Assessing the Connecticut Multicultural Health Partnership's (CMHP) Progress in Strategic Planning and Implementation of the CLAS Standards

Report

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ABSTRACT

This report summarizes the key findings from the CMHP CLAS Standards Strategic Planning Survey, which was administered to members of the Connecticut Multicultural Health Partnership in the summer of 2011. The National Standards for Culturally and Linguistically Appropriate Services (CLAS Standards) were developed by the U.S. Department of Health and Human Services, Office of Minority Health to increase access to health care, increase acceptability of health care services, improve the quality of care and ensure services are equitably available. The Connecticut Multicultural Health Partnership aims to increase awareness and practice of the CLAS Standards in health care and social services throughout the state. CMHP members include senior management, direct service and administrative/support staff working at hospitals, community health centers, government agencies, universities, CBOs, foundations, advocacy organizations, consulting agencies, as well as other individuals concerned with eliminating racial and ethnic health disparities. The CMHP CLAS Standards survey was designed to assess the CHMP membership's perspectives on progress in strategic planning and implementation of the CLAS Standards at their organizations.

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INTRODUCTION

A. Background

The Connecticut Multicultural Health Partnership (CMHP) is a consortium of public and private partners whose purpose is to address health disparities and multicultural health issues in Connecticut by integrating the National Standards for Culturally and Linguistically Appropriate Services in Health Care (CLAS) developed by the Office of Minority Health[1]. The Partnership was launched by the Connecticut Department of Public Health (DPH), Office of Multicultural Health in July 2008 through funding from the U.S. Department of Health & Human Services, Office of Minority Health. The United Nations Commission on Economic, Cultural and Social Rights 2000 includes in its definition of human rights that everyone has *the right to the highest attainable standard of health*, through accessibility, acceptability, quality and availability of health care. The CLAS Standards were developed to increase access to health care, increase acceptability of health care services, improve the quality of care delivered and ensure services are equitably available.

CMHP members belong to a broad range of agencies--from large-scale government agencies and hospitals with over 200 staff, to small nonprofits and consulting firms with less than ten staff. The Partnership also includes members from other health care organizations, community-based organizations, university research centers, advocacy organizations, schools, language interpreter services, foundations, and consulting agencies.

B. Objectives

The CMHP Data & Evaluation Committee is charged with assessing the Partnership's progress in achieving its mission. Through conducting a baseline assessment of CMHP members, the Committee aims to identify targeted areas for future activities that will assist and prepare members to proficiently implement the CLAS Standards in the delivery of care and

[1] http://www.nhmamd.org/pdf/CLASfinalreport.pdf

services. The Committee also aims to identify and promote best practices and highlight organizations that are making strides in eliminating health disparities and/or increasing access to quality health care for everyone.

The Committee developed the CMHP CLAS Standards Strategic Planning Survey[2] as a baseline evaluation instrument to:

1. Assess member awareness and knowledge of the CLAS Standards.
2. Assess content of strategic plans pertaining to the CLAS Standards.
3. Assess progress in implementing strategic plans pertaining to the CLAS Standards.
4. Assess policies and procedures designed to eliminate access and utilization barriers.

The design of this survey was based on the premise that Standard 8 is the most important standard because it is an essential step for assigning accountability to the CLAS Standards.

> ***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.***
> ***CLAS Standard 8***

To assess how well members rate their organizations in addressing cultural and language issues related to health disparities, five broad conceptual areas were identified as follows:

1. Strategic planning process
2. Providing culturally competent care
3. Providing language access services
4. Systems and procedures in place to provide these services
5. Barriers to implementation.

Multiple response items define each conceptual area, the majority of which were adapted directly from the CLAS Standards.

[2] The CMHP CLAS Standards Strategic Planning Survey is copyrighted and funding is being sought to conduct reliability and validating testing of the instrument.

C. Methods

The CMHP CLAS Standards Strategic Planning Survey was administered anonymously (in paper form) during the Partnership's annual meeting (N=63) in mid-June 2011 and administered online (via SurveyMonkey.com) to additional members not present at the meeting (N=53) during the following six weeks via several emails sent to the entire membership. Of the 252 Partnership members, 106 initiated taking the survey, with 95 completing the survey.

Since this evaluation was intended primarily to report on progress regarding the CLAS Standards for service providers, we chose to focus our analysis on those respondents who reported that their agency either provides health care services or provides other direct services (e.g. case management, prevention, housing assistance etc.) to patients/clients. Of the 106 members who initiated our survey, 75 (71%) reported working for agencies that provide health care and/or other direct services.

D. Overview of Report

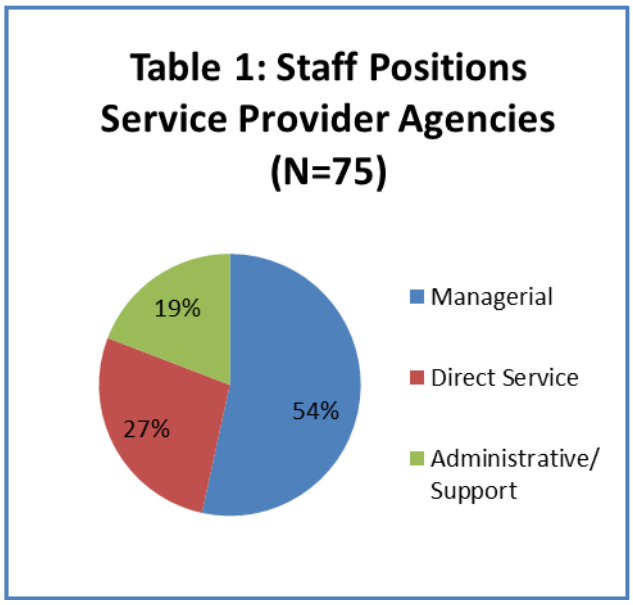
Following this introduction, the Survey Results are presented in five parts, *with a discussion section at the end of each section*. Part One provides general information about CMHP members and the agencies where they work. This section also provides information on the catchment areas, defined by county, served by these member agencies. Part Two provides information on members' ratings of their personal knowledge of the CLAS Standards, knowledge of the strategic plan, and policies and procedures at their agencies. It includes an analysis of whether or not members in different types of organizational positions reported different levels of knowledge. Part Three provides member assessments of their agencies' plans to implement each of the recommended CLAS Standards (with the exception of Standard 14) and of how much progress members think their agency is making in carrying out its plans. Part Four shows member rankings of various barriers to implementation of the strategic plans. Part Five provides a summary of some of the other steps agencies are taking to eliminate racial and ethnic health disparities and related recommendations of our members. A summary discussion of the findings and the Data and Evaluation Committee recommendations for the Partnership members and leadership based on these findings conclude this report.

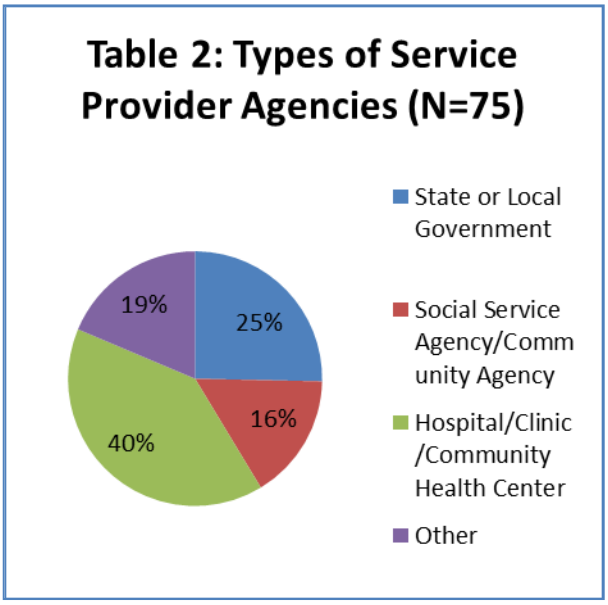
SURVEY RESULTS

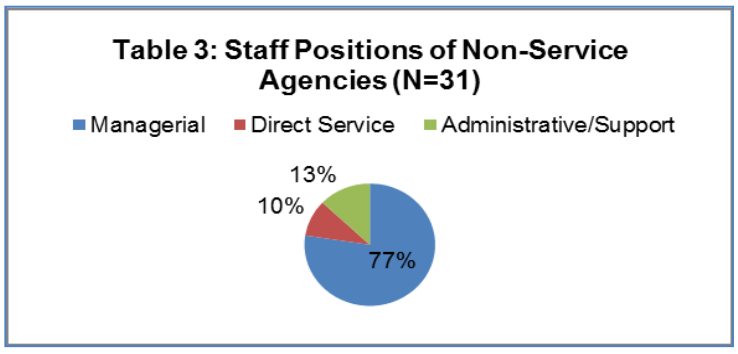
Part One: Demographic Information of Members & Agencies

