individually or as a group) in their quality improvement plan.

Workshop Session III Forms:

CLAS Quality Improvement Plan

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 and 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 this? Please describe the expected short-, medium-, and long-term outcomes. Short-term outcomes include changes in knowledge, skills, and attitudes. Medium range outcomes might focus on changes in behaviors, practices, or policies. Long-term goals may entail changes in the environment such as improved health care access, reduced health disparities, or better language access.

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 challenges might be faced when implementing each standard.
- What might you do to overcome the challenges?

1. *Health care organizations should provide understandable and 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 not applicable?

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

*Why would it not be feasible?

Anticipated challenges to implementation:

Ideas to overcome challenges:

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

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 not be feasible?

Anticipated challenges to implementation:

Ideas to overcome challenges:

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 not applicable?

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

*Why would it not be feasible?

Anticipated challenges to implementation:

Ideas to overcome challenges:

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 not applicable?

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

*Why would it not be feasible?

Anticipated challenges to implementation:

Ideas to overcome challenges:

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

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

*Why is this standard not applicable?

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

*Why would it not be feasible?

Anticipated challenges to implementation:

Ideas to overcome challenges:

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

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

*Why is this standard not applicable?

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

*Why would it not be feasible?

Anticipated challenges to implementation:

Ideas to overcome challenges:

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

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

*Why is this standard not applicable?

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

*Why would it not be feasible?

Anticipated challenges to implementation:

Ideas to overcome challenges:

8. Health care organizations should have a written strategic plan with goals, policies, operational plans and management accountability to provide CLAS.

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 not be feasible?

Anticipated challenges to implementation:

Ideas to overcome challenges:

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

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

*Why is this standard not applicable?

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

*Why would it not be feasible?

Anticipated challenges to implementation:

Ideas to overcome challenges:

10. Health care organizations should collect, integrate and periodically update data on patient race, ethnicity, 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 not be feasible?

Anticipated challenges to implementation:

Ideas to overcome challenges:

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

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

*Why is this standard not applicable?

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

*Why would it not be feasible?

Anticipated challenges to implementation:

Ideas to overcome challenges:

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

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 not be feasible?

Anticipated challenges to implementation:

Ideas to overcome challenges:

13. Health Care organizations should have conflict/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 not applicable?

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

*Why would it not be feasible?

Anticipated challenges to implementation:

Ideas to overcome challenges:

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

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

*Why is this standard not applicable?

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

*Why would it not be feasible?

Anticipated challenges to implementation:

Ideas to overcome challenges:

CLAS Quality Improvement Plan Evaluation Checklist Instructions

GOALS

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

The goal of using the Checklist is twofold. First, it provides a quantitative summation of CLAS Standards addressed in a given plan. Second, it provides a quantitative assessment of which aspects of each individual CLAS Standard the plan identifies. It is intended to provide an objective, quantitative measure of relevance between individual participant project plans and the targeted CLAS standard/s.

Although the Evaluation Checklist is intended to evaluate plans after they have been written, it may be helpful to provide the Checklist to participants for use when 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 having participants 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 the participants conceived plan and efforts to accurately document it using the CLAS Quality Improvement Plan form.

CLAS Quality Improvement Plan Evaluation Checklist

Department/Organization/Service Area:

Project Title:

Which CLAS Standard(s) does this project address:

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 provide understandable and 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/administrative information		
Effective care resulting in positive outcomes, appropriate preventative services, diagnosis, treatment, adherence, 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 and leadership that 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 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 (continue) preferred language		

