

Promoting Cultural Competency among Family Planning Providers: Lessons from the Field



A Meeting Report of the Immigrant Women's Health Initiative of the Education Fund of Family Planning Advocates of New York State

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Who We Are

Family Planning Advocates of New York State (FPA) is a nonprofit, statewide membership organization dedicated to advancing public policies that fulfill the rights of individuals to comprehensive sexual and reproductive health services and education. Based in Albany, New York, FPA is comprised of over 200 organizational members as well as thousands of individual members throughout the state. The Education Fund is the 501(c) (3) arm of FPA which conducts research, carries out policy analysis and provides a variety of education, training and outreach programs on several project areas related to sexual and reproductive health services and education¹.

Introduction

In 2004, the Education Fund of Family Planning Advocates of New York State (Ed Fund) received funding from the Ford Foundation to conduct a two-year project aimed at assessing and enhancing the capacity of three family planning centers in New York State to serve immigrant women in culturally and linguistically competent ways. The project, *Increasing Immigrant Women's Access to Reproductive Health Care: Strengthening Cultural Competency among Family Planning Providers*, seeks to help family planning providers respond to the growing needs of an increasingly diverse patient population by understanding what it means to be culturally competent in health care and how to achieve cultural competence within an institutional setting. The goals of the project are to:

- Develop a user-friendly assessment method to help family planning centers evaluate the needs of their increasingly diverse patient population.
- Use the results of the assessment to increase the capacity of three family planning centers to provide culturally and linguistically competent care.
- Share the assessment methods and best practice models for serving immigrant women in culturally and linguistically appropriate ways.

The following report summarizes the proceedings of a meeting sponsored by FPA, *Promoting Cultural Competency among Family Planning Providers: Lessons from the Field*, held to share the results and findings of a two-year cultural competency assessment project that began in November 2004. The meeting, held on June 15, 2006, at the New York City office of Planned Parenthood Federation of America, brought together participants in three centers to share the assessment methods, results and lessons learned from the project, as well as to brainstorm future actions to improve access to care for limited English proficient patients. Approximately 70 people representing the three assessment sites, experts in the field of cultural and linguistic competency, Planned Parenthood centers, individual family planning centers, immigrant-serving organizations, NYS Department of Health, health care advocates and policymakers were present to discuss the project's findings.

This report is divided into five main sections. The first section summarizes the relationship between cultural competency and reproductive health, including an explanation of the *National*

¹ For more information on our organization and programs, please visit www.edfundfpa.org and www.fpaofnys.org.

Standards for Culturally and Linguistically Appropriate Services in Healthcare (CLAS) and why providers must strive to be culturally and linguistically competent. This section also presents an overview of the assessment process. The second section focuses on the three assessment sites, outlining the specific experiences, actions, and outcomes of each site, and addresses questions raised by meeting participants. The third section presents the views of three experts in the field regarding the project process, the measurement of cultural and linguistic competence, and discussion of these topics among meeting participants. The fourth section summarizes the results of the small work group sessions, listing the resources that were identified as necessary to improve cultural and linguistic competency in the family planning setting. The fifth section provides an overview of final participant views and evaluations, and raises questions about the future of promoting cultural competency in the family planning setting.

1. Background

Immigrants now comprise a sizeable and growing proportion of the U.S. population. Foreign-born residents in the U.S. number at least 35 million, more than triple the 1970 figure. Almost 52 million persons now speak a language other than English at home, a phenomenon not limited to the major cities but common throughout smaller communities and rural areas. Twenty percent of the population of New York State—approximately four million people—are foreign-born.²

Two million immigrant women speaking over 150 different languages need reproductive health services in New York State.

FPA and the family planning centers it represents have a strong commitment to reduce racial/ethnic and class disparities in health care. There is ample evidence that women of color and low-income women bear a greater burden of negative health outcomes, including higher morbidity and mortality rates. The Commonwealth Fund's survey on ethnic disparities in health found that minorities were less likely to feel they were involved in decision-making and more likely to feel disrespect from providers. Nonetheless, almost 20% of Caucasian patients expressed similar dissatisfactions.³ Minority patients are like "canaries in the coal mine," according to one participant from the meeting: when they are doing poorly, it is a sign that the system is not meeting patients' needs

Reproductive health services are often the main point of entry to the health care system for women.

Linguistic and cultural barriers make navigating the health system daunting for many immigrants and constitute an obstacle to access for thousands of people in need of services. Improving cultural competency and assuring clients that they will be treated in a respectful manner and provided care in a language they understand will not only attract clients but improve health outcomes.

² U.S. Census Bureau. (2005). *American Community Survey*. Retrieved September 1, 2006 from <http://www.census.gov/acs/www/>

³ The Commonwealth Fund. (2001). *Health Care Quality Survey*. www.cmwf.org

The CLAS standards are a potential ‘roadmap’ for a way out of these difficulties. Issued by the U.S. Department of Health and Human Services’ Office of Minority Health, the 14 CLAS standards are a collective set of mandates, guidelines and recommendations intended to inform, guide and facilitate required and recommended practices related to culturally and linguistically appropriate health services.⁴ The standards offer an effective framework to identify critical areas in which cultural competence should be evident and to develop a practical guide for implementing and monitoring institutional progress toward cultural competence.⁵

Although both private and public agencies often encourage health care centers to adopt and implement the CLAS standards, there are few practical suggestions on how to do so, and specific funding for improving cultural competency is rarely available. The Ed Fund set out to provide assistance to a select group of interested affiliates in the form of a systematic self-assessment process on cultural competency. This assessment project provided clear guidelines by which agencies could measure their performance and identify areas for improvement using a simple process that did not burden busy providers and other staff. Mini-grants of \$3,500 were provided to each participating center to improve their performance in one or more of the areas evaluated. A final goal was to refine the assessment methodology so that the process could be replicated by others.

Three family planning centers were chosen to partner with the Ed Fund to perform the self-assessments. The centers were chosen based on their interest and commitment to improving cultural competency. The three centers were Planned Parenthood Mohawk Hudson (PPMH) at their clinic site in Utica; Planned Parenthood of New York City (PPNYC) at their Boro Hall clinic in Brooklyn; and Community Healthcare Network (CHN) at their CABS Health Center in Brooklyn. The process, experience and results of each of the assessments were presented at the June 15, 2006 meeting.

1.1 Why Cultural Competency?

JoAnn M. Smith, President and CEO of the Ed Fund of FPA, opened the meeting by explaining that combining educational work and research with advocacy links programming with practical policy applications. The project, *Strengthening Cultural Competency*, was consistent with this strategy. While the initiative focused on improving service provision through linguistic and cultural awareness, FPA worked in parallel to restore benefits for undocumented immigrant women in the state that had been eliminated by changes in federal government policy.

To illustrate the barriers to reproductive health care faced by immigrant women and the need for culturally appropriate services, the Ed Fund showed a moving video interview with Ms. Ladan Alomar. Ms. Alomar is the executive director of Centro Cívico, a multi-service, community-based agency in Amsterdam, upstate New York, that provides services to Latinos and other underserved communities. In the video, Ms. Alomar, a Muslim woman, recalls her dismay and shock upon receiving gynecological services from a male physician over 20 years ago when she was a recent immigrant from Iran. She explains how language barriers and cultural differences

⁴ U.S. Department of Health and Human Services’ Office of Minority Health. (March 2001). *National Standards for Culturally and Linguistically Appropriate Services in Health Care, Final Report*.

⁵ See Appendix E: Summary of CLAS Standards.

resulted in an examination by a male rather than female doctor and how this experience traumatized her so greatly that she did not seek reproductive health care services for years afterward.

Years later, I think of that experience and I'm extremely sensitive. I work with many immigrant women and I think about how my experience can make a difference – not only by sharing it but also how I can smooth the path, talk to health providers as much as I can...to make them understand the importance of not just understanding the language and being able to communicate with someone, but respecting someone's culture and what the culture says, and each individual's beliefs and values that might be very different for every single one of us.