A. Staff Positions and Types of Agencies

The majority of survey respondents who reported working at agencies that provide direct services were in managerial-level positions (54%). Almost one-third were in direct service positions (27%) and the others were in administrative/support positions (19%). The breakdown of types of service agencies that were represented by survey respondents included hospitals, clinics and community health centers (40%), state or local government (25%), and social service/community agencies (16%). Additionally, 19% belonged to other types of agencies such as higher education, insurance/payer, public school system, quality assurance agency, consulting, and advocacy.

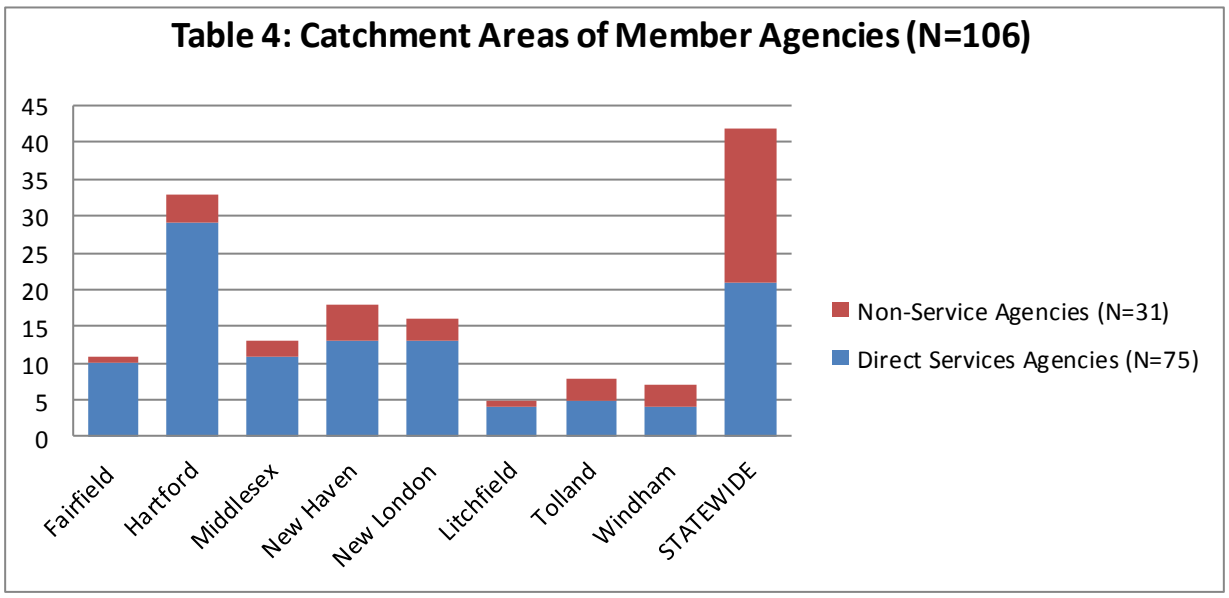






B. Catchment Area and Region Types

CMHP members work at agencies that serve one or more counties in CT. We asked each member to select their agency's service area at the county level. Each member could select multiple counties, and also had the option of selecting statewide (representing all the counties). The highest number of members reported that their agency served Hartford County or provided services statewide. After Hartford, the most representation was for members whose agencies served New Haven, New London, Middlesex and Fairfield Counties, in decending order. The more rural counties of Litchfield, Tolland and Windham were not as well represented by our survey respondants. The majority of members said that their agency served urban (91%) and/or suburban areas (61.3%), with 45.3% reporting that their agency served rural areas.



C. Discussion Demographic Findings

Managers and upper-level administrators generally have the flexibility to participate in coalitions and attend meetings outside the office, which may account for the higher percentage of managerial staff represented in CMHP membership. At the same time, direct service providers and administrative/support staff generally have the least flexibility in self-scheduling with the demands of patient care, running an office and needing staff coverage to participate in other activities. However, direct service and administrative/support staff likely have the most contact with patients and clients and are in key organizational positions to advance or hinder the provision of culturally and linguistically competent care.

The fact that the majority of survey respondents work at agencies that serve Hartford County is consistent with the location of the majority of CMHP members, many of whom work at the Department of Public Health and other state agencies. Hartford County is the state capital region and also where the monthly CMHP meetings are held. It also may be more difficult for health and social service employees in rural areas to take on additional responsibilities with agencies usually being smaller and having fewer resources and/or in being able to leave the worksite and participate in coalition and committee meetings because travel time is greater.[3] It is therefore not surprising that fewer survey respondents represent Litchfield, Tolland and Windham Counties.

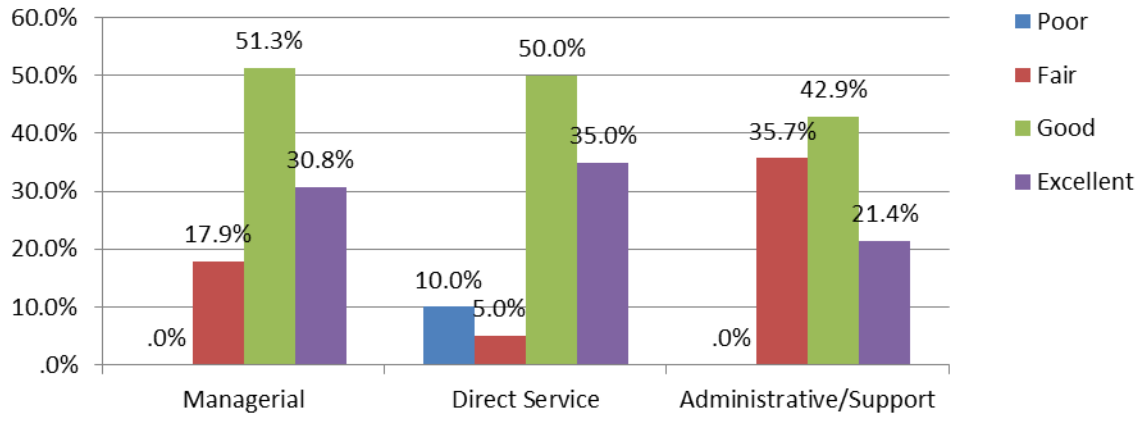
[3] Though there are always electronic meeting options, it has been difficult for the Partnership to engage and maintain engagement without face-to-face participation.

Part Two: Knowledge of The CLAS Standards, Strategic Plan, and Policies & Procedures

A. Self-Report Knowledge of CLAS Standards

Of the members who work at agencies providing direct services, the majority rated their knowledge of the CLAS Standards as good or excellent. This was true whether or not the member was in a managerial, direct service, or administrative/support position. Statistically, there was no significant difference in the mean CLAS standard knowledge scores across the three groups. However, 10% of direct service staff reported having poor knowledge of the CLAS Standards. Also, 35.7% of administrative/support staff and 17.9% of managerial staff reported only having fair knowledge of the CLAS Standards.