For written notice of the right of clients to receive services in 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 client.	**Yes**	**No**
To measure if bilingual clinicians have a command of English and target language		
To measure if bilingual staff 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		
To formally train & test Interpreters: 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 client-related materials and post signage in the languages of the commonly encountered groups.	**Yes**	**No**
Translate vital documents		
Measure commonly encountered languages		
Provide for verbal notification of the right to receive oral translation of written materials to non-common languages		
Deliver oral translation of written materials to non-common languages		
Measure signage in commonly encountered language of client rights		
Increase signage in commonly encountered language of client rights		
Measure signage in commonly encountered language of available conflict/grievance resolution processes?		
Increase signage in commonly encountered language of available conflict/grievance resolution processes		
Measure signage in commonly encountered language of direction finding		
Increase signage in commonly encountered language of direction finding		
Measure materials in alternative formats for illiterate, non-written languages and/or sensory, developmentally, or cognitively impaired		
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 with 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/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, procedures		
Identify an ongoing evaluation of progress		
Integrate cultural and linguistic competence-related measures into existing quality improvement activities community		
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/consumer and community survey		
Standard 10: Health care organizations should collect, integrate and periodically update data on client race, ethnicity, spoken and written language in the health records and management information systems.	**Yes**	**No**
Promote the collection of clients' race		
Promote the collection of clients' ethnicity		
Promote the collection of clients' spoken language		
Promote the collection of clients' written language		
Promote the collection of clients' additional identifiers		
Initiate the collection of clients' race		
Initiate the collection of clients' ethnicity		
Initiate the collection of clients' spoken language		
Initiate the collection of clients' written language		
Initiate the collection of 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 giving identifiers is not required		
Use self-identification and avoid use of observational/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 census figures		
Use voter registration data		
Use school enrollment profiles		
Use county/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/client involvement in CLAS.	**Yes**	**No**
For community partnerships to include input on 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/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. Including; 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-grievance services		
Ensure that clients are informed about complaint-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: System Change and CLAS

Overview: An established leader from the organization will discuss leadership strategies and their management philosophy with the participants in this session. The participants will be given the opportunity to reflect on how they can be an effective leader and an agent 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 assist with further developing and implementing the **CLAS Quality Improvement Plans**.

Learning Objectives

At the end of **Workshop Session IV**, the participants should be able to:

Knowledge

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 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

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

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

Facilitator Preparation Prior to 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 plans address the CLAS standards,
2. The impact it has on culturally and linguistically appropriate services, and

3. How practical it is to implement.

For the last issue, it may be helpful to involve 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 in regards to the following:

Collaboration and Coordination

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

Addressing the Needs of the Organization

1. Collectively, do the plans address the predominant concerns about CLAS brought up in the key informant interviews or discussions in the prior sessions? If not, these should be pointed out 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 up 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 minutes]

As stated earlier, the welcome and check-in is an important part of every session. It helps the participant to get into 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 it went with developing their **CLAS Quality Improvement Plan** before moving ahead to the **Leadership and Process of Change** talk.

Didactic: Leadership and Process of Change [60 min]

It is important that the top level of leadership explicitly supports the participants' efforts towards 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 their own style and perspectives on leadership thereby clarifying what they need and expect from their managers (the participants). The participants also benefit from understanding these expectations, and from hearing about the strategies utilized by someone 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 challenge leaders?
3. What are effective strategies for participants to effectively reach their project and larger institutional goals?
4. What challenges will be faced 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 do the following in the next 60 minutes:

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 the challenges to implement the plan.
3. Discuss the potential overlaps, opportunities to share resources, and ways to collaborate and mutually support each others' projects.
4. Finalize their **CLAS Quality Improvement Plans** based on these discussions.

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

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 should also emphasize to the participants that they now know more about the CLAS standards than many cultural competency trainers, particularly when it comes to strategies to realistically implement CLAS. In order to close this part of the curriculum, you should ask the participants how things went for them. Other questions that help promote reflection and conclusion of the curriculum are:

1. What was the most challenging part of the curriculum? What was most rewarding?
2. Were there things that surprised you 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…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 conclusion, you should spend some time to thank the participants for their hard work, the organization's top leadership for prioritizing 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 30-40 minutes in total to do this. The **Participant Satisfaction Survey** will help to assess the quality of each module, the facilitation, speakers, and logistical support. This is helpful for you in terms of 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. This can be compared with the **Pre-Curriculum Survey** to look at changes in knowledge, skills, and attitudes.

Workshop Session IV Forms:

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 patients limitations when developing care plans
   - [ ] Performing learning needs assessments with patients
   - [ ] Integration of methods to mitigate barriers to learning

4. Racial/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 them
   [ ] 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 what they need to do to get better
   [ ] Cultural beliefs regarding health shared by members of a group
   [ ] All of the above

8. How many CLAS standards are there?
   [ ] 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
   [ ] US Department of Health and Human Services, Office of Minority Health
   [ ] California Department of Public Health
   [ ] 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. There is evidence that cultural factors such as ethnicity, class, religion, spirituality, sexual orientation and racism impact health care decision making.

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

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

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

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 towards CLAS

16. Language barriers have been shown to impact 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, it is important to provide materials/ assistance in a 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 delivering 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. It is possible to implement CLAS-based programs.