-Ladan Alomar

In the opening session on “Why Culture Matters in Health Care,” Dr. Hetty Cunningham, assistant clinical professor of Pediatrics at Columbia University and attending physician at Morgan Stanley Children’s Hospital of New York-Presbyterian, talked about the need to examine culture to eliminate health disparities and increase quality of care. She cited the 2002 Institute of Medicine Report that found that racial/ethnic disparities are consistently found across a wide range of healthcare settings, disease areas, and clinical services even when controlling for socioeconomic status and health insurance.

Racial and ethnic disparities in healthcare exist and, because they are associated with worse outcomes in many cases, are unacceptable.

-Finding 1-1 of “Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care,” Institute of Medicine, 2002

Dr. Cunningham described current thinking in medical education on the importance of eliciting patients’ subjective understanding of their health conditions and the meaning of their illnesses, including their fears and expectations related to the medical care interaction. “People don’t just want a cure; they want healing,” said Dr. Cunningham. Although the physical aspects of sickness are constantly improving, patients remain more dissatisfied than ever if they sense that providers treat the disease in isolation of their personal experiences of living with the disease. Cultural competency requires incorporating the patients’ cultural values, ideas and beliefs about illness to better understand and serve patients of diverse backgrounds. Dr. Cunningham also discussed studies that show how culturally competent care is associated with improved quality of care and improved outcomes.

Provider agencies often find that striving for cultural competency will lead to improved care for all clients because staff strives to become more attuned to their clients’ subjective experiences of illness and medical care.

1.2 How Do You Assess Cultural Competency: Practical Tools for Action

The second presentation by Karen Anderson and Sang Hee Won of FPA outlined the assessment process and tools that were used in this project. They pointed out that the assessment tools that were adapted and developed were designed to evaluate the degree to which the CLAS standards are being effectively implemented at the organizational level. In order to develop a practical assessment process with usable outcomes, the methodology that was developed was systematic and comprehensive while being user-friendly, feasible and action-oriented at the same time. The components of the approach are summarized below:

Process

- Identify three family planning clinics/centers interested in participating in the project
- Solicit orientation and input from national experts in the field of cultural competence
- Visit assessment sites with project team and national experts to kick-off process
- Return to sites to conduct Organizational Cultural Competency Assessment
- Carry out data analysis and develop written report summarizing the demonstration site's strengths, areas for improvement and recommendations based on CLAS standards
- Present written report and recommendations to clinic leadership
- Provide mini-grants to help clinics implement recommendations
- Provide ongoing technical assistance to demonstration sites during implementation
- Organize statewide meeting to present, and discuss, the results of the assessment process
- Refine, and share widely with statewide family planning clinics, the model assessment methods and best practice improvements to serving immigrant women in culturally and linguistically appropriate ways.

Tools

- Organizational cultural competency survey
- Six checklists to assess key areas of cultural competence
- Meetings with clinic leadership
- Statewide meeting of family planning providers and key experts in the fields of linguistic and cultural competency
- Identification grid of strengths, areas for improvement and recommendations
- Mini-grants

The Organizational Cultural Competency survey, developed by Dr. Stergios T. Roussos, adjunct professor of Public Health at San Diego State University, measures institutional performance on

the CLAS standards. The survey was used in conjunction with six checklists to assist organizations in clarifying where they stand on a continuum of cultural competency and what areas require the most attention in regards to cultural and linguistic competency.

National experts in cultural competency were consulted in the development and implementation of this assessment project. In addition to Dr. Roussos, Wilma Alvarado-Little, program manager at the SUNY Albany Center for the Elimination of Minority Health Disparities and co-chair of the Board for the National Council on Interpreting in Health Care, was consulted. Ms. Alvarado-Little has more than 20 years experience in medical interpreting. Dinah Surh, Vice President of Ambulatory Care Services at The Brooklyn Hospital, was also consulted. Ms. Surh was previously an administrator at the Lutheran Family Health Centers in Brooklyn when the institution revamped its procedures to deal with the influx of Spanish, Russian, Arabic and Chinese speaking immigrants to the hospital's catchment area. Ms. Surh also served on the original CLAS Standards National Advisory Committee.

To kick-off the assessment process, the assessment team met with each clinic's leadership team and/or staff and presented the outline of the process. During the assessment process all staff answered the anonymous survey comprised of 20 questions. Respondents rated each statement in terms of their perception of the agency's present competence as well as the importance of that item. The twin ratings provided insight into which of the competencies described in the CLAS standards were most in need of improvement.

In addition, senior staff answered a series of six checklists to provide essential background information on patient demographics, staff demographics, assessment by leadership, current actions to address cultural and linguistic issues, patient and community access issues, and community involvement, input and support. The project leaders were particularly cognizant of the need for the process to provide quick, practical suggestions for each clinic's leadership so that both they and participating staff could see results from the assessment process almost immediately. The results of the assessment along with recommendations to improve cultural and linguistic competency were summarized into a final report and presented at each center. A mini-grant of \$3,500 was provided to each assessment site to help them implement at least one of the recommendations that was derived from the assessment.

2. Lessons from the Field: Reports from the Three Assessment Sites

The next session was a panel presentation by representatives of the three clinics that participated in the cultural competency assessment project. The panel was moderated by Dinah Surh and included:

- Planned Parenthood Mohawk Hudson (PPMH) president and CEO Margaret Roberts and flow coordinator Cheryl Lincoln-Lovely
- Planned Parenthood of New York City's (PPNYC) Boro Hall Center director Nellie Santiago-Rivera
- Community Healthcare Network (CHN) president and CEO Catherine Abate, assistant vice president for clinical operations Martha Febuz, and office manager Rosemary Gomez

The three presentations are summarized below:

2.1 Planned Parenthood Mohawk Hudson (PPMH)

Background on PPMH: Services and Population Served

President and CEO Margaret Roberts began her presentation with an overview of PPMH's services and the population they serve. PPMH is comprised of 12 health centers located throughout central New York that provide a full range of reproductive health services to over 23,000 clients per year. PPMH's Utica Center was chosen as a logical site at which to conduct the assessment due to its large and ethnically mixed immigrant and refugee population. Census figures on racial demographics typically are not disaggregated by language group, making it harder for agencies to determine who is in their catchment area. In 2003, Utica, which is a government-designated refugee resettlement area, had a total population of 60,000 people with approximately 12,000 immigrants, many of them refugees, including Vietnamese, Cambodians, Italians, Polish, Puerto Ricans, Lebanese, Russians, Bosnians, Sudanese, Liberians, Somalis and Kenyans. These residents now are estimated to comprise between 12% and 15% of the local population.

Utica Center Prior to the Cultural Competency Assessment Project

Before the assessment, the Utica Center had made efforts to serve these populations, including hiring Spanish- and Bosnian-speaking staff and using interpreters from the local refugee center. They placed signs in the main site in English, Spanish, Bosnian and Russian and obtained Spanish-language forms through PPFA and the state health department as well as documents in Bosnian and Russian.

However, senior staff quickly recognized a variety of problems. Interpreters were not available for all languages, and non-English-speaking patients often would bring relatives to help them or just show up on their own. Not all clients wanted local people to assist them in interpretation due to privacy issues. For example, Roberts related the case of a Pentecostal woman from Byelorussia who came in for an abortion. The local interpreter who assisted her later revealed the fact to others in the religious community. Although the clinic denounced the breach of confidentiality, the damage was done.

Employees who served as ad hoc interpreters at the Utica Center often were front-line staff rather than clinicians. Children were often used as interpreters, which was problematic when dealing with discussions of abortion and other sensitive health issues. It was also difficult for staff to know how accurately the minors were interpreting the communications.

The Utica Center also used telephonic interpretation services, despite the general belief that telephonic services are not as satisfactory as an on-site interpreter. According to Ms. Roberts, these language lines may offer hundreds of languages, but from one week to the next, a given language may not be available. Another limitation was that if the phone line was only available in the pre-exam counseling room, key communications occurring later during the patient's visit could not be translated.