Table 5: Self-Report Knowledge of CLAS Standards (N=72)

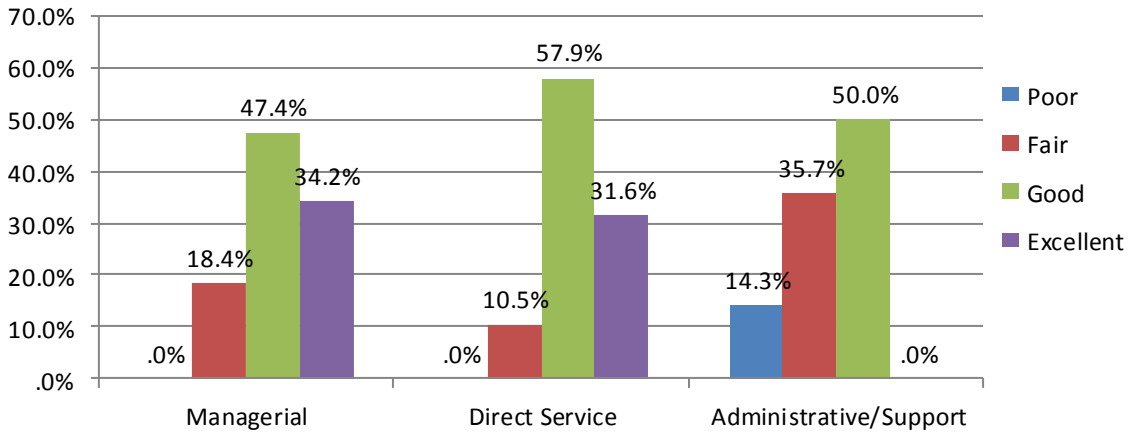


No significant difference in knowledge in the CLAS Standards between members in the three different staff positions was identified using a one-way ANOVA test (for table with means see appendix C).

B. Self-Report Knowledge of Strategic Plan

Managerial, direct service, and administrative/support staff reported different levels of knowledge of their agency's strategic plan. Administrative/support staff reported significantly poorer knowledge when compared with both managerial and direct service staff, with none reporting excellent, 50% reporting good, 35.7% reporting fair, and 14.3% reporting poor. Since staff members did not necessarily belong to the same agencies, one should be cautious in interpreting these findings.

Table 6: Self-Report Knowledge of Strategic Plan
(N=71)

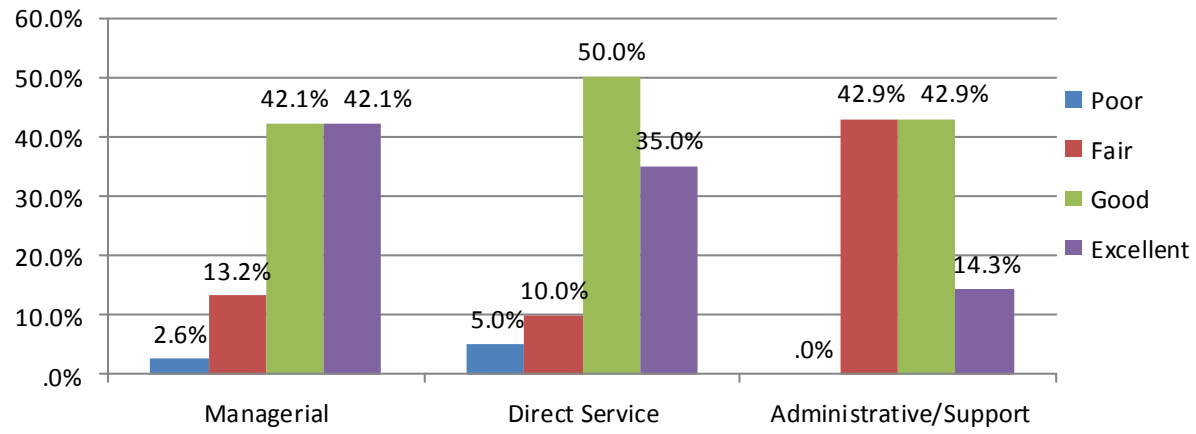


A highly significant difference in members' reported knowledge of their agency's strategic plan by their staff position (p=.001, F=7.69, df=2) is indicated by the one-way ANOVA test at 0.05 level of significance. Administrative/support staff report significantly lower knowledge of their agency's strategic plan as compared with both the managerial staff (p=.001) and direct service staff (p=.001) according to the post hoc Least Squares Difference (LSD) test. It is important to note that most of the staff surveyed belonged to different agencies (for table with means see Appendix C).

C. Self-Report Knowledge of Policies and Procedures

Regarding knowledge of their agency's policies and procedures towards eliminating health disparities, individuals in all three staff positions reported similar levels of knowledge as measured by their mean score. However, relatively few administrative/support staff reported excellent knowledge and far more reported fair knowledge. A contradictory finding was that a very small percentage of managers and direct service staff reported poor knowledge, as compared with none of the administrative/support staff.

Table 7: Self-Report Knowledge of Policies and Procedures (N=73)



No significant difference in members' knowledge of their agency's policies and procedures toward eliminating health disparities by their position as staff is indicated by the one-way ANOVA test (for table with means see Appendix C).

D. Discussion of Self-Report Knowledge Findings

The relatively high level of knowledge of CLAS Standards reported by CMHP members indicates the effectiveness of the Partnership's activities in promoting awareness of the CLAS Standards. According to the CMHP Program Director, virtually no one was familiar with these Standards when the Partnership began in 2008 when a show of hands was asked during the first several Executive Committee meetings. It may be that those few staff members who reported poor or fair knowledge of the Standards are less engaged in the Partnership and have had limited exposure to the CLAS Standards within their agencies. Although we had a relatively good response rate (38%) to the survey, a limitation of these findings is that they may not be representative of our entire membership due to selection bias in the sampling of members; those who chose to complete the survey may have been more actively engaged and committed to the mission of CMHP and also more knowledgeable of the CLAS Standards than those who did not complete the survey.

The fact that administrative/support staff report significantly poorer knowledge of their agency's strategic plan may reflect their exclusion from the strategic planning process and poor communication across all staff levels of the agency's strategic plan. Since administrative and support staff in health care settings are likely to also represent populations experiencing disparities in accessing and receiving health care, their low levels of knowledge of their agency's strategic plan pertaining to racial and ethnic health disparities is of significant concern.

Part Three: Rating Plans and Processes for Implementing the CLAS Standards

A. Strategic Planning Process

We asked our members to rate their agency's strategic planning process as it pertains to the CLAS Standards, as well as how much progress their agency was making in implementing its plans. The response options for each of the following items were:

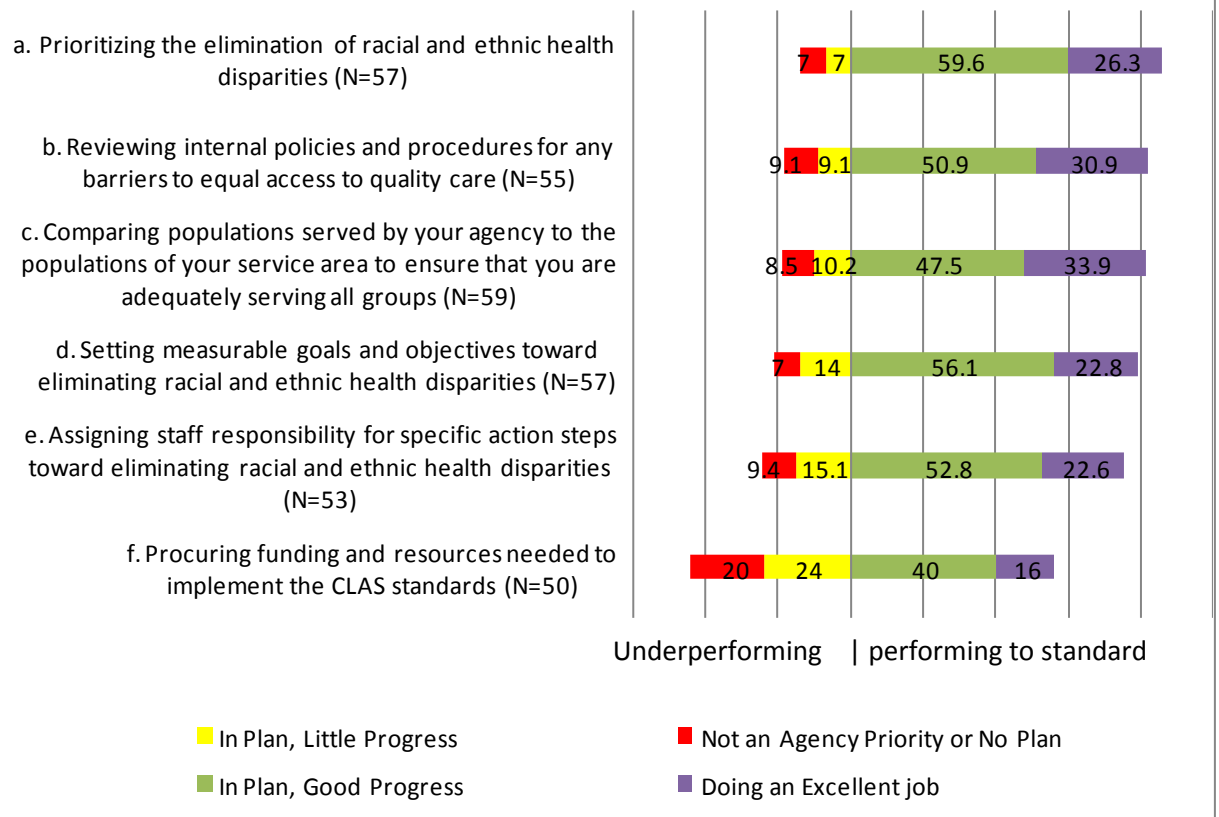
1. Not in Plan, or Not an Agency Priority
2. In Plan, Making Little Progress
3. In Plan, Good Progress
4. Doing an Excellent Job
5. Don't Know
6. Not Applicable

In interpreting the results, we classed the first two response items into the 'underperforming' category coded as a score of 1 or 2, respectively, and the latter two responses into the 'performing to standard' category, coded as a score of 3 or 4 respectively. 'Don't know' and 'Not Applicable' were not computed within the mean score.

FIGURE 1 - Strategic Plan Components

The items for which over 20% percent of members reported that their agencies were underperforming were: 1) *Procuring funding and resources needed to implement the CLAS Standards,* with 44% reporting their agency was not performing well; and 2) *Assigning staff responsibility for specific action steps toward eliminating racial and ethnic health disparities,* with almost 25% reporting poor performance in this area

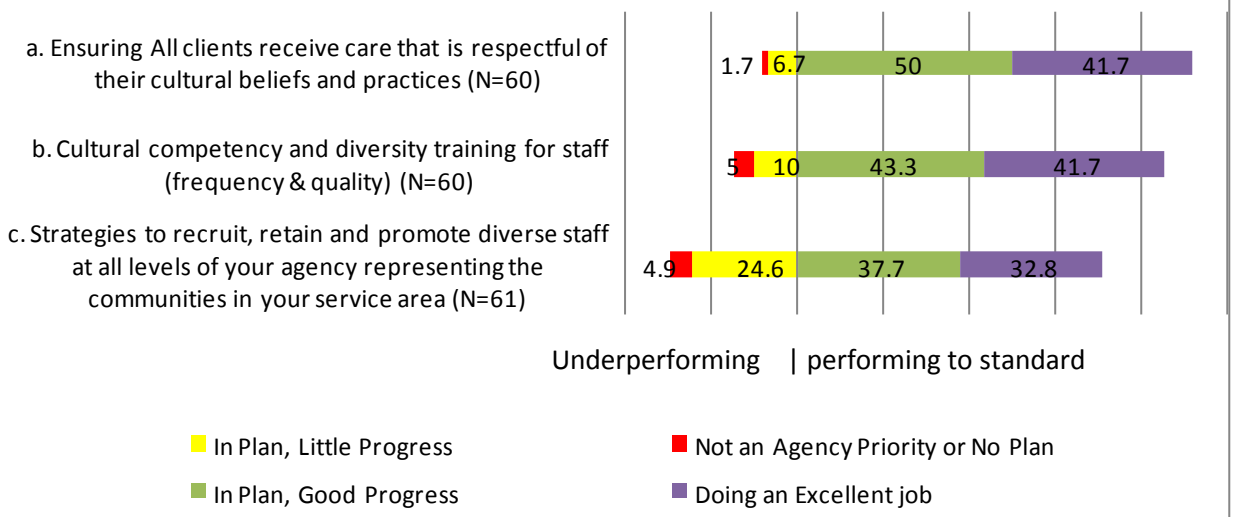
Table 8: Strategic Planning Process
(valid %)



B. Provision of Culturally Competent Care

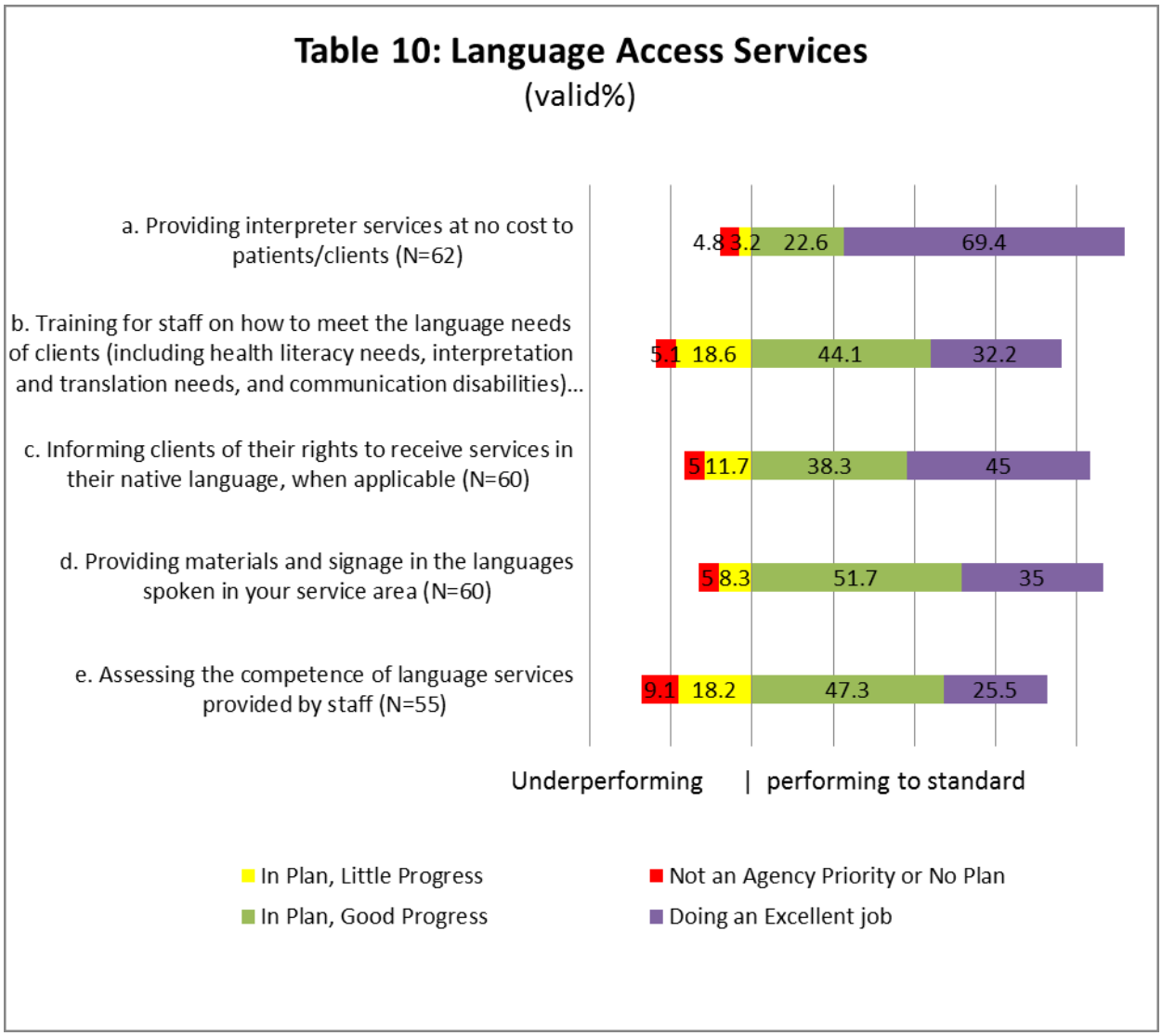
The provision of culturally competent care was indicated by three items in the CLAS Standards to include: a. Ensuring all clients receive care that is respectful of their cultural beliefs and practices, b. Cultural competency and diversity training for staff and c. Strategies to recruit, retain and promote diverse staff representing the communities in your service area. Item c. was the weakest area, with 30% reporting that their agency was underperforming.