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

22. It is important that quality improvement efforts include consideration of the CLAS standards.

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

23. A diverse workforce is important to providing quality health care.

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

24. It is important to understand the cultural backgrounds of patients.

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

25. It is important to understand the cultural backgrounds of my co-workers/colleagues.

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

26. It is important to have equity in health care.

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

27. Understanding the patient's experience of their illness is important to providing quality health care.

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

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

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

31. Linguistically appropriate services are important to providing 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. I believe that CLAS-based efforts can improve quality of health care and/or services.

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

35. I believe that 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 the following patient data – Race?

[ ] Yes [ ] No

39. Do you have access to the following patient data – Ethnicity?

[ ] Yes [ ] No

40. Do you have access to the following patient data – Preferred language?

[ ] Yes [ ] No

41. Do you adjust service delivery based on the 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 operationalize one or more of the CLAS standards.

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

Participant Satisfaction Survey

Please rate the following components of the curriculum

Session I: Introduction to the CLAS Standards					
	Excellent	Good	Fair	Poor	N/A
Overall Rating of Session I					
Degree to Which Session Met the Learning Objectives					
Cultural Meaning of Names Exercise					
PowerPoint Presentation					
Vision Statement Exercise and Discussion					
Systems Change Exercise and Discussion					
Small Group Sessions					
In-Class Assignments					
Intersession Assignment: CLAS A to Z					
Intersession Assignment: Illness Narrative					
Handouts					
Quality of Facilitation					
Comments:					

Session II: Quality of Care for Culturally Diverse Patients					
	Excellent	Good	Fair	Poor	N/A
Overall Rating of Session II					
Degree to Which Session Met the Learning Objectives					
Illness Narrative Exercise					
Video: Robert Phillips					
Video: Justina Chitsena					
Case Vignettes: Large Group Discussion					
Case Vignettes and CLAS: Small Group Discussion					
Intersession Assignment: Research CLAS Standards					
Handouts					
Quality of Facilitation					

Comments:

Session III: Getting to Know the CLAS Standards					
	Excellent	Good	Fair	Poor	N/A
Overall Rating of Session III					
Degree to Which Session Met the Learning Objectives					
Participant Presentation of CLAS Standards					
Guest Speaker: Model Program					
Handouts					
Intersession Assignments: CLAS QI Plan					
Quality of facilitation					

Comments:

Session IV: System Change and CLAS					
	Excellent	Good	Fair	Poor	N/A
Overall Rating of Session IV					
Degree to Which Session Met the Learning Objectives					
Developing CLAS: Small Group Discussion					
Guest Speaker: Leadership Talk					
Handouts					
Quality of Facilitation					

Comments:

Overall Rating of the Series

	Excellent	Good	Fair	Poor	
Overall Rating					
Degree to Which Session Met the Learning Objectives					
Videos					
PowerPoint Presentations					
Guest Speakers					
Handouts					
Small Group Sessions					
In-Class Assignments					
Intersession Assignments					
Quality of Facilitation					
Would you recommend this course to colleagues?	[ ] Yes	[ ] No			

Comments:

Facilitator #1 Evaluation				
	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/Planning					
	Excellent	Good	Fair	Poor	
Written communication (email):					
Directions (Location, time, date):					
Location:					
Time:					
Date:					
Access to Facilities:					
Physical space: air temperature:					
Audio visual equipment quality:					
Noise level:					
Comments:					

Follow-Up Meetings: Keeping Up 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 be able to:

Knowledge:

1. Describe the key accomplishments and challenges that they have had with implementing their quality improvement plan;
2. Describe the key accomplishments and challenges that other members of their group have had with implementing their respective quality improvement plans;
3. Describe potential strategies to build upon accomplishments and address challenges;

Attitudes;

1. Maintain their commitment towards implementing their quality improvement plan;
2. Maintain their interest in the implementation of the other members' quality improvement plans;

Skills;

1. Be able to operationalize the potential strategies discussed above into practical steps to address challenges and build upon successes;
2. Be able to apply the challenges and success of other participant plans to the implementation of their own plan.

Project Updates [30min]

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 challenge with which the other members can help to troubleshoot. It is important for the other participants to give input that is both constructive and supportive in nature. Afterwards, the participant who is giving the update should be asked to identify, realistically, what is 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 can also use a copy as point of reference at the next meeting.

Facilitator's Summary [10min]

After the updates, you should conclude the meeting by summarizing the collective experience of the group in their work towards implementing their **CLAS Quality Improvement Plans**. Consider including the following in your summary:

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

Follow-Up Sessions Form:

CLAS QI Project Update Worksheet

Date:

Session Number:

Project Name:

Project Participants:

Interval Accomplishments:

Interval Challenges:

Group Feedback:

Identified Next Steps:

APPENDIX A: Personal Stories from Ethnographic Histories

(Alternative to Worlds Apart Exercise)

An option to the "Worlds Apart Exercise" featured in Workshop II is the *Personal Stories from Ethnographic Histories* of the Permanente Journal, fall 2006 Vol. 10 No 3. The Permanente Journal is a national peer reviewed series with a readership of 500,000 people in 160 countries around the world. This particular issue presents a collection of writings by medical students using a culturally focused interviewing approach called the ethnographic interview. It may be downloaded at http://xnet.kp.org/permanentejournal/ethnographic.pdf. A copy of the journal can also be found in the Resources Section of the Facilitator and Participant CD. Two of the articles, "The Barrier of Fear: Native American Health Disparities" by Dawson S. Brown and "New Lives: Latinos, Cancer, and Spirituality" by Stephen T. Magill is selected for use. It helps participants understand the experience of cultural diverse individuals and the health disparities they encounter as they navigate through the western health care system.

Part A: The Barrier of Fear: Native American Health Disparities by Dawson S. Brown (page 6)

Divide the participants into small, predetermined groups. Subsequently, have the Facilitator read the following sections to the participants at large [5 min]:

- Interview (page 6)
- His Heart and a Root (page 6)

In their small groups, have the participants discuss the following questions [10 min]:

- How prevalent is the use of complementary, alternative, or traditional medicine in your system?
- How do the providers in your system respond to alternative healing practices?
- How would they have responded to Ms. Doe's friend, should he have come to your facility?

Redirect the participant's focus back to the facilitator who continues by reading the following to the group at large [2 min]:

- Traditional Medicine (page 7)
- Responsibility for Health (page 7)

Reconvene the small groups and have the participants discuss the following questions [15min]:

- Why might Ms. Doe and her family view the Indian Health Services and other health care organizations with caution?
- Are their ways in which health care organizations contribute to these viewpoints?
- What can your organization do to mitigate this?
- At the end of the section Ms. Doe describes "her people as suffering from a sort of post-traumatic and intergenerational stress." Until they take responsibility and recognize that

there is no distinguishing between medicine and daily living, they cannot be truly healthy. How aligned is health care in general towards this perspective? If Ms. Doe was receiving services from your organization, what would your service do to help her achieve this sense of health? Discuss this in the context of the three Domains of the CLAS standards: Patient Care, Language Access, and Organizational Supports.

Conclusion:

To conclude this portion of the exercise, have the facilitator read the "My Personal Reflection on this Interview" section (page 7) to the group at large. Afterwards, allow a brief pause and then ask for volunteers to share their response to the author's comments. If time permits, have the facilitator ask volunteers to share their group's responses to one of the small group discussion questions. The conclusion section should take a total of 10 minutes.

Part B: New Lives: Latinos, Cancer, and Spirituality by Steven T. McGill (page 17)

Have the participants remain in their small groups for Part B of this exercise as the facilitator reads the following sections to the group at large: [5 min]

- Introductory Paragraph (page 17)
- Household Composition (page 17)
- Housing Costs (page 17)
- Family Work History and Income (page 17)

In their small group, have the participants discuss the following questions [10 min]:

- How might the family's socioeconomic status impact their ability to access and follow through with health care treatment?
- How does immigration status (documented vs. undocumented) impact this?

After the 10 minute discussion, have the participants redirect their focus back to the facilitator who continues by reading the following to the group at large [5 min]:

- Medicine and Herbs in the Home (page 18)
- Folk-Medicine Beliefs and Practices (page 18)
- Health Problems in the Family (page 18)

In their small groups, have the participants discuss the following [10 min]:

- How might providers in your system respond to Ivon's health beliefs?
- How well does your health system support cultural and spiritual beliefs and practices of your clients? Please discuss this in the context of the three CLAS domains: Patient Care, Language Access, and Organizational Supports.
- Do you think this degree of support should change?

Conclusion [10 min]:

To conclude this portion of the exercise, have the facilitator read the "Analysis and Personal Reflections" section (page 19) to the large group. Afterwards, allow a brief pause and then ask for volunteers to share their response to the author's comments. If time permits, have the facilitator ask for volunteers to share their group's responses to one of the small group discussion questions. The conclusion section should take a total of 10 minutes.

Appendix B: 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 "getting to know 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 be able to:

Knowledge

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

1. Be able to assess the qualities of your participants that may impact 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

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

Introduction

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

1. Potential challenges 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. 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 challenges 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 challenges 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 challenging. Participants may regard the facilitator with skepticism, feel that he or she has unrealistic expectations, or lacks true understanding of the participant's work context. The facilitator may be subjected to negative attitudes or minimal engagement as a result of resistance to looking at emotionally sensitive topics of racism and unequal treatment, defensiveness about "needing" CLAS standards training, and/or frustration with the constraints of the system in which they work. As a result, CLAS standards/cultural competence trainers often face challenges that are more emotionally difficult than trainers of other areas. It is unlikely that a single approach will be able to address these issues. Moreover, the different interpersonal and learning styles of the participants highlight the importance of 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 their own negative 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 (ala 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?
- Are there other roles that you feel are 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

There is significant diversity in the way people learn. This includes what type of information and experiences people regard as being 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 to listen to didactics and spend time at home digesting the information provided. The challenge of the facilitator is to recognize the particular style of their learners, to facilitate a learning context that is consistent with that learning style, and to also challenge them 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.

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	
▪ Outward focused ▪ Focuses on other people and things when making decisions ▪ Gets energized from social relationship	▪ Inward focused ▪ Focuses on one's own thoughts and feelings when making decisions ▪ Gets energized from inward 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 HJ: Georgia State University Master Teacher Program (2006). *On Learning Styles*. 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 present the most difficulty 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 C: Culturally and Linguistically Appropriate Services (CLAS) Standards (abbreviated version)

Health Care Organizations should:

1. Implement understandable and respectful care compatible with cultural health beliefs and in the preferred language;
2. Have recruitment, retention and promotion of diverse staff and leadership that are representative of the demographic characteristics of the service area;
3. Have 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 with goals, policies, operational plans and management accountability to provide CLAS;
9. Have ongoing organizational self-assessments of CLAS, and integrating 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, integrated and updated in the health records and management information systems;
11. Maintain current demographic, cultural, and epidemiologic profile of the community and perform a needs assessments to implement CLAS;
12. Have participatory, collaborative partnerships with communities to facilitate community/patient involvement in CLAS;
13. Have conflict/grievance procedures addressing CLAS 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 D: Recommend Readings

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, Washington: 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 a must read for developing, implementing, and evaluating any project featuring 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 is both 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. There is a lot of information in the full that is not included in the summaries, although the summaries are still over 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.

This is additional reading. This is a great resource for understanding linguistic competence within the larger construct of cultural competence.

[*] A copy can be located in the Resources & Reading section of the Facilitator's Manual & Participant's CD

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 a must read. The University of Massachusetts Medical School, Office of Community Programs, in a project funded by the DHHS OMH, developed this physician toolkit and curriculum. The toolkit and curriculum, although specifically developed for clinical practitioners, does demonstrate an effective mechanism and potential resource for instituting organizational change. It is also 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, D.C.: 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 a must read. 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 which 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 must read. They provide 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. (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.

These are must read publications. This cultural and linguistic competence volume series is a must read. It coined the terms cultural and linguistic competence and should be part of the knowledgebase of anyone doing work in cultural and linguistic competence. In short, it 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 a variety of cultural, linguistic, and organizational issues using a variety of engaging case studies and real feedback from providers and professionals in health care settings. It is a good example of the CLAS Standards being applied 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 a variety of self assessments, case studies, video vignettes, learning points, and pre and posttests, as well as opportunities to submit feedback 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 a great resource for individual, organizational, and systemic models for cultural and linguistic competence. The models described within the document provide the reader with an expansive list of past efforts 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 different 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 needed 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 article is for additional reading. This excellent concise article which 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 patient's perspectives, and how communication skills are to be developed. Researchers adapted Bennet's developmental model of intercultural sensitivity into five developmental levels of cultural competence in medicine. The program utilized lectures, case discussions, community presentations, videotapes, role plays with simulated patients, and one-on-one faculty-resident evaluation of residents' videotaped clinical encounters. Evaluation showed residents felt the letter to be most helpful. In a self assessment, residents' knowledge and skills increased significantly, as did their level of "cultural competence." There was high correlation between residents' and faculty members' assessments of ending levels of competence. The authors have done educators a great service in presenting both participants' positive *and* negative comments, as well as program planners' challenges in getting past participants' resistance in 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 is a must read. This report provides a comprehensive presentation of health care initiatives which have demonstrated success in improving culturally and linguistically competence 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 is a must read. This is a good example of a health care system's attempt to implement a self-learning tool based on improving cultural and linguistic competence for providers and staff. The purpose of the self-learning packet is to present health care professionals with an introduction 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.

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Measuring Cultural and Linguistic Competence

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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 is a must read. This is a great report which provides insights into past efforts and future trends in creating more culturally and linguistically competent individuals, organizations, and systems.

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This is a must read. This article provides useful information around 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 is a must read. This article provides 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, D.C.: The National Academies Press.

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This is a must read. This report provides a comprehensive review of the literature on organizational change strategies in cultural and linguistic competence. Additionally, it provides 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 A B.D. Smedley & A.R. Nelson (Eds.), *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care* (444-527). Washington, D.C.: National Academics Press.

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*Faden, R. & Powers, M. (2003). Racial and Ethnic Disparities in Health care: An Ethical Analysis of When and How They Matter. In A B.D. Smedley & A.R. Nelson (Eds.), *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care* (722-738). Washington, D.C.: National Academics Press.

Fiscella, K, Franks P., et al. (2000). Inequality in Quality: Addressing Socioeconomic, Racial and Ethnic Disparities in Health Care. *Journal of the American Medical Association,* 283, 2579-2584.

These are must read reports. The previous reports provide useful and meaningful information regarding health disparities experienced by culturally diverse persons in California. They provide a good picture into the unique health needs of culturally diverse communities in California.

*Geiger, H.J. (2003). Racial and Ethnic Disparities in Diagnosis and Treatment: A Review of the Evidence and a Consideration of Causes. In A 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.

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Horowitz, C., et al. (2001). Approaches to Eliminating Socio-Cultural Disparities in Health. *Minority Health Today,* 2(2)33-43.

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

*Institute of Medicine. (2002). *Shaping for 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.

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*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 is a must read. This 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 impacts for racial and ethnic minority populations.

*Joe, J.R. (2003). The Rationing of Health care and Health Disparity for the American Indians/Alaska Natives. In A B.D. Smedley & A.R. Nelson (Eds.), *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care* (528-551). Washington, DC: National Academies Press.

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

*Murray-Garcia, J.L. (2002). The California Endowment. Multicultural Health 2002: An Annotated Bibliography.
Retrieved from
http://www.calendow.org/reference/publications/pdf/disparities/TCE0222-2002_Multicultural_.pdf

This is a must read. This is a great resource which provides a lot of research sources for multicultural health.

*Perez, T.E. (2003). The Civil Rights Dimension of Racial and Ethnic Disparities in Health Status. In A 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.
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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 A B.D. Smedley & A.R. Nelson (Eds.), *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care* (699-721). Washington, DC: National Academies Press.

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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 a must read. This is a 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 is a must read. This article makes an interesting argument for disparities being 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 is a must read. This report provides the most current information on health care disparities in the U.S. It also provides a lot of 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 is a must read report. It helps define both quality of care for culturally diverse populations and provides 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 is a must read. This is a report which clearly states 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/activities; 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 quite 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 from starting the study, to collecting, analyzing, and reporting the data, to putting the results into action in your treatment programme.

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 under-representation of culturally diverse students into U.S. medical schools. Specifically, the article describes the decrease in diverse students enrolled in medical schools following 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 provides evidence of the under-representation of culturally diverse Registered Nurses (RN) in California. It was found that in to keep up with California's population growth, the state would need to need to add more than 40k RNs by 2010 74k by 2020. The report stated that Hispanics were the most underrepresented group with only 4% of RNs in California while they make up over 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 provide compelling arguments and strategies for increasing the cultural diversity of this nation's physician workforce.

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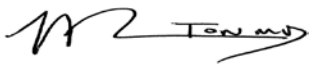
Message to the Facilitators and Participants

This toolkit has greatly benefitted from the valuable input 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 refine the curriculum to the final version of this toolkit. It is our hope that this toolkit will help other health care organizations to develop and deliver Culturally and Linguistically Appropriate Services that will reduce health disparities and improve the quality of care for all patients.



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