The Cultural Competency Assessment Process: Priorities and Outcomes

FPA's cultural competency assessment process at PPMH took place between March and June of 2005. Thirty-one of the 38 clinic staff (82%) participated in the survey process. PPMH received a final report that identified the center's strengths and areas for improvement based on the comparison of the comprehensive results of the assessment process to the 14 national CLAS standards. Recommendations were made on how to move steadily forward to more fully implement the 14 standards. PPMH leadership decided to proceed with the recommendations by focusing on the following CLAS standards:

- Standard #3 –Ensuring ongoing staff education
- Standard #4 –Providing language assistance services
- Standard #5 –Providing verbal and written notice of available language assistance services
- Standard #7 –Providing patient-related materials in the languages of commonly encountered groups.

PPMH chose to allocate their mini-grant to staff education and document translation. Some training on how to work with a medical interpreter was done with the local refugee center in July 2005. The clinic staff now hosts regular informational sessions at the center with tables in five or six languages, and bilingual staff and interpreters explain the services available. Maintaining close working relations with the local refugee center is very helpful, especially in preparing for the resettlement of a new refugee group into Utica. The agency and the refugee center share at least one board member, a multilingual immigrant woman.

The Utica Center adopted the use of language-ID charts where clients can point to their language; this seeks to address CLAS standard #5 regarding the requirement for verbal and written notices of language services. When patients cannot read in their own language, a world map can be used to which an individual can point to his or her country of origin. Patient charts are now labeled by language, and the primary phone message includes voice-mail options in Bosnian and Spanish.

Participating in FPA's Immigrant Health Resource Exchange (IHRE) also enhanced PPMH's ability to serve immigrants in a culturally competent way.⁶ For example, in one call PPMH learned that translating documents into Somali wouldn't make sense because Somalis have an oral rather than written tradition, and written materials might not make sense to them. Instead, the Utica Center was directed to a video produced by the Minnesota International Health Volunteers on "child spacing" for Somalis, a term more in tune with their religious beliefs than "family planning" or "birth control."

Because translation of documents is time-consuming and costly, Roberts recommended the use of bullet points that can be changed more easily than a whole paragraph. She emphasized the importance of reinforcing with staff that language assistance services are not just a mandate, but

⁶ The Immigrant Health Resource Exchange is a group of representatives from FPA's statewide family planning member centers who participate in ongoing discussions about local practices and strategies to develop, or strengthen, culturally and linguistically competent services.

that the agency wants to perform well in this area. The initial telephone contact is important to gather language information. Often, it is not the patient calling but an English-speaking friend or relative. Knowing there is a language issue in advance is key, so that staff can plan ahead. Posters and art in the clinic should reflect the ethnic groups served in order to make patients more comfortable in the clinic setting. Although the main responsibility for language competency should be assigned to one employee, everyone in the agency should appreciate the importance and participate, including non-provider staff and members of the board. Patients are grateful when they receive these services, and staff becomes more sensitive to English speakers with literacy issues.

Summary of Planned Parenthood Mohawk Hudson Outcomes of the Assessment Process

- Introduction to CLAS Standards
- Distributed the assessment results to the leadership team of PPMH
- Materials translated to Bosnian
- World maps available for patients with limited literacy to identify countries of origin
- Hired additional Spanish and Thai native speakers
- Changed primary phone message and call routing options for Bosnian and Spanish callers
- Developed new relationships between the education team and staff at the Refugee Center
- Acquired a child spacing video that was developed for Somalis
- Carried out roundtable birth control methods teaching session
- Held staff trainings on how to use a medical interpreter and planned cultural competency sessions with Refugee Center
- Negotiated with local medical interpreter providers on how to create videotape resources that explain PPMH's services to Somalis who often prefer an oral or storytelling tradition
- Greater staff interest in being trained as medical interpreter rather than a 'pressed into service' medical interpreter
- Networking through conferences and conference calls resulting in greater knowledge
- Brought an immigrant woman who is a staff member of the Refugee Center onto PPMH's Board of Directors

Lessons Learned

- Gather native language statistics during phone and direct contact
- Contact refugee agencies for help in forecasting future needs
- Learn what will be the right fit for the population
- Set and reinforce the standards with staff
- Share the stories
- Structure forms so that minor updates won't leave you with badly outdated translations
- Be alert to the impression left by posters and art
- A provider's effort to be culturally competent receives a patient's gratitude
- Heightened staff awareness helps native English speakers who struggle with literacy

2.2 Planned Parenthood of New York City (PPNYC)

Background of PPNYC: Services and Population Served

Boro Hall is one of three Planned Parenthood centers located in New York City. In New York City, the immigrant population has increased by 40% in the past 10 years and now totals 3 million of the metropolitan area's 8 million inhabitants. Half of Boro Hall's 46,000 annual clients speak a language other than English at home. PPNYC participated in this assessment project to strengthen its capacity to serve clients from culturally diverse communities and to inform the expansion of PPNYC's clinical program initiatives for diverse communities.

The Cultural Competency Assessment Process: Priorities and Outcomes

The assessment process at PPNYC Boro Hall took place between August and October of 2005. Boro Hall achieved 100% staff participation in the August 2005 survey process as all 32 employees completed the questionnaire. As in the case of PPMH, FPA developed a report based on the surveys that offered recommendations on how to move forward systematically toward implementing each of the 14 CLAS standards. Upon receiving the recommendations, PPNYC formed two work groups and gathered suggestions for how to proceed based on the report.

PPNYC leadership decided to proceed with the recommendations by addressing the following CLAS standards:

- Standard #2 – Recruit, retain and promote diverse staff at all levels
- Standard #3 – Ensuring ongoing staff education
- Standard #4 – Providing language assistance services
- Standard #5 – Providing verbal and written notice of available language assistance services
- Standard #6 – Assure the competence of language assistance provided
- Standard #7 – Providing patient-related materials in the languages of commonly encountered groups
- Standard #10 – Ensure that data on race, ethnicity and language are collected
- Standard #11 – Maintain current demographic, cultural and epidemiological profile of community

The agency decided to use its mini-grant to implement the recommendations on two of the CLAS mandates by providing training for seven bilingual Spanish-speaking staff members in five day-long sessions. In order to participate, bilingual staff was screened with oral and written assessments of their language skills. Wilma Alvarado-Little, who led the training, explained that interpreter competence involves the ability to grasp and translate abstract concepts, convey circumlocutions and false starts, achieve fluidity in the interpreting process and create a mental picture of technical terms.

The Boro Hall Center also took additional steps to welcome immigrant populations in response to the assessment process, including several outreach initiatives such as the Medical Mobile Unit Community Outreach Initiative and the Bronx Immigrant Outreach for West African and Hispanic populations in the South Bronx.

To address CLAS standard #2, assuring that staff is representative of the ethnic groups served, Boro Hall is working on a Linguistic Competency Assessment developed for its Human Resources department to increase recruitment of bilingual staff. Work on standard #3, continuing cultural competency education, will involve the New York University School of Medicine's Center for Immigrant Health to provide this training at all three of Planned Parenthood's New York centers.

In addition to interpreter training, PPNYC contracted with Cyracom Transparent Language Services to respond to standard #4, provision of free interpreter services, thereby adding services in dozens of additional languages. PPNYC also purchased signage for the Brooklyn and Bronx centers in response to the recommendations on standard #7 on multilingual signage and materials. To cover the budget shortfall, PPNYC added to the \$3,500 mini-grant with additional funding from the City Council and shared the funding with its education and clinical services departments.

Ms. Santiago-Rivera echoed previous speakers in noting that demographic data only provides racial, not nationality or language-group, categories. The need to conform to Standard #10 on recording patient language and ethnicity data led the center to re-examine its patient intake forms and to decide on a manual registration form on place of origin and other relevant information.

The cultural competency project gave employees a chance to discuss the goals implied in the CLAS standards and emphasized the importance of providing front-line staff with opportunities for professional advancement in this area—a sharp contrast to the ad hoc interpreting services these employees are often called upon to provide.