Table 9: Provision of Culturally Competent Care
(valid %)



C. Language Access Services

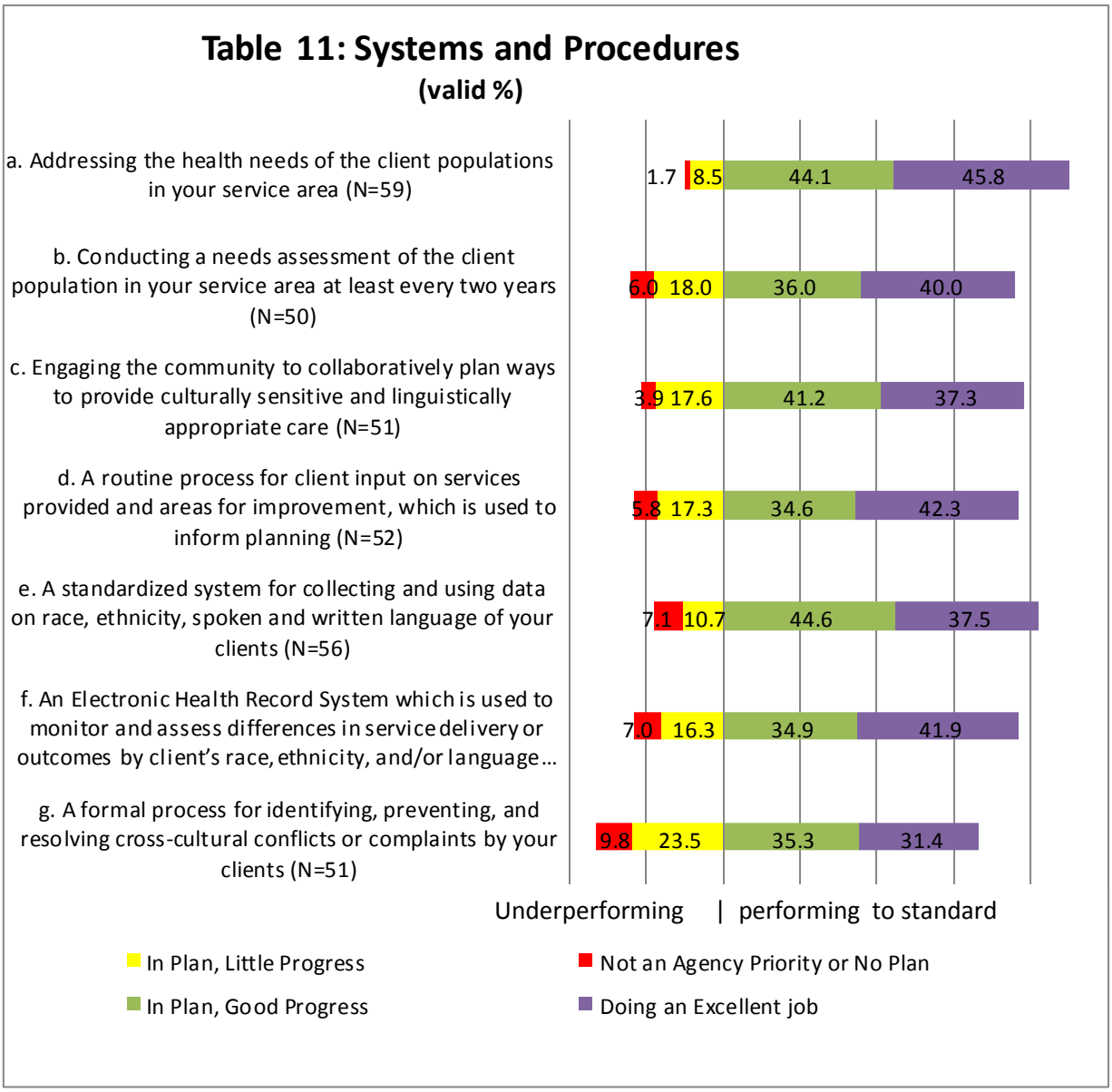
Members next rated the provision of language access services at their agency. Each of the following items is federally mandated, yet still a fair number of members reported that their agencies were underperforming. The lowest performing area was: *Assessing the competence of language services provided by staff*. Over 27% rated their agency as underperforming in this area. Another area for improvement was: *Training staff on how to meet the language needs of clients*, for which 24% of members reported their agency was underperforming. This item specified that the training should cover health literacy needs, interpretation and translation needs, and communication disabilities.



D. Systems and Procedures

Members were asked to rate the systems and procedures at their agency having to do with implementing the CLAS Standards. The area most in need of improvement was *having a formal process for identifying, preventing and resolving cross-cultural conflicts or complaints by clients*. Over 33% reported that their agency was underperforming in this area. Three other areas in which over 20% rated their agency poorly were: 1) Conducting a needs assessment of client population every two years; 2) Engaging the community collaboratively in plans to provide culturally and linguistically competent care; and 3) Using EHR to monitor and assess differences in service delivery or outcomes by client's race, ethnicity and/or language.

Table 11: Systems and Procedures
(valid %)



E. Discussion of Ratings

The majority of the CMHP membership who responded to this survey are aware of health disparities and knowledgeable of the acceptable standards of practice to eliminate them. Their agencies have begun taking steps to eliminate racial and ethnic health disparities by including the CLAS Standards in strategic plans and are making efforts to ensure that non-English speaking clients from diverse cultural backgrounds are receiving language interpreter services when needed. The training and monitoring of staff providing interpreter services could be improved for a sizeable percentage of member agencies, including some hospitals and community health centers. Further analysis of these findings indicate that those agencies reporting the lowest overall scores on the provision of language access services are social service agencies.

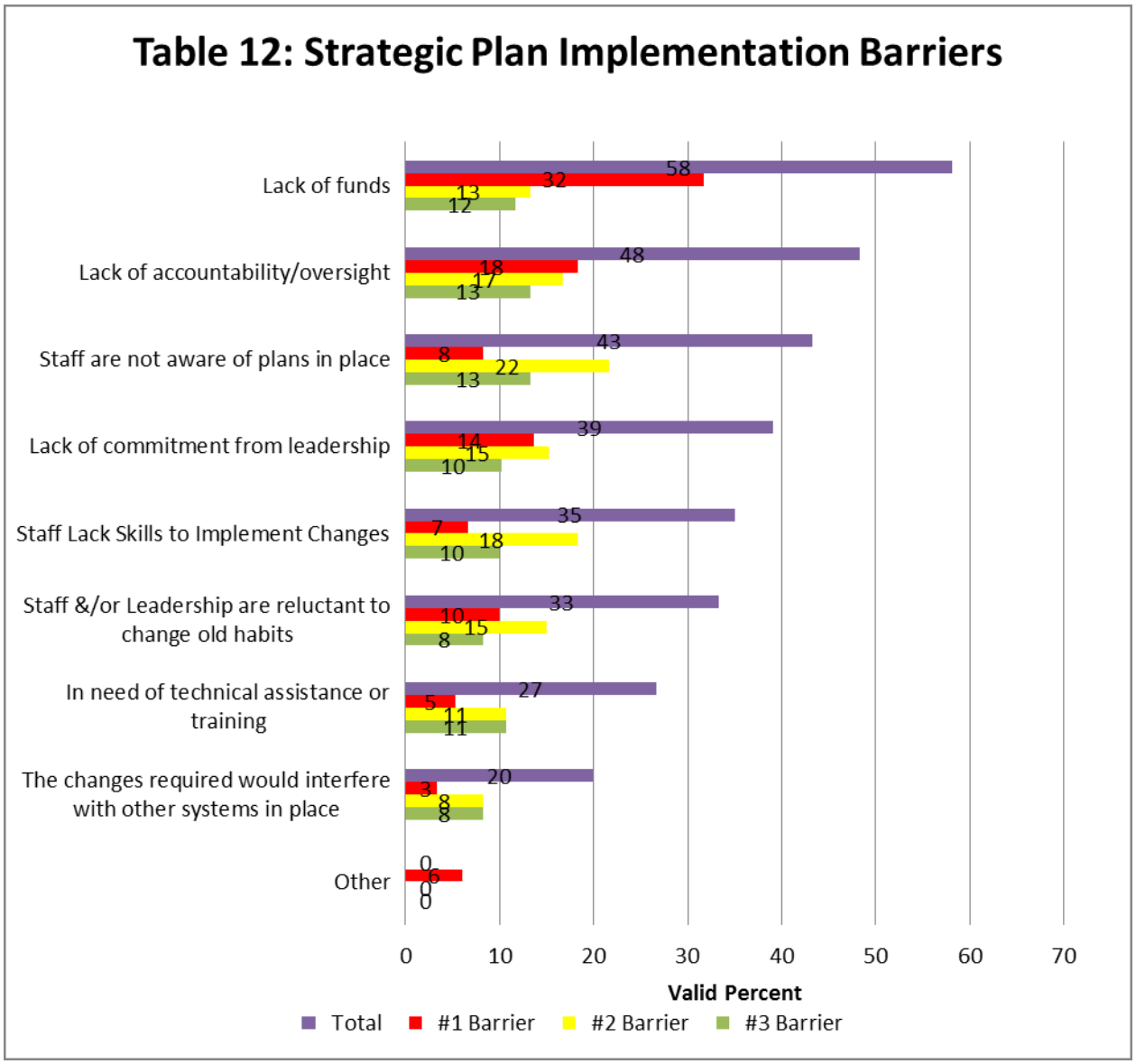
Most of our members reported that their agencies are either doing a good job or consistently doing an excellent job in meeting the health needs of their patients/clients. Yet, needs assessments of their client populations could be conducted more regularly according to approximately 24% of survey respondents. Systems and procedures to actively gather input from the community regarding the quality of services delivered and the cultural and linguistic competency of staff were generally rated as good, however over 20% of respondents reported that their agency was underperforming in these areas.

The fact that some of our members work at agencies that do not have fully functioning electronic health record systems (EHR) is expected given that these systems are intended primarily for health care providers. There is currently an initiative underway to improve the electronic exchange of information between social service, public health and health care providers across state agencies through establishing a CT Health Information Network and other similar initiatives. Thus, in the near future we may expect to see increased adoption of EHR for agencies represented by our membership.

In sum, the findings regarding the areas most in need of improvement to reduce health care disparities pertain to establishing ongoing systems, processes and policies to ensure accountability to the communities being served and to ensure that the highest quality of linguistically and culturally competent care is being delivered.

Part Four: Strategic Plan Implementation Barriers

We asked our members to identify the biggest barriers to implementing plans at their agencies. *Lack of funds* was by far the biggest barrier reported by our members. It ranked highest overall, being listed as one of the greatest barriers by 58%, and ranked as the #1 barrier for 32% of members. The second most frequently selected barrier was *lack of accountability/oversight*, which was listed by 48% of our members and ranked #1 for 18% of our members. The third most frequently mentioned barrier was that *staff are not aware of plans in place*, which was selected by 43% of our members, and ranked #1 for 8% of members and #2 for 22% of members.



A. Discussion of Barriers

These ratings of barriers are consistent with the ratings of the weakest areas in strategic planning and implementing the CLAS Standards on previous items. In rating the strategic planning process (Table 8), for example, 20% had stated that procuring funds and resources to implement the CLAS Standards was not an agency priority or not in the agency's strategic plan and 24% stated that it was in the plan, but that little progress had been made. Previously, also we noted that a sizeable percentage of members rated their agency low with regard to the training of staff and assessing the quality of language translation services provided (Table 10), both of which are actions that would improve accountability and oversight. The barrier having to do with staff not being aware of the plans in place relates to the previous finding (Table 6) that administrative/support staff report lower knowledge of the strategic plan when compared with managerial and direct service staff.

Part Five: Summary of Open-Ended Comments

We asked our members: "What other goals and/or actions has your agency taken to eliminate health disparities? (e.g. addressing the availability, accessibility, quality, and acceptability of care for the underserved groups in your community)?" We also asked them if they had any other general comments, to which some members provided other recommendations for addressing racial and ethnic health disparities. These open-ended responses are summarized below, organized into different stages of implementing the CLAS Standards.

For some agencies an important step they are taking is to create plans to qualify and train bi-lingual employees as interpreters and to include the elimination of racial and ethnic disparities in their workforce as well as patient care in their strategic plan.

Agencies slightly further along in implementing the CLAS Standards are already regularly implementing language interpreter, cultural competency and other trainings around multicultural patient-centered care. Those with the resources and/or higher commitment to delivering trainings have policies making completion of cultural competency trainings on an annual basis *mandatory* for staff, or have created a specific position to coordinate agency, network and regional trainings and initiatives.

Member agencies demonstrating a strong commitment to ensuring accountability have taken significant steps at the organizational level to create staff positions charged with managing and/or coordinating agency activities to eliminate racial and ethnic disparities, such as establishing a Director of Multi-Cultural Affairs, who solely concentrates on the cultural needs of clients, or establishing a Patient Care & Family Education Coordinator. Another approach that was mentioned is to establish a Cultural Diversity Council.

In order to promote a more diverse workforce, some agencies are training high school and college students early in their educational careers to work in medically underserved communities. In order to be more accountable to the diverse populations they serve and overcome barriers that relate to health disparities, agencies are also collaborating with community groups for cultural consultation and referrals, or partnering with the NAACP Health Committee to work toward eliminating health disparities.

Several of our members commented that that they would like to see improvements in engaging patients and community members at their agency. Recommendations for improvements include: 1. create community advisory bodies; 2. Increase involvement with grassroots consumer advocacy organizations; 3. Strengthen the collaboration between health care providers and community leaders; 4. Collaborate with ethnic specific organizations in the community for cultural consultation and referrals.

A. Discussion of Open-Ended Comments

For agencies providing language interpreter services onsite, it is unclear what criteria are used for qualifying interpreters (e.g. completion of training, a proficiency exam, or national certification). From the comments, it appears that agencies could be doing more to reach out directly to their patients/clients/community members to inform their efforts in providing culturally and linguistically competent care.

CONCLUSION & RECOMMENDATIONS

A. Discussion Summary

The CMHP is committed to advocating, educating and supporting health and social service agencies in implementing the CLAS Standards. To achieve this mission, the Executive Committee aims to ensure that members are knowledgeable of the Standards and participate within their agencies to incorporate them as best practices of care. Initially when the Partnership started, educating members on the CLAS Standards was the top priority, and the first two annual meetings were dedicated to this task. The results of this survey represent the first formal assessment of our membership's knowledge of the Standards and their agencies' activities to meet the Standards.

Overall, survey respondents were representative of the membership at large, with the majority of respondents working as managers in health care organizations located in Hartford County. They are likely well positioned to influence their agencies' strategic plans and to develop culturally and linguistically responsive policies and procedures. The findings from this survey revealed that administrative/support staff are the least familiar with the strategic plans and thus greater attention should be given to involving them in strategic planning and/or keeping them informed of the plans.