Summary of Planned Parenthood New York City Outcomes of the Assessment Process

- Provided 40-hour medical interpreter training to 13 PPNYC bilingual staff
- Linguistic competency assessment to be developed for Human Resources Department to improve recruitment of Spanish bilingual staff
- Cultural competency training delivered by NYU Center for Immigrant Health, at NYU School of Medicine, to PPNYC staff
- All PPNYC Centers now offer Cyracom Transparent Language Services
- Follow-up to medical interpreter training series—using medical interpreter training for health center staff
- Multilingual signage in Boro Hall and Bronx Health Centers (English, Spanish and French)
- Refinement of PPNYC's patient manual registration form to capture data related to ethnicity and assessment of need for interpreter services

Lessons Learned

- The development of opportunities for all levels of staff to collectively discuss issues related to cultural and linguistic competency builds an environment of trust and confidence.
- When front-line staff are provided developmental opportunities to actively participate in change processes related to cultural and linguistic capacity building, rich ideas, potential strategies and solutions can emerge.
- Interdepartmental participation and collaboration is essential to the strategic planning and implementation of cultural and linguistic capacity building initiatives.

2.3. Community Healthcare Network (CHN)

Background on the Community Healthcare Network: Services and Population Served

Catherine Abate, president and CEO of CHN, began by explaining that CHN was created in 1981 to reach out to “underserved communities” with patient-centered care. The CABS Health Center, which was originally established in 1969, was selected to be the site for this cultural competency assessment project. CHN is comprised of eight health centers, a satellite clinic and two medical mobile vans. Nearly all staff (87%) speaks a language common in the community served. Forty percent of clients are uninsured. CABS serves a mostly black and Latino population in Williamsburg, Bushwick and Bedford-Stuyvesant with immigrants coming mostly from Puerto Rico, the Dominican Republic, Mexico and Ecuador, although 12% of clients are Asian. Most are low-income and have limited English proficiency. More than 3,000 patients speaking 14 languages were served last year at the site. Thirty percent of staff is bilingual in Spanish.

The Cultural Competency Assessment Process: Priorities and Outcomes

The cultural competency assessment process took place at CABS between February and April 2006. Thirty of the 33 staff (91%) took part in the survey. Staff indicated they did not feel confident talking about reproductive health concerns specific to different ethnic groups and expressed the need for further cultural competency training. CHN formed a cultural diversity committee which held their first meeting on May 2nd, and purchased phone interpreting equipment as well as signage. Use of a language bank was revived, and patient materials and forms were translated. The mini-grant provided by FPA will be used to conduct cultural competency training with staff tailored to each demographic.⁷

The agency’s planned future actions include periodic trainings, celebration of multi-ethnic holidays, partnering with other CBOs for resource sharing, and building up its bank of multi-lingual patient materials. One presenter commented that this was ‘only the beginning of long road ahead.’

⁷ CHN’s CABS Center was the last of the three assessment sites. As of this meeting on June 15, 2006, CABS had not yet started their mini-grant activities. Implementation of the activities is expected August-October 2006.

2.4. Question & Answer Period

For agencies contemplating but hesitant about performing an internal cultural competency assessment, presenters encouraged them to plunge forward. “Just do it,” said one. “It’s easy and will give you good information.” Even if the agency thinks it’s doing a good job, the assessment will provide new insights. One key to success is involving the whole staff from the beginning of the process.

One questioner suggested that services for the hearing-impaired should fall under the cultural competency banner, a feeling confirmed by others. Hospitals are already mandated to provide American Sign Language (ASL) services for the hearing-impaired, but the question is interesting in that it shows how cultural competency awareness pushes providers beyond the usual definitions of culture to question what constitutes good care. The issue is not just language but rather *communication* in the healthcare setting. As one commentator noted, the same principle could be applied to differences in age, sexual orientation, literacy, “or anything that historically has been left out or misunderstood.”

Are CLAS standards likely to become legal mandates? The four CLAS standards related to the provision of language services for patients are legal mandates, although there is little capacity for enforcement. The other ten are guidelines and recommendations. Some funders require grantees to abide by the CLAS standards. But the big stumbling block is funding: if the law requires these services, they have to be financed somehow. FPA is working with Voices for Change: Immigrant Women and State Policy of the University of Albany and New York University’s Center for Immigrant Health on a statewide conference to push for funding in this area. Significant resources will be required just to translate the many forms used by providers into the many different languages spoken by patients.

On the question of whether staff who receives training as interpreters should be compensated at a higher rate, presenters said the issue was still under review. Some suggested that interpretation skills may be a factor in new hires.

The use of children as interpreters in the healthcare setting is strongly discouraged, and there is steady reinforcement of this position from state authorities. The principle is based on the idea that minor children, whether or not they are relatives of the patient, are at a different cognitive and developmental stage from adults and should not be entrusted or burdened with that responsibility. When individuals resist having an interpreter who is not a member of their family some agencies use a form to record that the service was offered, but that the patient declined. Telephonic interpreting is sometimes a good solution in these situations.

Translation also involves the notion of “transcreation,” which emphasizes that the transmission of ideas and content is equally as important as the translation of words. For example, advertising often doesn’t work in direct translation because it is aimed at getting people to take an action or to change their minds. This requires a subtle understanding of the nuances involved.

A common concern is how to monitor telephonic interpreting services when staff members do not know the languages themselves. Participants with experiences encouraged agencies to adopt

a pro-active role as consumers of the product. “If you have questions, the language line service should be eager and willing to answer them,” said Wilma Alvarado-Little. Recommendations and references are important, and FPA is looking into some training exercises incorporating family planning issues for telephonic interpretation services, especially if several agencies employ the same service. In addition, there are some standard questions for evaluating a language service.⁸

3. Perspectives on Measuring Cultural and Linguistic Competency: Expert Commentators

Dr. Francesca Gany, director of the Center for Immigrant Health of NYU School of Medicine and a nationally recognized leader in the area of cultural and linguistic competence, moderated the final panel discussion. Panelists shared reflections on the cultural competency assessment process based on their experience and expertise in the field.

3.1 Panel

- Stergios T. Roussos, PhD, MPH, Adjunct Professor, San Diego State University School of Public Health;
- Ann Kenny, RN, BSN, MPH, Science Applications International Corporation;
- Wilma E. Waithe, RD, CDN, PhD, NYS Department of Minority Health

Dr. Roussos expressed admiration for the sophistication of the questions from the participants. He commented that the groups in attendance are ahead of most of their peers.

Organizational assessment occurs in no more than 1% of all institutions in the country, and even fewer think about cultural competency.
-Dr. Stergios Roussos

The assessment tool his team developed was meant to be used in a practical setting. Because the process was poorly funded, the team had to do things very simply and quickly. The result is that the survey can be completed in ten minutes and is very easy to understand.⁹

Dr. Roussos applauded the fact that in all the presentations the assessments were tied to the decision-making process within the organization. This connection should be formalized: the assessment tool has to be in the hands of the stakeholders.

A good rule of thumb is to ask whether the assessment results are jargon-free and concrete enough to be understood by clients.
-Dr. Stergios Roussos

⁸ See the Federal Interagency’s Working Group on Limited English Proficiency’s “On Choosing a Language Access Provider” at <http://lep.gov/leptatool.htm> and the National Council on Interpreting in Health Care’s “Linguistically Appropriate Access and Services: An Evaluation and Review for Healthcare Organizations” at <http://www.ncihc.org/workingpapers.htm>.

⁹ See Appendix F: Reflections on the Organizational Assessment of CLAS.

One weakness of the assessment results is the question of whether the self-reported information constitutes evidence. Is this the true situation or just the perception of the situation by those involved? The conversations must start with the stakeholders.

Dr. Waithe began her comments with an affirmation that the CLAS standards provide consistent definitions of cultural competency in health care and enable institutions to imagine and measure what culturally competent care might look like. Although the standards have existed for five years, the State Health Department has not shown organizations how to use them to measure their own progress. Other disciplines are further along in cultural competency such as the mental health field, which acknowledges and incorporates the importance of expanding cultural knowledge to meet unique needs.

Although the CLAS standards are unfunded mandates and guidelines, they provide a strategic point of departure. The presenting agencies are in a good position to craft an action agenda focusing on evaluation that could piggyback on most requests for proposals, and thereby get around the funding problem. Cultural competency must be put into a broader framework, suggested Dr. Waithe.

Meanwhile, the NYS Office of Mental Health, as part of its cultural competency plan, funds teaching hospitals through the Graduate Medical Incentive Pool to provide cultural competence training.

One weakness in this discussion is the lack of evidence showing the benefits of cultural competency, especially given the large number of potentially confounding variables that may be masking the link with outcomes or with cost savings. Dr. Waithe suggested that a possible approach is to link intermediate outcomes that contribute to health status in an “if-then” scenario:

- If CLAS standards are implemented, then communication improves.
- If communication improves, then adherence to medication and treatment protocols improves.
- If adherence improves, health outcomes improve.

Dr. Waithe also proposed testing interventions with a series of six questions:

- Did the intervention do what it was supposed to do? Did people get services?
- Did the intervention affect processes? Did comprehension and treatment negotiation improve?
- Did it improve utilization of services or access? Did people get appropriate tests and enter the right protocols?
- Did it affect satisfaction and health behavior?
- Did it affect health outcomes or affect behavior?
- Did it affect efficiency and cost-effectiveness of health delivery? Did it increase preventive care or facilitate early intervention that would reduce treatment costs?

Cultural competency improvements will not work if they are conceived as merely meeting external requirements with the least possible effort. Instead, it provides an opportunity “to look deeply into the soul of an organization, to expose its protected silences” and challenge assumptions that may be preventing quality care delivery for the entire population.

-Dr. Wilma Waithe

Ann Kenny said although many people have never heard of the CLAS standards, changing demographics all over the United States are presenting health systems with new challenges. Many state governments are aware of these problems and responding with legislation: New Jersey, California and Washington require cultural competency training for licensing doctors, and similar bills are pending in Illinois, Arizona, Ohio and New York. Medicaid and Medicare have training programs for doctors who bill them. Many other cultural competency programs also exist, and accrediting bodies such as the Joint Commission on Accreditation of Healthcare Organizations, American Medical Association, American Nurses Association, and American Academy of Family Physicians, pharmacist organizations, EMS teams, and osteopaths are endorsing cultural competency education.

The HHS Department’s Advisory Committee on Minority Health will be issuing new recommendations on how to evaluate cultural competency. The Civilian Health Services Division, SAIC (CHS) curriculum uses a classroom setting with practice interactions. Some people prefer the on-line format as they can read over materials and think about them, participate in discussions with other providers, and reflect on their own beliefs and attitudes. A wealth of new written materials is now available as well, including pamphlets, journal articles and handbooks. Feedback from the course has shown that cultural competency training can significantly influence providers.

Thinking about cultural competency makes providers stop and think before going in to see a patient and consider their own beliefs.

-Ann Kenny

The CHS curriculum is free and available online. It was launched in December 2004, and includes case studies and moderated peer-to-peer discussion threads.

Pharmacists also need the training. Kenny said her office gets a lot of feedback from pharmacists who are trying to serve diverse cultures and have a hard time explaining to people how to take their medication.

3.2 Discussion and questions

Discussants grappled with the issue of how to make busy providers receptive to improving cultural competency when they may perceive it as an additional burden, and whether they should be awarded additional compensation or Continuing Medical Education (CME) credits or other incentives. One suggestion was to place emphasis on the gains involved in improved patient understanding of the information they are being given, such as reduced return and emergency room visits and better adherence. Some malpractice insurers offer discounted rates for providers completing cultural competency training in recognition of these improvements in outcomes. If providers are involved in crafting training modules and contributing their own real-life vignettes, the experience may be more meaningful to them. Agencies may want to find an alternative to the term “cultural competency” itself to avoid resistance or pre-conceived notions of what it entails.

The assessment process may provide only a partial view of the situation in a given site because it utilizes staff views and opinions but not those of clients. According to Dr. Roussos, however, staff often will mirror the views of patients as they usually come from the same pool of residents and have relatives who seek care at the facility. Other data-gathering tools, such as focus groups with patients, also may be used. Community advisory bodies incorporating the cultures, religions, and age groups represented will help a clinic to keep its finger on the pulse of that community. The “secret shopper” approach, in which a researcher pretends to be a client seeking services, can also be used to evaluate performance.

4. Small Group Work: Identifying Support or Assistance Needed to Enhance Cultural and Linguistic Competence at the Organizational, Systems and Policy Levels

During the session, “Identifying Barriers and Strategies for Change,” participants were asked to address the following question in small groups:

What support or assistance is needed to enhance cultural and linguistic competence in the following areas?

- In my organizational or clinic setting
- At the systems level
- At the state and federal policy level

The results of this session from four groups were compiled and are summarized below.

In the organizational/clinic settings, participants suggested that cultural and linguistic competence could be enhanced through a wide range of actions, including: identifying the population served and hiring staff that represent the cultural backgrounds and views of the clients; evaluating the gender ratio of providers and issues that arise in that area; increasing time spent with clients; mandating basic and CME cultural competency trainings; securing commitment from senior management; collecting data in order to document the need for cultural competency and secure resources; offering differential pay; obtaining patients’ views regarding

competency and satisfaction; and involving community representatives in the organization's planning and quality improvement meetings.

At the systems level, participants believed that enhancement of cultural and linguistic competency could be accomplished by securing the commitment of the board as well as incorporating that commitment into the strategic vision of the organization. This commitment could further be carried out by integrating cultural and linguistic competency into orientations, job descriptions and evaluations. Additional proposals included conducting systems-wide assessments (including community assessments); providing formal training programs and incentives; developing tools to monitor and evaluate competence and the impact of training; implementing systems to collect patient racial/ethnic and language preference data; providing on-site interpretation services; supporting transcreation in translating documents; and producing and providing culturally and linguistically appropriate materials to patients.

At state and federal policy levels, participants stressed the need for legislation that would mandate and reimburse for interpreter services in health care. They also highlighted the importance of transforming institutions by standardizing training and licensing in cultural competency for students, physicians, nurses, medical interpreters and anyone else involved in health care. Additional suggestions included offering scholarships; providing standardized web-based tools for easy access; supporting more initiatives like the Ed Fund's assessments and mini-grants through the provision of resources and funding; and collecting and analyzing data at the national and state levels to assess need. One group emphasized the broader issue of immigrants' rights and how related policies can help or hinder the quest for cultural and linguistic competence.

5. Wrap Up: Evaluations and Where Do We Go From Here?

Hearing about the experiences of the clinics that piloted the assessments was a great way to start thinking about what cultural competency would and could mean for my agency.

-Conference Participant

Participants generally expressed appreciation for the opportunity to hear detailed reports from agencies that had completed the internal assessment and implemented practical steps to improve their performance in cultural competency, including training and hiring interpretation services. They also found the step-by-step presentation of the CLAS guidelines helpful, as well as an explanation of the importance of cultural competency for service quality. Finally, several participants mentioned learning of new resources and connecting with other groups and individuals engaged in cultural competency work.

This is an amazing project with tangible outcomes—how can we take this to other places?

-Conference Participant

Not surprisingly, many participants wondered how to take the next steps and whether FPA's project would continue. If it does not, at least in its present form, questions were asked on where organizations can go to obtain the human and material resources needed to do assessments and training. The most commonly reported needs were: help with assessment, training and bilingual materials as well as performance appraisal measures. Some commented that their agencies were at such an early stage in understanding cultural competency that they did not know how to begin.

Other participants wrote that they perceived cultural competency as part of larger political issues including immigration and immigrants' access to health care and wondered how these would be addressed, including the role of alliances with immigrant groups. Many also mentioned the subjective aspects of improving cultural competency and how to assess and address the sensitive issues that arise in this area as people's core values are challenged by people with very different social practices, including some that seem to be "at odds with public health goals." Several others mentioned the need to incorporate these perspectives in provider training at an earlier stage so that professionals enter their fields with a basic working knowledge of cultural and linguistic competency that agencies can build on in future trainings.

When we talk about reproductive health, it is our body...it is our temple, and we all have our ways of protecting that temple, and that has to be considered, and respected. *-Ladan Alomar*

Overall, the participants provided very positive feedback regarding the meeting and pinpointed several areas for future discussion around the development of cultural and linguistic competency in health care.¹⁰ As a small token of our appreciation to all the participants, handmade butterfly pins made by the women of the Rari zone of Chile were distributed to each participant at the end of the meeting. The butterflies, which are dyed and woven from horses' manes, were meant to symbolize a poignant quote by Stephanie Marshall that says:

Adding wings to caterpillars does not create butterflies...it creates awkward and dysfunctional caterpillars. Butterflies are created through transformation.

In other words, cultural competency cannot be an isolated process; it must be integrated into the individual, organizational and systems levels in order to be successful. We hope that the butterflies will act as an inspirational reminder to all the participants that cultural competency is an ongoing process that requires time and dedication.

¹⁰ See Appendix B: Evaluation Summary.

Acknowledgements

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Appendices

Appendix A: Meeting Agenda

Registration	9:30 am
Opening	10:00 am
Welcome JoAnn M. Smith, President/CEO, Family Planning Advocates of NYS (FPA)	10:10 am
Why Culture Matters in Health Care Hetty Cunningham, MD, Assistant Clinical Professor of Pediatrics, Charles B. Rangel Community Health Center, Columbia Presbyterian Medical Center	10:20 am
How Do You Assess Cultural Competency?: Practical Tools for Action -Karen Anderson, MPH, MEd, Director of Public Policy, FPA -Sang Hee Won, Program Associate, FPA	10:40 am
Lessons from the Field: A Work in Progress <i>Moderated by: Dinah Surh, MPH, Vice President, The Brooklyn Hospital</i> -Planned Parenthood Mohawk Hudson, Utica Center -Planned Parenthood New York City, Boro Hall Center -Community Healthcare Network, CABS Center	11:00 am
Discussion	11:45 am
LUNCH (<i>provided</i>)	12:15 pm
Perspectives on Measuring Cultural and Linguistic Competency <i>Moderated by: Francesca Gany, MD, MS, Director, Center for Immigrant Health, NYU School of Medicine</i> -Ann Kenny, RN, BSN, MPH, Science Applications International Corporation -Steve Roussos, PhD, MPH, San Diego State University and AKOUO -Wilma E. Waithe, RD, CDN, PhD, NYS Department of Minority Health	1:00 pm
Discussion	1:45 pm
Identifying Barriers and Strategies for Change	2:15 pm
Wrap-Up: Where Do We Go From Here?	2:45 pm

With generous support from the Ford Foundation

Appendix B: Evaluation Summary

1. Participants and Responses:

Number of participants: 71

Number of responses: 39

2. Content *(Figures below show number of responses for each category):*

	Excellent	Very Good	Good	Average	Poor
Overall Meeting	9	18	2	0	0
Why Culture Matters in Health Care	11	19	6	2	0
How do you Assess Cultural Competency?	6	25	5	1	0
Lessons from the Field	16	18	3	1	0
Perspectives on Measuring Cultural and Linguistic Competency	6	21	8	1	0
Identifying Barriers and Strategies for Change	5	12	7	2	0

3. Themes:

Most useful aspects of the meeting

- “Lessons from the Field” and hearing about the assessment sites’ experiences
- “Perspectives on Measuring Cultural and Linguistic Competency”
- Overview of CLAS standards
- Question and answer sessions
- “Why Culture Matters in Health Care”
- “How do you Assess Cultural Competency?” and learning about assessment tools
- How current bilingual staff can become medically trained interpreters
- Learning about telephonic language interpretation services
- Realizing that translator does not equal interpreter
- Transcreation
- Small group session
- Networking and sharing of information

Ways to improve the meeting

- More small group work and time for discussion
- More structure for the break out sessions
- More time to problem solve around challenges and propose next steps
- Spend more time on the evaluation/assessment tools
- More information on FPA’s project and how organizations can participate
- Discuss funding issues and specific costs
- Discuss the broader social and political realities

- A discussion of how to address cultural and linguistic competency in health care provider training (residencies, etc.)
- Would like to see translators and interpreters at work and the challenges they face

Areas to explore in future meetings

- How to bring cultural competency and training back to the affiliate/organization
- Demonstrating actual training activities and curricula
- A “baby steps workshop” to motivate organizations still in a “pre cultural competency setting”
- How to design and fund cultural and linguistic competency services
- How to evaluate efforts
- Language assessment of bilingual staff
- Addressing attitudes and values of staff and patients and how they affect cultural competence
- Group and culture-specific information (LGBTQ, migrant workers, Native Americans, etc.)
- How culture relates to social, political, and economic realities
- Differences among cultures regarding views of family planning
- The current political climate’s effect on the provision of culturally and linguistically competent services

Additional comments and suggestions

- The meeting was helpful and brought up important issues
- More specific information on costs and funding is necessary
- We need to recognize that “cultural competency is sometimes at odds with public health goals” when certain cultures embrace values that are not necessarily shared by the public health community (i.e. valuing men over women).
- We must all be aware “that we each come to the cultural competency “table” with a set of values/experience” and we must ensure “that we are not projecting those onto others.”

Needed resources and services

- 13 respondents would like assistance with cultural competency training, for both medical and front line staff, that addresses a wide variety of topics
- 8 would like to explore medical or other bilingual interpreter training
- 10 requested translated materials related to many healthcare topics, for both educational and administrative purposes
- 11 desired assistance with organizational assessment of cultural and linguistic competency
- Other needs include funding and a way to build a “compelling story about cultural competency for staff/board/donors”

Appendix C: Featured Speakers & Moderators

Wilma Alvarado-Little, MA

Ms. Alvarado-Little is a Program Manager and Focus Group Leader at the University at Albany's Center for the Elimination of Minority Health Disparities. A medical interpreter and trainer with over 20 years of experience in the health care field, she is the co-chair of the Board for the National Council on Interpreting in Health Care and serves on the Board of Directors for the Chicago Area Interpreter Referral Service. Along with having been an ESL instructor, she has many years of experience counseling Spanish-speaking families on the financial aspects of medical care. She was the manager of Interpreter Services at Children's Memorial Hospital in Chicago, where she established the interpreter program and worked closely with the Chicago Health Outreach Immigrant and Refugee Health Task Force. Ms. Alvarado-Little provides education to health care institutions on the implementation of hospital and community-based interpreter programs and the role of the medical interpreter as well as interpreter services for Spanish/English-English/Spanish, and has media experience in presenting information to the public on the importance of the role and participation of a trained medical interpreter.

Hetty Cunningham, MD

Dr. Cunningham is Assistant Clinical Professor in Pediatrics at Columbia University and Attending Physician at Morgan Stanley Children's Hospital of New York-Presbyterian. For the past seven years, her primary interest has been the development and implementation of cultural competency curricula for medical students and residents at Columbia. She is a member of the Columbia Center for the Health of Urban Minorities and New York-Presbyterian Hospital's Limited English Proficiency Steering Committee. As a member of the General Pediatrics faculty, she sees patients and teaches residents in a community-based practice in Harlem. Dr. Cunningham is a graduate of the University of Pennsylvania School of Medicine and completed her pediatric residency at the Children's Hospital of Philadelphia in 1996.

Francesca Gany, MS, MD

Dr. Gany is the founder and Director of the Center for Immigrant Health, and a member of the faculty of the New York University School of Medicine. She has extensive background in immigrant health research, curriculum development, education, and program and policy development. She has published and lectured widely on immigrant health issues, has facilitated the dissemination of model projects nationally, and has served as the Principal Investigator on a number of pioneering immigrant health projects. As a Robert Wood Johnson Faculty Scholar, Dr. Gany conducted a study that led to the development of long-term policy and programmatic changes in tuberculosis screening for immigrants. She developed the NCI/NIH-funded Cancer Awareness Network for Immigrant and Minority Populations. Dr. Gany has done much to enhance the provision of culturally competent services in medical practice, including research into current and best practices on culturally competent health care delivery, knowledge-garnering efforts on cultural beliefs and practices and their impact on health-seeking behavior and decision-making, development of a comprehensive cultural competence curriculum, cultural competence trainings for health care and other institutions, and review, and analysis, of evaluation tools used to assess cultural competence. Dr. Gany spearheaded a medical interpreter project entitled, *Access Through Medical Interpreter and Language Services*, which led to the

development of a medical interpreter screening and assessment tool, the implementation of a number of training curricula, and the revolutionary Remote-Simultaneous Medical Interpretation System.

Ann Kenny, RN, BSN, MPH

Ms. Kenny is an Assistant Vice President at Science Applications International Corporation and also serves as a Program Manager and the Director at the Center for Communication, Outreach, and Training Support Services, Civilian Health Systems. She is the Project Director for the Department of Health and Human Services (DHHS), Office of Minority Health project, Implement, Maintain and Evaluate Interactive Online and DVD Continuing Medical Education Programs in Cultural Competency for physicians, nurses, and other health care provider populations. Ms. Kenny manages the training and support services contract that provides cultural competency education and outreach for the Centers for Medicare and Medicaid Services' Quality Improvement Organizations. She is a retired military officer and has served as a member of the faculty at the Military Medical Department Center and School at Fort Sam Houston, Texas and has served as a visiting professor at George Mason University, the University of Maryland, and the University of Texas Health Sciences Center in San Antonio. Ms. Kenny has extensive experience in implementing and managing a diverse range of public health programs at community and national levels.

Stergios T. Roussos, PhD, MPH

Dr. Roussos is a researcher and educator for community health and health care initiatives, specializing in behavior change at the community and organizational levels. His current work aims to understand and improve how health and human services organizations contribute toward eliminating health disparities, especially among persons with limited English proficiency. Current research includes interventions to improve service delivery for persons with limited English proficiency, and the development of measures to assess individual and organizational cultural and linguistic competencies. Areas of expertise include the evaluation design and support of community health initiatives and networks, and the design and research of programs and interventions targeting behavioral change, especially at a system or community-level. His research is based out of San Diego State University, where he also serves as Adjunct Professor at the Graduate School of Public Health, and the Alliance for Community Research and Development, a private research firm. Dr. Roussos works with scientists and practitioners from various disciplines to provide research and evaluation services, training, and educational activities to organizations throughout the world.

Dinah Surh, MPH

Ms. Surh is the Vice President of Ambulatory Care Services at The Brooklyn Hospital. Previously Senior Vice President/Administrator of Lutheran Family Health Centers in Brooklyn, NY, she has over 23 years of direct senior ambulatory care management experience in large hospital-based and community-oriented primary care networks. Ms. Surh has a passion and commitment to increasing access for the medically underserved and uninsured, improving quality care, and reducing ethnic health disparities. She was key in the development of cultural competence initiatives throughout Lutheran Family Health Centers including facility design, signage, creating patient relations representative and navigator roles, instituting staff training, utilizing new technologies, and monitoring quality activities. She is President and past Treasurer

of the Board of Directors of the New York Association for Ambulatory Care, serves as a Board Member/Vice Chair of the Public Policy Committee of the Community Healthcare Association of NYS, and was formerly on the Board of Directors of the Public Health Association of NYC. Ms. Surh is a member of the DHHS National Center for Cultural Competence Advisory Committee and of the Brooklyn Borough President's Women's Health Task Force and Health Advisory Committee, and formerly served on the DHHS Cultural and Linguistic Appropriate Services (CLAS) Standards National Advisory Committee.

Wilma E. Waithe, RD, CDN, PhD

Dr. Waithe directs the Office of Minority Health in the New York State Department of Health (OMH). Serving in a variety of leadership positions in both nutrition and general public health, she has made a number of important contributions to the department and to communities across the state. Dr. Waithe received her PhD in Curriculum Design and Instruction, specializing in Qualitative Research and Program Evaluation, from the State University of New York at Albany. Although issues of cultural competency, sensitivity, awareness, humility, and cross-cultural communication have always been part of her work in community and public health, they have become more pronounced during her tenure with the OMH. Working to address minority health concerns in the state has meant focusing on the national goal of eliminating health disparities. As governmental agencies, communities, and health care providers seek to design and implement interventions in pursuit of this goal, cultural competency has emerged as an important part of solutions being offered. Consequently, the OMH has been playing a role in building awareness and understanding of the national standards for providing culturally and linguistically appropriate services.

Clinic Assessment Sites

Planned Parenthood Mohawk Hudson, Inc.

The mission of Planned Parenthood Mohawk Hudson (PPMH) is to empower every individual to make responsible and informed decisions about sexual and reproductive behavior. Formed through a merger of Planned Parenthood Association of the Mohawk Valley and Planned Parenthood Health Services of Northern New York in 2000, PPMH is comprised of 12 health centers that serve the counties of Essex, Fulton, Hamilton, Herkimer, Madison, Montgomery, Oneida, Saratoga, Schenectady, Schoharie, Warren and Washington. With administrative offices located in Utica and Schenectady, PPMH serves both rural and urban communities with diverse populations. In Utica, many of the patients served by PPMH are refugees who speak a wide variety of different languages. Because of the steadfast commitment of staff, volunteers, and donors, PPMH was able to serve 23,140 patients and provide 47,658 family planning visits last year.

- **Margaret Roberts, Co-President/CEO**

Ms. Roberts has worked for the Planned Parenthood organization for 20 years. In her current position, she oversees an organization that provides reproductive healthcare, education, advocacy, WIC, and Rape Crisis programs. She has twice been awarded Woman of the Year honors by the YWCA of the Mohawk Valley, has been named to Who's Who Among Outstanding Business Executives, and has also been the recipient of the "Annie Oakley Award for Bravery" presented by Planned Parenthood Association of

the Mohawk Valley. She has served on the boards of many organizations including the Adolescent Pregnancy Prevention Partnership, Herkimer County HealthNet, Mohawk Valley Perinatal Network, Family Planning Advocates of New York State, and the national Planned Parenthood Chief Executives Council.

- **Cheryl Lincoln-Lovely, Flow Coordinator**

Ms. Lincoln-Lovely has worked for Planned Parenthood for eight years, first with Planned Parenthood of the Southern Finger Lake's Ithaca Center and then with Planned Parenthood Mohawk Hudson's Herkimer and Utica Centers. She has worked in a variety of roles while at PPMH including support service positions at reception, Family Planning Specialist, Educator within the Community Based Adolescent Pregnancy Prevention program, and Clinic Nurse. Since April of 2005, Cheryl has held the position of Flow Coordinator in the Utica clinic while also pursuing her degree as a registered nurse.

Planned Parenthood of New York City, Boro Hall Center

Planned Parenthood of New York City (PPNYC) works to empower individuals to make independent, informed decisions about their sexual and reproductive lives, to provide information and health care, and to promote public policies that make those services available to all. With roots dating back to Margaret Sanger's pioneering work in the early 1900s, PPNYC now offers a wide variety of services that help to accomplish its mission. In 2005, PPNYC's health centers served more than 46,000 women, men, and adolescents throughout New York City. With health centers in Manhattan, Brooklyn and the Bronx, PPNYC serves patients from NYC's burgeoning population of foreign-born immigrants. PPNYC's Boro Hall Center, located in Brooklyn, serves a diverse population, with close to 50% of the community speaking a language other than English at home.

- **Nellie Santiago-Rivera, Center Director**

Ms. Santiago-Rivera has served as Director of the Boro Hall Center since 2000 and has over ten years of experience in healthcare management, serving as Clinic Coordinator and later as Operations Director at Settlement Health. At PPNYC, she has developed and implemented an efficient patient process that resulted in an increase in annual visits, organized a planning committee to develop community advisory boards at each center, successfully developed three community advisory boards, participated in the preparation of the Title X grant reapplication and NYSDOH audit review, and created an environment at each center that fosters a positive team approach. Ms. Santiago-Rivera is a member of several health care management committees, including serving as Chairperson of PPNYC Community Advisory Boards.

Community Healthcare Network, CABS Health Center

The Community Healthcare Network (CHN) is a not-for-profit health care organization that provides comprehensive medical care and social services to underserved New Yorkers. The network's services encompass primary and preventive care, reproductive services, pre- and post-natal care, pediatric care, dental services, social services, comprehensive HIV care including treatment adherence and one of the largest case management programs in New York State, mental healthcare under an Article 31 license, teen pregnancy prevention programs, and nutritional counseling. CHN serves more than 60,000 individuals a year who would otherwise

have little or no access to critical health care. CHN operates health centers and offices in the boroughs of Bronx, Brooklyn, Manhattan and Queens, as well as two medical mobile units. The CABS Health Center has served the Bushwick and Williamsburg communities of Brooklyn since 1969 and has the mission to provide 100% access to primary health services with 0% disparities in those communities.

- **Catherine Abate, President & CEO**

Ms. Abate has served as President and CEO of CHN for the past seven years, and also has extensive work experience in New York's political and governmental arena. She began her career as an attorney and worked at the Legal Aid Society for 13 years. She has served as a New York State Senator, Executive Deputy Commissioner of the NYS Division of Human Rights, Chair of the NYS Crime Victims Board, and Commissioner of both the New York City Departments of Correction and Probation. She is currently Chair of the Board of Directors for Family Planning Advocates of NYS. At CHN, Ms. Abate leads a network of nine health centers and two mobile health units, which is affiliated with the New York Presbyterian Healthcare System

- **Martha Febuz, Assistant Vice President for Clinical Operations**

Ms. Febuz has been with CHN for the past 13 years. As Assistant Vice President for Clinical Operations since February 2005, she oversees the network's clinic operations, working closely with center directors and office managers. Her previous experience at CHN includes HIV Counselor, Office Manager and Center Director.

- **Rosemary Gomez, Office Manager**

The bulk of Ms. Gomez' experience has been at New York City Tech, where she worked in Human Resources from 1997-2001 before she joined CHN in January 2005 as Office Manager. Her responsibilities include managing patient flow, referrals, overseeing financial screenings, center event planning, and technology management.

Appendix D: Participant List

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Appendix E: National Standards for Culturally and Linguistically Appropriate Services in Health Care (CLAS)

CLAS Standards: The collective set of CLAS mandates, guidelines, and recommendations issued by the Health and Human Services' Office of Minority Health intended to inform, guide, and facilitate required and recommended practices related to culturally and linguistically appropriate health services.

Culturally Competent Care (GUIDELINES)

Standard 1. Health care organizations should ensure that patients/consumers receive from all staff members effective, understandable, and respectful care that is provided in a manner compatible with their cultural health beliefs and practices and preferred language.

Standard 2. Health care organizations should implement strategies to recruit, retain, and promote at all levels of the organization a diverse staff and leadership that are representative of the demographic characteristics of the service area.

Standard 3. Health care organizations should ensure that staff at all levels and across all disciplines receive ongoing education and training in culturally and linguistically appropriate service delivery.

Language Access Services (MANDATES)

Standard 4. Health care organizations must offer and provide language assistance services, including bilingual staff and interpreter services, at no cost to each patient/consumer with limited English proficiency at all points of contact, in a timely manner during all hours of operation.

Standard 5. Health care organizations must provide to patients/consumers in their preferred language both verbal offers and written notices informing them of their right to receive language assistance services.

Standard 6. Health care organizations must assure the competence of language assistance provided to limited English proficient patients/consumers by interpreters and bilingual staff. Family and friends should not be used to provide interpretation services (except on request by the patient/consumer).

Standard 7. Health care organizations must make available easily understood patient-related materials and post signage in the languages of the commonly encountered groups and/or groups represented in the service area.

Organizational Support for Cultural Competence (GUIDELINES)

Standard 8. Health care organizations should develop, implement, and promote a written strategic plan that outlines clear goals, policies, operational plans, and management accountability/oversight mechanisms to provide culturally and linguistically appropriate services.

Standard 9. Health care organizations should conduct initial and ongoing 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 outcomes.

Standard 10. Health care organizations should ensure that data on the individual patient's/consumer's race, ethnicity, and spoken and written language are collected in health records, integrated into the organization's management information systems, and periodically updated.

Standard 11. Health care organizations should maintain a current demographic, cultural, and epidemiological profile of the community as well as a needs assessment to accurately plan for and implement services that respond to cultural and linguistic characteristics of the service area.

Standard 12. Health care organizations should develop participatory, collaborative partnerships with communities and utilize a variety of formal and informal mechanisms to facilitate community and patient/consumer involvement in designing and implementing CLAS-related activities.

Standard 13. Health care organizations should ensure that conflict and grievance resolution processes are culturally and linguistically sensitive and capable of identifying, preventing, and resolving cross-cultural conflicts or complaints by patients/consumers.

Standard 14. Health care organizations are encouraged to regularly make available to the public information about their progress and successful innovations in implementing the CLAS standards and to provide public notice in their communities about the availability of this information. **(RECOMMENDATION)**

Appendix F: Reflections on the Organizational Assessment of Culturally and Linguistically Appropriate Services (CLAS)

By Stergios Roussos, PhD, MPH – Community Scientist

Since 2003, an interdisciplinary team of practitioners, researchers, educators, researchers, and community advocates has been developing, implementing and refining a method to assess organizational cultural competency. Three aims guide our work to understand and improve organizational assessment of CLAS:

- 1) To assess organizational-level understanding and application of the *National Standards on CLAS*.
- 2) To engage participation among all organizational stakeholders to voice their concerns and recommendations for how to better address disparities in health services and patient outcomes.
- 3) To create a method of assessment that is sensitive to time, financial, staffing, skill, and resource limitations that prevent many organizations from ongoing measurement of their CLAS performance.

This organizational assessment approach is based on the principles of consumer empowerment and education. Staff and patients are involved in the assessment’s development, implementation, and interpretation of results. The method borrows and adapts assessment techniques used in community psychology, behavior modification, and social marketing. This means that the emphasis is on measuring behaviors, conditions that influence behavior, and broader environmental conditions that influence CLAS. At the heart of this approach is a survey based on the National CLAS Standards. The survey design uses staff input to provide a view of an organization’s understanding, environment, and support for CLAS.

Along with the survey, an observational “check list” of CLAS practices, policies,

Illustration of the Concerns Survey of Organizational Assessment of CLAS		
PLEASE RATE THIS ITEM.	A) Importance of item for how I serve patients	B) My satisfaction with my skill for this item.
	LOW <----- > HIGH	LOW <----- > HIGH
I know how to identify when a patient needs a medical interpreter. <i>Comments:</i>	1 2 3 4 5	1 2 3 4 5

programs, and resources is used to verify the existence of items assessed in the survey and items that can best be assessed through direct observation. These findings are followed up with interviews with key informants within and outside of the organization to help clarify the meaning of the survey and observational results.

The cumulative results are presented and discussed in meetings including organizational staff and community stakeholders to interpret their meaning, draw conclusions, and outline recommendations to improve CLAS and address disparities in health services and patient outcomes.

Some Lessons & Recommendations for Conducting Organizational Assessment of CLAS

- Organizational assessment of CLAS is most useful when it is designed to address specific decisions required to improve quality of care.
- The appropriateness and validity of organizational assessment tools are strongly influenced by the degree to which the organization’s key stakeholders (administration, staff, clients) participate in assessment creation and implementation.

“Today with a myriad of instruments we can explore things we never imagined. But we no longer see directly what is right in front of us.”

- Thomas Merton, *Conjectures*, 1966

- Decisions about what to assess should be guided by what organizational stakeholders will accept as “evidence” (e.g., What quantitative and qualitative data counts? What matters? Why?)

- The *National Standards on CLAS* offer a comprehensive and widely accepted framework to guide assessment, but specific measures based on

these Standards require precise and clear definitions of terms.

- CLAS assessment of should be careful to address cultural factors beyond ethnicity (e.g., religion/faith, sexual orientation, gender, disabilities) and linguistic factors beyond verbal ability (e.g., literacy, ASL).
- The validity of organizational assessments of CLAS should ultimately be judged by changes in health services and patient outcomes.

Resources

National Standards on Culturally and Linguistically Appropriate Services (CLAS)

<http://omhrc.gov/templates/browse.aspx?lvl=2&lvlID=15>

Overview of Multicultural and Culturally Competent Program Evaluation: Issues, Challenges & Opportunities

<http://www.calendow.org/evaluation/reports.stm>

Organizational Assessment of CLAS, June 2006, S. Roussos, steve@akouo.org, 209-723-4399, www.ACRD.us