Our findings suggest that agency leadership already give importance to the elimination of health care disparities in mission and in meeting mandated CLAS Standards requirements. Most agencies are also taking population data into consideration in assessing the health care needs of their clients. However, they are less likely to set measurable goals to implement the Standards recommendations more fully. Financial resources are rated as the greatest barrier to providing culturally and linguistically competent services in this and other surveys conducted in the state.[4] Weaknesses were also identified in assigning accountability to ensure access and ongoing quality in the provision of culturally and linguistically competent care, as well as in methods of handling cross-cultural conflicts. In other words, there appears to be a discrepancy between the mission set by leadership of eliminating health disparities and the allocation of human and financial resources toward meeting these goals. There are ways to meet the CLAS Standards that do not necessarily require up-front expenditure, including many examples provided by the Office of Minority Health. These solutions, however, do require staff training, planning, commitment and the allocation of time. Despite these barriers and weaknesses, approximately 90% of respondents reported that their agency is making good progress or consistently

[4] CT AHEC. 2004 Language Access Services

doing a good job when it comes to addressing the health needs of client populations in their service area (Table 11).

In utilizing the theory of change[5] that underscores Motivational Interviewing[6], it can be said that CMHP members are ready for action. Initially, Partnership leadership determined that many members were unfamiliar with the CLAS Standards ('Pre-Contemplation Stage,' outside awareness). Their goal was to move members toward greater awareness and understanding of the importance of the CLAS Standards ('Contemplation Stage'). Currently, members could be considered to be in the Determination Stage, generally having good knowledge and understanding of CLAS Standards as they pertain to their agencies' policies and procedures (or the lack of policies and procedures). The 'Action Stage' is for our diverse membership to take concrete actions within their agencies to assist in developing more robust strategic plans that contain measurable goals and objectives; assign levels of accountability; and allocate funds or set goals to procure the necessary resources towards more fully implementing the CLAS Standards. Future activities to support these efforts should also include evaluating outcomes and institutionalizing best practices, leading to the ('Maintenance Stage'), which also involves ensuring policies and procedures are being consistently communicated to staff and patients/clients (preventing relapse or the inconsistency with applying new policies and procedures).

One limitation is that there may have been some selection bias in those who chose to respond to the survey. Also, the survey measures members' *perceptions* of how well their agencies are implementing the CLAS standards, and social desirability bias may impact their responses. We tried to reduce bias by having the respondents remain anonymous and by giving them the option to select 'don't know.' Lastly, respondents were mostly from different agencies, so it is problematic to draw definitive conclusions regarding the differences across staff positions.

Despite these limitations, CMHP members who responded have identified gaps in strategic planning and in policies and procedures that could be addressed to help advance the CLAS Standards and work toward the larger goal of eliminating health care disparities. This is just the first step in a longer process. Next steps include: to develop new policies pertaining to stronger adherence to the CLAS Standards, to communicate the policies to staff through training, to institute new documentation procedures, and to follow up with evaluation to ensure the policies are used correctly and consistently, and that they are having the intended impact on patient health or system outcomes. These next steps require a long standing commitment.

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[5] Prochaska, J. O. and DiClemente, C. C. The Transtheoretical Approach: Crossing Traditional Boundaries of Therapy. Homewood IL. 1984

[6] This model was selected because it is considered a best practice in cross-cultural health care service delivery.

B. Recommendations for the CMHP Members

The CMHP aims to position its leadership and its members to serve as strong advocates for best-practices in the implementation of the CLAS standards into health care and social service strategic plans across the state. To further our mission we recommend that:

1. Members with the time and commitment to the Partnership's mission can join and become more actively involved in CMHP committees and help recruit others to join the Partnership.
2. Members can make use of available expertise and resources in the Partnership to organize and promote trainings at their agencies in best-practices for implementing the CLAS standards including: strategic planning, fundraising, the formation of community partnerships and advisory committees, and the certification and assessment of the cultural and linguistic competency of their staff.
3. The Partnership members and leadership can play a leading role in advocating for statewide legislative policies that 1) not only will support, but also will reward, health care and social service agencies that practice the CLAS Standards; 2) will help recruit, retain, and promote a diverse workforce in health care in Connecticut at all levels of employment; 3) will address social determinants impacting racial and ethnic disparities in access to care, health literacy, quality of care and health outcomes.

C. Recommendations for CMHP Leadership (including Officers, Members-At-Large, Committee Chairs, and Committee Members).

The following strategic goals are recommended for the CMHP leadership to help address some of the identified gaps and challenges our members are reporting in their own knowledge and involvement in strategic planning at their agencies and in working with others at their agencies to more fully implement the CLAS Standards.

<u>Recommendations for Membership Committee:</u>

1. Recruit and engage new members to increase geographic representation across the state.
2. Engage a broader range of employee involvement to include all levels ranging from administrative/support staff to senior leadership, and governance.

<u>Recommendation for Awareness and Outreach Committee</u>:

3. Integrate the CLAS Standards into awareness and outreach presentations as best practices and a foundation for the (new) Joint Commission Standards, the Patient-Centered Medical Home and healthcare reform strategies.

Recommendation for Consumer Initiatives Committee:

4. Recruit and prepare community members to be more informed of their rights to culturally and linguistically competent care, and to engage them in Partnership activities as representatives of populations who are impacted by health care disparities.
5. Encourage community groups and health care agencies to initiate partnerships and joint advisory committees charged with ensuring greater accountability in the provision of culturally and linguistically appropriate services to the community.

Recommendations for Professional Development Committee:

6. Promote workforce development that recruits and retains a diverse staff, at all levels of an agency, and that are representative of populations served.
7. Promote the development of strategic plans that assign responsibility for continuous quality improvements based on data and input from community members to better and more fully implement the CLAS Standards and achieve the broader goal of eliminating health disparities.

Recommendations for Language Access Services Committee:

8. Improve statewide utilization of CLAS Standard trainings and certification programs to improve patient-provider communication to provide health education materials inclusive of health literacy needs, interpretation and translation needs, and communication disabilities.

Recommendation for Data & Evaluation Committee:

9. Reassess membership knowledge and implementation of the CLAS Standards in the summer of 2013 for a comparative analysis of CMHP progress.

APPENDICES

Appendix A: Handling of Missing Data

A total of 106 surveys were returned representing a 43% response rate. Data from the surveys were entered online and then transferred into SPSS 19 for analysis. Of the total, 10.4% (N=11) had over 50% of items without responses, resulting in a lower response rate of 38% for many items. These surveys were subsequently dropped from the analysis on an item by item basis. It was hypothesized that since the individuals with missing data were completing the surveys online, that likely the missing responses were random. Most individuals stopped at the point where they were asked specific questions about the CLAS Standards, therefore we concluded they may have stopped filling in responses since they had already completed the paper version of the survey at our annual meeting. Time limitations at their job may have been another factor.

The results reported here are mostly descriptive and report the valid % per item. Response categories for the CLAS Standards items included the response option of Don't Know and Not Applicable. For the purposes of the analyses involving mean scores in this report, these were also classified as missing data.

Appendix B: Survey Open-Ended Response Items and Comments

We had several open-ended response items at the end of our survey. Below are the responses we received to the question: "What other goals and/or actions has your agency taken to eliminate health disparities? (e.g. addressing the availability, accessibility, quality, and acceptability of care for the underserved groups in your community)?" We also asked for any other general comments, for which some members provided specific recommendations for improvement.

Some things our members are doing:

- I am trying to understand the culture and problems of under-served groups
- I became a member of the Medicaid Advisory Council
- I joined CMHP, ditto

Some things our members and their organizations are doing:

Leadership Support

- Multicultural Committee mission to eliminate health disparities in statement.
- Agency support of staff to participate on community committees, health disparity forums, support of trainings offered on social determinants of health.
- Hired a Coordinator to address disparities in member organizations.
- Appointment of the position of Director of Multi-Cultural Affairs which solely concentrates on the cultural needs of the client.
- Creation of specific position to coordinate agency, network and regional trainings and initiatives.
- Established a Cultural Diversity Council that addresses health disparities.
- Eliminate health disparities among workforce as well as patients is in our strategic plan.
- Development of position of Patient Care (?) & Family Education Coordinator.
- Held a leadership retreat with a 100% focus on cultural competence.
- Identified new designated area of the hospital's (administration to?) focus on health policy & health disparity.
- Creating plans to qualify and train bi-lingual employees as interpreters.

Staff Training & Support

- Annual mandatory cultural competency training.
- Various trainings throughout the year to strengthen and encourage staff to be more informative & committed to their clients.
- Pilot site for Kellogg-funded health equity demonstration grant.
- Training staff as medical interpreters.

Collaboration

- Training high school and college students early in their educational careers to work in medically under-served communities.
- Provide workforce training for those that come from under-represented backgrounds in health care.
- Developing community based advocacy group in collaboration with local agencies.
- Collaborate with ethnic specific organizations in community for cultural consultation and referrals.
- Partner with the NAACP Health Committee to address health disparities.

Member Association Support

- Support member hospitals to train & advocate for interpreting services.
- Held a Supplier Diversity Fair.
- Training and technical assistance for cultural competence primarily among health care providers, and also with community coalitions.
- Research, training and clinical quality toward eliminating health care disparities.
- Provide intrastate CMEs (continuing medical education) to individuals and peer associations at the national level toward the goal of eliminating health disparities.

Health Disparity Outcome Data:

- Annual Report by the division of the Office of Health Care Access of DPH on the number of Preventable Hospitalizations by hospital, regions, age, race, etc. to improve access to care for underserved.
- Statewide facilities and service plans to identity locations of all health care services as well as gaps in services for vulnerable populations. OHCA first report due 7/2012.

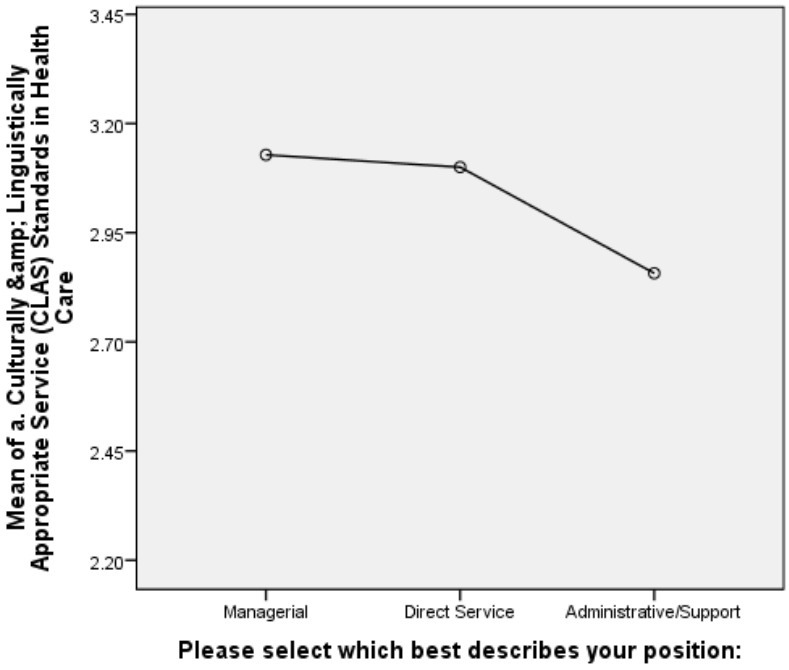
Member-Identified Recommendations:

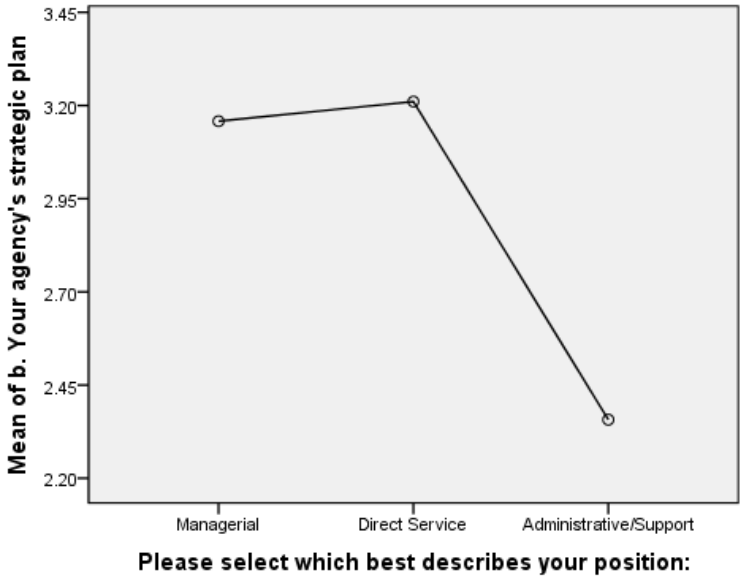
- Qualifying and training bi-lingual staff as medical interpreters; development of policies on accessing and utilizing dual role interpreters.
- Promote the Implement of *Ask Me 3!*
- Improve leadership support: Cultural competency training and the elimination of health care disparities is not a priority of the Executive Director or Board Members, cited several times.
- Low Medicaid reimbursement is sited as a barrier by leadership in outreaching to this medically underserved group (in order to *keep the doors open*).
- Support diversification of leadership: The ED & Board Members do not mirror the culture of the population we serve (leadership not reflective of consumers/patients).
- Integrate cultural competency beyond health care to include working with developmental disabilities, sensory disabilities and other “special populations” such as youth involved with the judicial system.
- Give preference to grant proposals that provides outreach to the community and primary care physician that raises health disparity awareness in cancer care and cancer clinical trials.

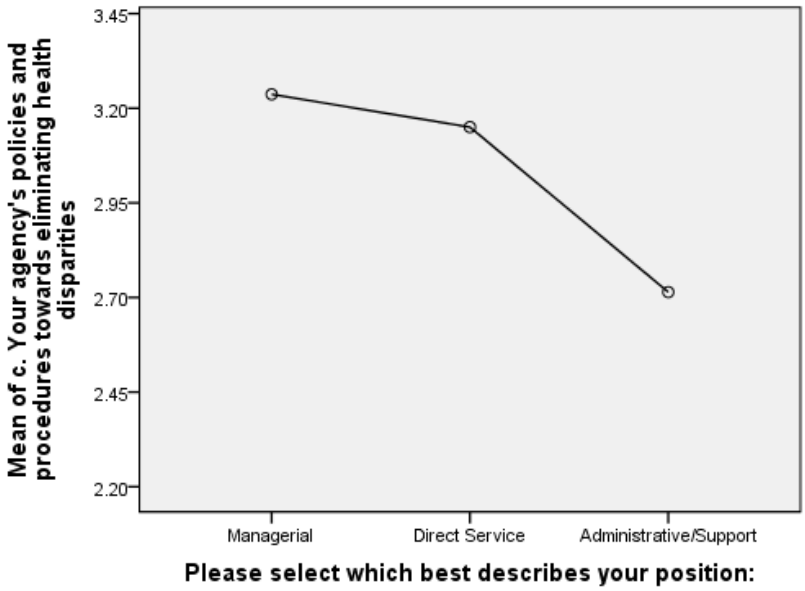
Strengthen Community Involvement:

- Engagement of community participants, create community advisory bodies.
- Increase involvement with grassroots consumer advocacy organizations.
- Strengthen the collaboration between health care providers and community leaders.

Appendix C: Mean Scores for Self-Reported Knowledge






Mean of c. Your agency's policies and procedures towards eliminating health disparities
3.45
3.20
2.95
2.70
2.45
2.20
Managerial
Direct Service
Administrative/Support
Please select which best describes your position: