

Reflections on the CLAS Standards: Best Practices, Innovations and Horizons

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October, 2003

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Prepared by
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Office of Minority Health, Office of Public Health and Science
United States Department of Health and Human Services
Under Contract Number 01T23210301D
Guadalupe Pacheco, Project Officer

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I. Acknowledgements

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Our most grateful acknowledgements to:

Guadalupe Pacheco, Project Officer, Office of Minority Health, Office of Public Health and Science, U.S. Department of Health and Human Services

Kinza Schuyler, Interim Executive Director, Cross Cultural Health Care Program

Special thanks to the following individuals and groups:

Lowell Community Health Center in Lowell, Massachusetts:

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Douglas Eby, MD, Vice President of Medical Services
Participating ANMC Staff

Special thanks to:

Teresita Bautista
Donald J. Camp, MDiv
Edward Chu, MD
Eric Hardt, MD

Thanks to:

Neils Agger-Gupta, PhD, Dale Allison, PhD, Oscar Arocha, Joe Betancourt, MD, Shiva Bidar-Sielaff, Judy Bigby, MD, Fred Bigjim, Susan Carlson, MD, Caroline Chang, Alice Chen, MD, MPH, Joy Connell, Oscar Espinosa, Brian French, Vanessa Northington Gamble, MD, Ron Garcia, MD, Iris Garcia-Caban, PhD, Jean Gilbert, PhD, Ellie Graham, MD, Carola Green, Carey Jackson, MD, Laura Lavalley, Thomas A. LaViest, PhD, Cheryl Leigh, RN, MS, CS, FNP, Robert C. Like, MD, Greg Lorenz, Merideth Mathews, MD, Jane McClure, MD, Marilyn Mochel, RN, Alicia Monroe, MD, David Nerenz, PhD, John Nickrosz, Linda Okahara, Ray Pastorino, PhD, JD, Mae Marie Quan, Cynthia Roat, Frank Stackhouse, MD, Mick Storck, MD, Joseph Telfair, DrPh, MPH-MSW

II. Executive Summary

"Reflections on the CLAS Standards: Best Practices, Innovations and Horizons."

BACKGROUND

The Cross Cultural Health Care Program (CCHCP) was commissioned to report on "best practices" in the field that are consistent with the National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health Care, published in March 2001. The fourteen CLAS standards were the result of a multiyear process conceived by Guadalupe Pacheco of the Department of Health and Human Services Office of Minority Health (OMH). The standards are intended to systematically advance the provision of health and social services to minority populations who encounter barriers to accessing and receiving effective health and social services and to be inclusive of all cultures.

The goals of the CLAS standards are to correct inequities that currently exist in the provision of health and social services and to be more responsive to the individual needs of all patients/consumers. Ultimately, the aim of the standards is to contribute to the elimination of racial and ethnic health disparities and to improve the health of all Americans. The standards are grouped under three themes:

- Culturally competent care
- Language access services
- Organizational supports for cultural competence

This study, conducted by a team of four investigators in cooperation with carefully selected national sites, provides a view of best practices that reflect some or all three themes of the CLAS standards. The hope is that the examples of best practices profiled in this study will inform, guide and facilitate the implementation of CLAS standards. In addition to highlighting reflections of the standards in each of the sites reviewed, the study reports on innovative and advanced programs at five sites.

PROCESS

The study was fully initiated in 2002 and completed in 2003. It was launched with an extensive literature search of publications featuring sites that were reputed for excellence in programs serving disadvantaged populations. Individuals that had knowledge of the field were researched and a lengthy list of contacts was generated from a variety of sources. Over 50 phone interviews were conducted and a list of 24 sites was developed. The search was narrowed down to 12 sites of which six were visited and five became finalists and have their programs described in this report.

CCHCP researchers conducted visits at selected sites. Each site visit was comprised of key informant and focus group interviews of program managers, staff and clientele as well as site observations of programs and projects. The CLAS standards were utilized as a benchmark for review of the structure and style of programs and services. An effort was made to preserve each site's history, views and programmatic approaches and to thereby inform the CLAS

standards via real time operating experience. Descriptions of each site were prepared by CCHCP site visitors and have been reviewed by site personnel.

The five sites profiled in the study include:

- Lowell Community Health Center in Lowell, Massachusetts
- Project Vida in El Paso, Texas
- The Men's Center in East Baltimore, Maryland
- Harborview Medical Center in Seattle, Washington
- Southcentral Foundation and Alaska Native Medical Center in Anchorage, Alaska

FINDINGS

The organizations studied had their beginnings prior to the articulation of the CLAS Standards. The standards, however, were developed from the language of contracts, laws and rule sets that were in use during the preceding decades. Thus we were not surprised to find that the standards were generally met with vigor in the sites we visited. What was informative, however, was the degree to which these organizations worked to engage the special qualities and needs of the populations they serve and the often-remarkable programs they had developed.

- The organizations that are part of the study clearly tailor their services and programs to the realities of the communities and populations they serve.
- This effective mode of response has moved them beyond a narrow definition of health and health services to engaging combinations of health, community and social services in meeting the needs of individuals and families.
- All five sites are actively contributing to community capacity development and often in arenas that are not traditionally viewed as “medical.” Rebuilding the spirit and fabric of the community when it is in jeopardy is seen as a major step towards the long-term goal of eliminating disparities in health outcomes.
- Successful programs are mission driven and culturally and linguistically appropriate services are not superimposed on existing programs but are woven into the way of doing business.
- Linguistically appropriate care is equally relevant to both LEP and English speaking populations because historical and contextual diversity find many forms of linguistic expression. For this reason, programs often consider background, life experience and culture in matching programs, providers and patients.
- These organizations clearly believe that meaningful relationships and partnerships with the community are critical to achieving equity in health outcomes and to eliminating gaps in service.
- Successful programs are community driven and have community control.

- Every site is engaged in the struggle to fund care and is involved in fund raising from multiple sources. Other financial strategies include efforts to cross fund and use categorical funding to keep vital programs alive.
- Themes of relationship and trust were raised and woven into programs at every site. These themes are not clearly articulated in the language of the CLAS standards. The variety of programmatic approaches to both provider-patient and community-institution interactions we observed suggest that a clear statement focused on the development and maintenance of relationship be added to the standards.

Voices from the sites:

“What ties us together is what provides the best health care. Partnership is mandated, our common bond is the patient.”

“Communication...you can't say it enough.”

“Listen to people's hopes and ideas and keep your commitments.”

“It takes a lot of trust and knowledge.”

"Our whole system is about relationships."

CONCLUSIONS

While the findings of this study reinforce the purport and intent of the CLAS standards, the sites profiled in this study bring the current CLAS standards to life. In addition they demonstrate innovative pathways to health while redefining and informing the reach of CLAS. Several key areas emerge from this study, which if incorporated in to the CLAS standards will broaden the standards, and maximize their successful integration into health systems. The array of CLAS standards and programmatic approaches illustrated in this study will hopefully inform the incorporation of best practices in health care programs around the nation.

III. Introduction

The Focus on Disparities and Cultural Competence in Health Care

Over the last two decades, a number of local and national efforts have focused on the provision of quality health care to people of all cultural backgrounds. Health services research as well as studies incorporating such issues as class, race, ethnicity, poverty, and perceived bias have informed the evolving concept of cultural competency as a means to approach health care disparities. In 1998, Healthy People 2010¹ established a national commitment to eliminate racial and ethnic health disparities. A later Institute of Medicine (IOM) report on disparities² further fueled these efforts. The IOM report identifies the need to change behaviors, attitudes and practices among the staff within health systems as well as the need to address systemic issues contributing to disparities.

Across the country, health care organizations have confronted the need to reconstruct approaches to health care delivery, to examine their corporate culture, structures and assumptions and to incorporate the principles of accommodation and respect for different cultural views about health and illness. Health care organizations and institutions have directed internal efforts to apply the concepts of culturally competent care to health service delivery and have accumulated rich experiences and lessons in the process.

National efforts to eliminate racial and ethnic health disparities, combined with an accumulation of practical experience studied and reported in the literature and at multiple local and national conferences, have led to a much-needed dialog around the conscious and coordinated development of guiding principles for culturally competent health care.

The Origins of the CLAS Standards

The creation of standards for the provision of culturally and linguistically appropriate services (CLAS) occurred after decades of research focused on health care disparities.^{3,4} In addition, by the late 1990's a number of actions had been initiated under Title VI of the Civil Rights Act of 1964, by the Office of Civil Rights.⁵ In 1997, the United States Department of Health and Human Services, Office of Minority Health, asked two organizations⁶ to review existing cultural and linguistic competence standards and to submit a draft for national standards. This task was undertaken by reviewing 30 policy documents⁷ that made specific reference to cultural and linguistic competence.

¹US Dept Health and Human Services, Office of Public Health and Science: Healthy People 2010 Objectives: Draft for Public Comment, 09/15/98, Goal #2 – To Eliminate Health Disparities.”

² Smedley BD, Stith AY, Nelson AR (Eds): Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care. The Institute of Medicine, The National Academies Press, Washington DC, 2003.

³ Geiger HJ: (Editorial) Race and health care: an American dilemma. N Engl J Med 1996; 335:815-6.

⁴ Smith DB: Health Care Divided: Race and healing a nation. Ann Arbor, The University of Michigan Press, 1999.

⁵ Perkins J, Simon H, Cheng F, Olson K and Vera Y: Ensuring linguistic access in health care settings: Legal rights and responsibilities. National Health Law Program, Menlo Park, CA, Henry J. Kaiser Foundation, January 1998.

⁶ Julia Puebla Fortier of Resources for Cross Cultural Health Care, Principle Investigator, the Center for Advancement of Health and C. Godrefy Jacobs of IQ Solutions who served as project director.

⁷ These documents included Medicaid Managed care contract language for 10 states, a summary of state law requirements for 9 states, cultural competence standards and contract requirements from the states of New York, California (2 documents, one from Medi-Cal Managed Care and the other from the Department of Mental Health) and the Commonwealth of Massachusetts, OCR rulings, NCQA and JCAHO standards, The Consumer Bill of Rights, the NHeLP publication on linguistic access in Health Care Settings and Medicare + Choice Regulations. A complete list of these thirty documents can

The policy documents were representative of national, federal and state agencies as well as institutions engaged in the oversight and review of health care such as the National Committee for Quality Assurance (NCQA), the Joint Commission for Accreditation of Healthcare Organizations (JCAHO) and the National Health Law Program (NHeLP). The documents were selected and identified from a variety of sources including work published by NHeLP^{8,9} and the Center for Health Policy.¹⁰

Project personnel proposed an initial list of 21 standards to a 27 member National Advisory Committee at a meeting in Washington DC in July, 1998. At the committee's suggestion, the standards were reduced to 14 and revisited by a focus group at a national conference. Multiple revisions led to a draft submission to the OMH in May 1998. A national process of review was then undertaken in which public comment was solicited in three meetings held in San Francisco, Baltimore and Chicago (January – April, 2000). Input from these meetings and from responses to solicitation by mailings to 3000 stakeholders¹¹ and notice in the *Federal Register* further informed the process.¹²

Draft standards had first been published in the *Federal Register* December 15, 1999¹³ (with a period of public comment invited). Final revisions were published a year later on December 22, 2000 "as recommended national standards for adoption or adaptation by stakeholder organizations and agencies."¹⁴ The preamble to the full document containing the standards describes their purpose:

“...These standards for culturally and linguistically appropriate services (CLAS) are proposed as a means to correct inequities that currently exist in the provision of health services and to make these services more responsive to the individual needs of all patients/consumers. The standards are intended to be inclusive of all cultures and not limited to any particular population group or sets of groups; however, they are especially designed to address the needs of racial, ethnic, and linguistic population groups that experience unequal access to health services. Ultimately, the aim of the standards is to contribute to the elimination of racial and ethnic health disparities and to improve the health of all Americans.”¹⁵

be found on pages 128-29 of U. S. Department of Health and Human Services, Office of Minority Health, National Standards for Culturally and Linguistically Appropriate Services in Health Care, Final Report, Washington DC, March 2001.

⁸ Perkins J et al: Ensuring Linguistic Access, January 1998.

⁹ Ibid., The Office for Civil Rights' 'Bottom Lines' for Linguistic Accessibility, pp 25-26.

¹⁰ Rosenbaum et al., Negotiating the New Health System: A Nationwide Study of Medicaid Managed Care Contracts (1st Ed.), The George Washington University Medical Center, Washington, and D.C. 1997.

¹¹ Stakeholders included national organizations such as the American Academy of Pediatrics, the American Hospital Association, the American Nurses Association, Blue Cross Blue Shield Association, the California Primary Care Association, the Chinese Community Health Plan, a number of City, County and State Health Departments the National Medical Association, the National Rural Health Association, to name a few. A list of the respondents can be found in Appendix B of the document cited at footnot 14 below, pp B 3-6.

¹² 309 individuals attended these meetings and 109 individuals and organizations responded to solicitation by mail and through the Federal Register.

¹³ U.S. Department of Health and Human Services, Office of Minority Health, Office of the Secretary: Call for comments on draft standards on culturally and linguistically appropriate health care and announcement of regional informational meetings on draft standards. Federal Register, December 15, 1999;64(240):70042-70044.

¹⁴ U. S. Department of Health and Human Services, Office of Minority Health, National Standards for Culturally and Linguistically Appropriate Services in Health Care, Final Report, Washington DC, March 2001, p 119.

¹⁵ Ibid., p 3.

Figure 1 - National Standards for Culturally and Linguistically Appropriate Services

Culturally Competent Care

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
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
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 (Mandated)

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
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
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)
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 Supports

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
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 Evaluations
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
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 the Cultural and Linguistic Characteristics of the Service Area
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
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
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

The 14 standards (outlined in Figure 1) are grouped into three themes: Culturally Competent Care (Standards 1-3), Language Access Services (Standards 4-7), and Organizational Supports for Cultural Competence (Standards 8-14).

Subsequent Work on CLAS Standard Applications

A number of CLAS related studies, bibliographies and guidelines have been published in the few short years since the CLAS Standards appeared. These include (but are not limited to) items

outlined in Figure 2. Interpreter services have received a great deal of attention based, in part, on the fact that the standards focused on language access services (CLAS Standards 4-7) are federally mandated. This focus on language is further illustrated by the efforts, trainings and publications of state and national organizations concerned about interpreting in health care settings.¹⁶ The work has called into play earlier efforts that have been utilized in cross-cultural health care such as the ‘patient satisfaction survey’ by Miguel Tirado.¹⁷ Finally, a recent literature review suggested that there might be too few studies and reviews to determine the degree to which culturally competent interventions may affect outcomes.¹⁸ It is important to caution administrators and researchers alike about such inquiries. In the programs visited and reviewed in this report, there have been fundamental changes in the very fabric of institutional design and practice, changes that accommodate and respond to communities. A separate listing of other CLAS focused resources is located in Appendix B of this report.

Figure 2 – Selected work on the CLAS Standards

- Guides to assist Managed Care Plans in planning and providing Culturally and Linguistically Appropriate Care^{19,20}
- A language access assessment tool for managed care contractors receiving federal funding,²¹
- Best practice recommendations for hospital-based interpreter services,²²
- A health plan report card for minority populations,²³
- An assessment of cultural competence in three sites (academia, government and managed care),²⁴
- NHeLP's description of language interpretation services in healthcare settings,²⁵
- An excellent review of promising practices in California primary care sites,²⁶ and
- A 28-item instrument (woven into state contracts) for safety net hospitals, developed in Massachusetts.²⁷

¹⁶ National Council on Interpretation in Health Care, www.ncihc.org (web-site includes numerous position papers on health care interpreting), the Massachusetts Medical Interpreters Association, www.mmia.org (has undertaken lengthy studies of interpreter functions in health care and is currently engaged in a joint effort with the California Health Interpreters Association, <http://chia.ws>, around issues of evaluating and certifying health care interpreters).

¹⁷ Tirado M: Final report to the Office of Planning and Evaluation, Health Resources and Services Administration on the project entitled Tools for Monitoring Cultural Competence in Health Care. San Francisco CA: Latino Coalition for a Healthy California, 1996. Appendix 5. A5 I-ix.

¹⁸ Anderson LM, Scrimshaw SC, Fullilove MT, Fielding JE, Normand J and the task force on Community Preventive Services: Culturally Competent health care systems: a systemic review. *Am J Prev Med* 2003; 24 (Suppl 3):68-79.

¹⁹ Paez K and Gunter M: Planning for Culturally and Linguistically Appropriate Services: A Guide for Managed Care Plans, 2002. Accessible at <http://www.cms.gov/healthplans/quality/project03.asp> (119 pages, Four Appendices >170 pages)

²⁰ Paez K and Gunter M: Providing Oral Linguistic Services: A Guide for Managed Care Plans, 2002. Accessible at <http://www.cms.gov/healthplans/quality/project03.asp> (103 pages with 10 Appendices)

²¹ Perkins J: Language Access Questionnaire for Managed Care Contractors that receive Federal Funding, Menlo Park, CA, Henry J. Kaiser Foundation, August, 1999.

²² Massachusetts Department of Public Health, Office of Minority Health: Best Practice Recommendations for Hospital-Based Interpreter Services, Commonwealth of Massachusetts, Office of Health and Human Services, Mass Department of Health, (Undated, released in 2001).

²³ Nerenz DR, Gunter MJ, Garcia M, Green-Weir RR, Wisdom K and Joseph C: Developing a Health Plan Report Card on Quality Care of Minority Populations, New York, The Commonwealth Fund, Field Report, July 2002.

²⁴ Betancourt JR, Green AR, Carrillo JE: Quality of Care for Underserved Populations, New York, Commonwealth Fund, Field Report, October 2002.

²⁵ Youdelman M and Perkins J: Providing Language Interpretation Services in Health Care Settings: Examples from the Field, Field Report, New York, Commonwealth Fund, May 2002.

²⁶ Mateo J, Gallardo EV, Huang VY, Niski C: Providing Health Care to Limited English Proficient (LEP) Patients: A Manual of Promising Practices. Sacramento, CA, California Primary Care Association, printed in 2001, available at http://www.cpcsa.org/government_affairs/files/PPGuide.pdf

²⁷ Garcia-Caban I: Senior Policy Analysis, Massachusetts Division of Medical Assistance, phone interview, 10/11/02, unpublished.

The Goals for this Report

At the request of the Office of Minority Health, the Cross Cultural Health Care Program (CCHCP) began work on this study in October, 2001. The project was originally conceived as a compendium of best CLAS-related practices around the country. Limitations to this approach quickly became apparent. To begin with, the American Medical Association published a cultural competence compendium in 1999 summarizing projects, programs and associations relating to issues of culture in health care.²⁸ A second project, funded by the California Endowment, which focused on cultural competence training materials, was well under way during our early work.²⁹ The breadth of materials covered by these efforts combined with funding limitations moderated our goals.³⁰

CCHCP saw the review as an opportunity to observe and describe practices reflecting the CLAS standards in a carefully selected number of institutions that have the reputation of highly developed programs and skills around health practice impacted by culture, by class and by linguistic difference.

The study has five goals: 1) to recognize several organizations and institutions that reflect well designed expression of the CLAS standards, 2) to disseminate -to other organizations- the successful and innovative approaches to the implementation of the standards that these organizations and institutions demonstrate, 3) to solicit and make recommendations for future CLAS work that are based on the grounded experience of these organizations, 4) to provide a selected (CLAS focused) annotated resource listing of organizations, institutions and individuals in the area of culturally and linguistically appropriate services in health care and 5) to contribute to the growing body of knowledge on the implementation of the principles of cultural competence in health care.

Methodology for this Report

Early tasks included a review of the literature searching for programs that might reflect best practices. A number of bibliographic resources were utilized.³¹ Selected materials were annotated, shared among study participants and used to inform study questions and design, contacts for networking and site selection. In addition, staff reviewed notes from the CLAS standard meetings in San Francisco, Baltimore and Chicago. This produced a separate list of contacts for networking as well as commentary about CLAS and about the design and implementation of programs around the country. A broad list of potential contacts was drawn from these sources, news articles about clinics, descriptions of programs and

²⁸ Hedrick H, Donini-Lenhoff F, American Medical Association: Cultural Competence Compendium, Chicago, AMA, 1999.

²⁹ Gilbert MJ: A Manager's Guide to Cultural Competence Training for Healthcare Professionals, The California Endowment, 2002.

³⁰ OMB regulations limited potential site visits to nine or less and our funding and scope of work further limited us to six or fewer sites.

³¹ MEDLINE, CINAHL, OCLC WorldCat, Dissertations Abstracts, HRSA Models That Work, Cochrane Library, CDC Wonder, NTIS, PsycINFO, Sociological Abstracts, Social Work Abstracts, National Library of Medicine, University of Washington Libraries, CRISP, and others were searched using variations and combinations of terms like cultural competency, ethnicity, race, diversity, programs, and institutions. Additionally, we accessed separate bibliographies recently completed (at CCHCP) around health care disparities (228 references) and language access (102 references).

institutions³² engaged in culturally focused issues in health care. Lists of participants at national meetings relating to issues of Language and Culture were reviewed along with the issues and focus of presentations; selected individuals from this review were contacted.

After extensive phone interviews and networking, a list of 24 sites was developed. Phone reviews were undertaken based on a formal interview protocol developed by project staff. Project goals and financing limited site visits to six sites. Of the list of 24 sites, 12 sites were considered in further detail and six finalist sites were visited. Five sites were then selected for highlighting in this report.

Site visits had two goals. The first goal was to learn about each site's history, mission, and the story of its work. We did this intentionally and without imposing the CLAS framework in hopes that observations of well-run programs would support the character and direction of the standards or would otherwise inform and enrich the standards. The second goal was to review the CLAS standards with site leadership and workers and learn how they fit or are informed by the work of the site.

Early on a decision was made to seek sites that had not been reviewed in CLAS focused commentaries. For this reason a number of excellent programs in California, recently highlighted in the California Primary Care Associations (CPCA) report, were not visited. Asian Health Services Language and Cultural Access program, for example, was on our finalist list but had been well described in the CPCA report. Additionally, finalist sites such as Boston City Hospital and organizations such as the Massachusetts Medical Interpreters Association (MMIA) were not highlighted. Like other sites that we did not include, each in its own right had vital and commendable work to describe. In fact, we believe that associations such as CPCA or the MMIA have their own critical role to play in defining and encouraging culturally competent best practices.

The Site Visits (January and February, 2003)

Our reporting methodology parallels our site visit approach. Each report contains a description of the site; its history, the populations served and unique qualities of its work. These site descriptions and stories are intermingled with commentaries about reflections on the CLAS standards. The five sites to be described include (in the order they were visited):

Lowell Community Health Center in Lowell, Massachusetts, a federally qualified community health center.

Project Vida in El Paso, Texas, a Presbyterian Church sponsored project.

The Men's Center in East Baltimore, Maryland, a non-profit clinic started under the umbrella of a Community Action Coalition.

³² For example, one of the finalist sites was found highlighted in the Bureau of Primary Health Care's "Models that Work Campaign."

Harborview Medical Center in Seattle, Washington, a major urban teaching institution.

Southcentral Foundation and Anchorage Native Medical Center in Anchorage, Alaska, an Alaska Native corporation's health foundation along with its partner hospital.

Site Visit Reporting Format

Our methodology included an intentional effort to elicit the story of each site. For this reason we purposely avoided requesting that sites conform to a prescribed reporting format. As a result, although each site had a stated mission some emphasized mottoes and some referred to operating philosophies, or core values. We chose to highlight their stories as they were presented at the time of the visit and in the (often voluminous) written materials that were provided to us. These materials included forms, posters, program ads, news articles, grant requests, patient education materials and the like.

Sites varied a great deal in the style, energy and passion with which they organized their discussions with site visitors. A passion for and excitement about the work were consistently present. So as you read, we hope you will experience the delight and frustration of finding a motto for one site, focus on mission at another and neither at a third!

These profiles are about each site's realities as they see it. Quotes are attributed by the name of the speaker only in those instances where we sought specific permission.

IV. Profiles

Lowell Community Health Center (LCHC)

Lowell, Massachusetts

Motto – “Linking Community to Health Care”

History/Demographics/Patients Served

LCHC is a Federally Qualified Community Health Center which serves 20,000 patients annually. The clinic’s origins date to 1970 when Lowell General Hospital established LCHC in a public housing apartment. Over time the clinic grew achieving the status of an incorporated non-profit organization in 1985. LCHC began to receive “330” Community Health Center funding (which now amounts to >\$1.5 million per year) in 1986.

As Lowell’s population continues to evolve and change, LCHC has undertaken major program shifts to meet these emerging needs. Lowell’s Limited English Proficient (LEP) community consists of large numbers of Spanish-speakers from Puerto Rico, the Dominican Republic, and other Central and South American countries. A Khmer speaking Cambodian community now comprises 27% of the population of Lowell. Currently, the clinic is experiencing an increase in Portuguese-speaking patients associated with immigration from Brazil and patients speaking multiple African languages.

LCHC cares for a number of high-risk populations. For example, 15% of the Lowell community is Latino, a population heavily impacted by asthma, and this community comprises 37% of the LCHC clientele. More than 28% of Lowell’s children live below national poverty guidelines (vs. 12.9% statewide). Statistics for AIDS and alcohol-related deaths in Lowell are both more than twice the Massachusetts statistics. The area’s poverty is reflected in the patient population’s health coverage – 72% Medicaid, 19% free care, self pay or sliding scale and 8% Medicare.

LCHC’s Work is Informed by Voices of its Staff and Communities.

“We work in the context of community – we form focus groups, we have multiple community boards...” (Dorcas Grigg-Saito, ED)

In line with federal policy for federally qualified community health centers, over 50% of LCHC’s governing Boards of Directors are consumers or community members. There is active community representation on its Cambodian Community Health (CCH) 2010 Advisory Board, the HIV consumer’s board, as well as advisory boards for the school program, the Metta Health Center and the Teen Coalition. Additionally, the CCH 2010 Project (focused on Cambodian patients) has an elder’s council comprised primarily of monolingual Cambodians.

The Need in Lowell

(population 105,000)

- 8th highest teen pregnancy rate in the state
- > 28% of Lowell’s children live below the poverty level
- Latinos are 3 times more likely to have asthma than the rest of the population
- > 50% of Cambodians experience moderate/severe mental health problems vs 15% of the general population
- Death rate due to alcohol and other drug use 39/100,000 vs. 14.2 statewide
- AIDS death rate 33.3 versus 14.2 statewide

Source LCHC PowerPoint, 2002

Accountability is present in both board and staff functions. Focus groups are run among the staff on both regularly scheduled and as needed basis. An outreach system is used to explore issues in different communities. Partnerships and relationships are formed and maintained with organizations ranging from the Lowell General Hospital to community based organizations (CBO) such as the Cambodian Mutual Assistance Association or newly emerging Brazilian and West African communities (represented by two CBO's, the Massachusetts Alliance of Portuguese Speakers and the African Assistance Center).

CLAS Standard 12- Participatory and Collaborative Partnerships with communities

LCHC has community input and involvement at almost every level. Community advice and consent is sought through its consumer majority Board of Directors, advisory boards, patient surveys and focus groups as well as actual partnerships.

Community partnership is exemplified by LCHC locating some of its clinic functions in the Cambodian Mutual Assistance Association and adjacent to school nurse clinics in middle school sites. Additionally, LCHC seeks to partner with community-based businesses and faith organizations, to undertake efforts at outreach and transportation and to provide significant business opportunities to small communities.

Dealing with Categorical Funding – A whole systems approach

Mental Health, Detox, HIV/AIDS and Primary Care funding streams are examples of overlapping categorical funding sources each of which carries focused, often narrow expectations. LCHC believes that the needs of individual patients and patient groups often cross these boundaries. “When we try to train, to work, to deliver care across these boundaries, we’ve attempted to maintain a whole systems approach. We have been trying to get buy-in from funders who continue to pursue this somewhat disruptive [categorical] approach.”

The Inpatient Detox Center at Tewksbury Public Hospital is an example of this kind of crosscutting relationship. LCHC’s long-standing relationship with Lowell General Hospital resulted in the Detox center being turned over to LCHC. The Center was moved and renovated by LCHC which sees detox work as having integral ties to outpatient addiction treatment, to HIV/AIDS programs, to Prenatal Services, and to its teen pregnancy prevention, to name a few.

CLAS Standards 8 and 9: Organizational Support

Categorical funding is a reality facing health care and social services institutions nationwide. The organizational supports described in CLAS standards 8 and 9 refer to operational plans, to oversight, to appropriate services, to audits and to outcome evaluations. These phrases carry significant weight as planning and programs are evolved. They often parallel categories driven by subspecialization in the health care process.

Lowell Community Health Center focuses planning on broad based identifiers such as teens, the Cambodian community or Primary Care in an integrated fashion (it is for this reason that mental health care is woven into the primary care functions of the Metta Health Center). This allows LCHC to apply categorical funding for HIV/AIDS, drugs and alcohol, teen pregnancy prevention in programs that consistently tie social, economic and medical realities together.

Metta Health Center – Cambodian Community Health 2010

“You can’t solve problems if you stay in the box.” (Dorcas Grigg-Saito, ED)

LCHC opened a primary care clinic in the Lowell CMAA (Cambodian Mutual Assistance Association) building - housed in a renovated paper mill. The Metta (a Buddhist word meaning love and compassion) Health Center was developed in response to the special needs of the Khmer-speaking population that utilizes the LCHC. LCHC staff now sees Cambodian and Lao patients in this site which combines Primary Care, Mental Health, and Traditional Healing Services under one roof.

Over 50% of Cambodian patients have mental health needs. A CDC funded REACH³³ partnership with CMAA and with the Cambodian-run health outreach organization, SABAI (the Southeast Asian bilingual Advocate, Inc), brings in elders, and provides health advocacy as well as teaching around heart disease and diabetes. This process simultaneously provides support, lessens isolation, provides transportation, gets elders out of the house and encourages socialization. During any given week, there are over 100 people impacted by this advocacy and outreach process. Patients in the program use the local Buddhist Temple (called a Wat) as well as a meditation room in the clinic building which is fashioned after a Wat, to practice meditation and stress reduction while teaching about disease. The Cambodian elders’ council oversees this process.

The Metta Health Center is also a primary site for LCHC’s efforts to reduce health disparities in a minority community. Using DHHS Bureau of Primary Health Care “330” grant, the clinic has been able to broaden the scope and depth of its work. This style of cross funding is typical of LCHC’s efforts over a broad range of needs, from mental health and HIV/AIDS to primary care itself. The Cambodian Health Service Improvement Program, for example, includes a focus on HIV education as well as substance abuse treatment.

“We use multiple sources of funding for most programs. If we relied on patient revenues alone, we couldn’t get the job done.”

D. Grigg-Saito, ED

Class Standard 12 – Community Partnerships

The elders’ council for a REACH funded program has created a role for community elders that validates their position as community advisors and simultaneously creates a sense of worth and self-respect.

The REACH elders' council reestablishes generational roles in the Cambodian community: "You can see it in the members of our elders’ council, even in the way they dress and the way they walk now- so proud."³⁴ The impacts of programs are often multifaceted.

³³ REACH is an acronym for a Racial and Ethnic Approaches to Community Health and this program has a focus on diabetes. Wessling S: Reaching Out to Improve Health: How REACH 2010 is helping make life better for ethnic minorities in two Massachusetts communities. On Call, October 2002, pp 26-20.

³⁴ Wessling S: Reaching out to Improve Health: How REACH 2010 is helping make life better for ethnic minorities in two Massachusetts communities. On Call, October 2002, pp 26-30.

Language Access - Bilingual Staff Model

LCHC uses a bilingual staff model for interpretation needs. The majority of LCHC's bilingual staff has been trained in medical interpreting, via a program run by the Merrimack Valley AHEC, and staffing in clinic sites is designed so that languages like Portuguese are covered throughout the system. In some sites staff have had to trade locations in order to cover language needs. For example, a Khmer speaking staff member from the school clinic trades places with a Portuguese speaker from the prenatal clinic once a week so that the needs of patients in these two sites can be met.

Blue Cross Blue Shield Foundation also funds training and LCHC provides incentives for language skills and training. Workers have dual roles in the clinics and many are purposely cross-trained. In area after area, language needs have necessitated shared work roles and have become a staff expectation as well as a source of excitement and pride. An internal course is being developed to train providers to work effectively with LEP patients and interpreters. Beyond training interpreters, LCHC has instituted language training at multiple levels. Staff trainings to introduce or to upgrade language skills are also available. The goals of these trainings range from acquiring sufficient skill to meet and greet individuals in their own language to achieving increased fluency in a second language.

CLAS Standards 4-6: Language Services

At LCHC, staffing is such that bilingual personnel are available in Spanish, Portuguese and Khmer in each major clinical area except for the Metta Health Center where Khmer, Laotian, and Thai are spoken. When staff are absent at smaller sites patients are scheduled by language and bilingual personnel are traded from site to site to meet the needs.

The clinic supports staff participation in trainings. Bilingual health workers who interpret have had two levels of medical interpreter training, introductory and comprehensive. Lowell's records reflect these training levels and plans are often undertaken to upgrade skills. Staff are given "bonuses" upon completion of courses, and language training is considered in annual reviews and salary increases.

Assessment and upgrading of signage (CLAS Standard 7) at each site is part of Lowell's annual cycle of self-assessment. Current signage is in the four commonly used languages at LCHC: English, Spanish, Portuguese and Khmer. Plans are underway to incorporate African languages that are entering the clinic.

Strategies to Deal with Providers and Special Patient Needs and Beliefs

"Our patients present all kinds of issues like the time the women wanted to talk about Insulin Tea in the diabetes support group. When patients bring up traditional remedies, talk about what to do to adjust their treatment, what's good, what's safe, what works – it's a challenge. We have to be open to traditional approaches and information and work with patients on Western approaches – we can show the way, and then patients decide." The underlying key at Lowell seems to focus on relationship building - clinician to clientele. One RN put it like this: "It's

learning to know the whole person in order to get the results; to make change [over] time, step by step.” (All quotes in this section are from bilingual LCHC RNs)

“We assist the provider to learn about the culture, often using the interpreter as a bridge. For example we may have to stop the provider and explain that what the patient is saying is important, that s/he must stop and listen. If the patient asks about taking herbal meds [like the ‘insulin tea’] together with Western drugs, for example, and asks if the two can be taken together ... we have to listen.”

CLAS Standards 1 and 6 – Patient beliefs/practices and competent language assistance

One trained bilingual staff member demonstrated a classic interpreter intervention while describing her interaction with an MD: “I hold my hand up and begin: ‘Excuse me Doctor, the patient wants to explain something...it seems quite important to her.’”

Partnering with Ethnic Communities

As new groups emerge in the Lowell community, the health center has partnered with Mutual Assistance Associations. Recent arrivals include Portuguese-speaking Brazilians and new language groups from Africa. LCHC has partnered with the Massachusetts Alliance of Portuguese Speakers (MAPS) and the African Assistance Center (AAC) to deal with outreach, language resources, and staff development and to initiate relationships with these communities. The model for this is the recent opening of a clinic branch in the Cambodian Mutual Assistance Association’s building. This primary care clinic serves Khmer and Lao speakers, and has social and mental health service capabilities. It includes traditional therapists and therapies (cupping, coining, massage therapy and acupuncture) as well as a meditation center where monks teach and groups work on stress reduction, and other activities.

Teen Coalition

“Our teens are an asset: We believe in the power of youth voices.”

This part of LCHC has been in place for more than 10 years. The coalition’s purpose is to prevent pregnancy, STD, HIV, and violence. The staff does street-based outreach, has meetings for former participants, hosts teen/adult events, provides trainings and conducts efforts focused on teen leadership and youth development. The program has had to accommodate to changing demographics (70% of teenagers in the program are now Southeast Asian).

LCHC acts as the Fiscal agent for this project and the coalition includes subcontractors who conduct after school programs (United Teen Equality Center, Big Brothers, Big Sisters of Greater Lowell and the YWCA). Youth participants carry out outreach and networking. Program leadership includes a male former teen participant from nearly a decade ago, who has returned to provide leadership.

Numerous Lowell Health Center leaders and workers are former recipients of care, or are individuals who have participated in special programs.

A common Lowell message: “I want to give something back to the Community.”

State support for special programs is essential. The teen coalition is funded by an initiative sponsored by the Massachusetts Department of Public Health. The Department has also provided critical statistical support. This includes supportive data about teen births, which have declined 27% from 35.4/1000 to 25.8/1000 between 1990 and 2000. This sort of information is used widely as LCHC workers evaluate their programs.

Cultural Competency Initiative

“A major focus on self reflection, learning and growth for staff.”

Lowell has prepared a Cultural Competency initiative for its staff and facilities. Grant funding has been secured to train cultural competency trainers within the clinic system, to improve signage, posters, and maps. Recruitment is under way to increase language capacity in Portuguese, Swahili and French. On-going trainings to improve the language capacity of staff members range from giving staff confidence to welcoming patients in their own languages to increasing the ability of those who already have multiple language skills.

"When I was young I was disabled by my asthma. I remember how well I was treated here and I want to give that back ... I was taken care of in so many ways."

(A Puerto Rican RN)

A major focus is improving the staff's capacity to work with each other. Training will include focus on self-evaluation and self-reflection with ongoing trainings around language, stereotypes, issues of power and hierarchy, “not knowing” and uncertainty in cross-cultural dynamics. In addition, on-going focus will be maintained around herbal medications, and how to acknowledge interactions between home remedies, family advice/illness management and the medical model.

LCHC will also use sporadic trainings for medical and providers on staff such as Grand Rounds, case conferences, and HIV/STD focused trainings. Each will have a component that focuses on cultural issues.

CLAS Standard 3 - Training Staff in Culturally and Linguistically Appropriate Care.

Three staff members of Lowell Community Health Center, the Massachusetts Alliance of Portuguese Speakers, and the African Assistance Center have begun work on an in-house cultural competency training program. All three have taken a training of trainers program. The program has a goal of producing ongoing modular trainings around culture specific issues reflecting the diversity of LCHC's clientele. Lowell staff themselves are a part of the rich resources LCHC can apply to this process. Staff members bring their own experiences to assist with these trainings.

“I grew up in Roxbury and Dorchester. My family wasn't getting the help it needed, we didn't have money, and we'd wait for hours. I'm doing this to give something back. To me, LCHC is like the UN of health care. It's the only place I can see everybody, it doesn't matter if you're rich or poor or have 30 cents in your pocket, you will be seen; [it's great] to help people be encouraged enough to ask – and sometimes demand.”

(An African American case manager)

School Clinic

LCHC has partnered with two middle schools to place an off-site clinic adjacent to the school nurse’s office. Operated as a separate LCHC site, the school clinic has worked to increase immunizations, enroll children and families in safety net health care plans and serve in a back-up and consultation role for the nurses. Some parents choose to use this clinic site for its care, convenience and efficiency. During the current school year, clinic personnel identified and assisted 340 students without health care coverage. Language coverage is arranged by trading Portuguese and Khmer workers with LCHC’s prenatal clinic four hours a week.

Middle School Clinic

- 800 students, 5th to 8th Grades
- Languages: Portuguese, Spanish, and Cambodian (Khmer)
- Staff have assisted 340 students and some families to obtain basic health care
- Partner with selected private primary care offices to provide immunizations
- High percentage Portuguese speakers

Lessons Learned about CLAS Standards 4-6 - Shared Staffing (around language skills) allows units to communicate and meet patient needs, via informal agreements within the LCHC clinics. Staff members know that when they establish ‘trades’ of time, language and skills, the LCHC administration will support them.

HIV/AIDS

The HIV/AIDS program has 326 patients in treatment, 48% are Latinos with a growing presence of patients from African countries. “Our first patient from Africa was found on a doorstep one morning ... she is now leading a productive life and works in her enclave to encourage others to be tested.” “We had 65 new cases last year – we added another case manager last year.” Women’s HIV testing increased once LCHC moved the process to the women’s clinic and out of an HIV/AIDS focused site. “In Lowell, everybody knows everybody’s business, it’s a small town.”

“Staff feel the patients’ concerns – many with visitor visas feel threatened, there are great fears of being sent back, of lack of meds in Africa and a sense that access to care isn’t available in home countries ... they fear the consequences of going home and receiving no meds!”
 “For many it’s about survival. We deal with issues of housing, lack of insurance, INS status and problems with drug use – 60% of our patients are [or have been] IV drug users.” (all quotes in this section are from staff working in HIV/AIDS program)

“We’re worried about the loss of basic health coverage in Massachusetts... Without our detox, methadone and safe living environments, many of our patients are likely to return to using.” “We will walk patients from one site to another, we work to build relationships and familiarity... We work to link our patients to clinical care and the social services key to their situation.” “When we transfer cases from worker to worker or site to site we make sure the client knows the contact’s name and our relationship. Building trust is key to the work.”

Trust and Relationship Building - These issues have arisen in every site visited during this study. Trust must be acknowledged at the level of individual care as well as between an institution and the communities it serves. Trust and relationship must also be nurtured and maintained within the institution itself. At LCHC regular and ad hoc meetings are held between administration and staff members.

CLAS Commentary Reflected by Lowell Community Health Center (LCHC)

LCHC has evolved over 30 years and has a reputation for excellence as it responds to a changing urban environment, serves immigrant populations and welcomes newcomer groups with energy, engagement and respect. The mission and purpose of Lowell Community Health Center include many of the underpinnings of the CLAS Standards.

In advancing the work of CLAS LCHC has placed an emphasis on trust, financial creativity, cross-job training and hiring from the communities being served. In addition to key messages regarding management of a multiethnic and multilingual clinic, Lowell offers a key focus on relationship building - institution to community. Building trust and relationship is woven into the institution's program planning and day-to-day administration. It is a reminder that mission must be acted upon on a day-to-day basis throughout an institution.

Project Vida

El Paso, Texas

To make a community whole.³⁵

History/Demographics/Patients Served

El Paso's Project Vida began in 1989-90 as a one-room health clinic in an impoverished neighborhood three blocks north of the Rio Grande River. Project Vida has defined health and healing broadly to incorporate issues of family/daily life, adequate food, work, education, safety, housing and community development. This broad look at “What’s wrong?” and “What’s needed?” is addressed in an annual Community Congress in which 100 or more adults from the neighborhood review and evaluate the project while planning its future directions. All of Project Vida’s programs interrelate and exchange resources with each other. “We are a community organization in every sense of the word.” The community’s voice is apparent at all levels of the project’s operations.

Early on the project began a thrift store and day care and after school programs, one for kids through grade 6 and the other for teens. Over the years Project Vida has added programs in health education, adult education, GED, financial literacy, gang prevention, and recently, micro-enterprise development. Programs evolve in response to need. For example, workers found that the children entering day care were behind developmentally. In response, day care shifted to an early childhood development program. The program includes family counseling and parenting education.

Additionally, lack of affordable housing led Project Vida to partner with the City of El Paso (in 1995) via a HUD-funded Home Investment Partnership Grant. This effort has produced 53 low cost apartment units with more under construction. Experience with social needs impacting lives of women and children in the community led to the development of safe transitional living quarters (in 1996) for homeless families impacted by domestic violence.

One of the neighborhood’s eight 'crack houses,' previously an abandoned laundromat, was converted into six two-bedroom apartments dedicated to this need.

The Need in El Paso
 – Population 700,000

- 34% (300,000) lack health insurance
- 70,000 have incomes below 100% of the FPL*
- 80-100,000 undocumented individuals
- 9.8% Unemployment
- >100,000 eligible children not enrolled in Medicaid and S-CHIP
- Low rates of reimbursement for common procedures
- City-wide provider panels 70% Medicaid, 30% commercial

*FPL = Federal Poverty level

Project Vida's staff, Community and Families

Project Vida recruits from the community with funding from a variety of sources including the Americorps Program. A relationship with Americorps was established in 1994. The staff is Spanish speaking and many are bilingual. Project Vida uses funding from multiple sources to

³⁵ Project Vida’s director looks to the Greek word ‘iaomai’ to define the basis of their work. It has two meanings, to cure or heal and to make whole. We have combined these concepts to describe Vida’s concept of ‘health.’

support programs that are interrelated and under one umbrella. Once a patient or family signs up for Project Vida they become eligible for all of its programs. Many staff members are paid with Americorps funding and it is used to build community capacity. Staff members are primarily from the community and many staff who began as volunteer or Americorps workers have now become key program staff or even program managers.

CLAS Standard 2: to recruit, retain and promote ... staff that are representative of the demographic characteristics of the service area. Project Vida carries through on this standard by hiring and training staff from the community. Certified staff, RN's, MSW's, MD's, etc., recruited locally are with one exception Spanish speaking. Vida then takes this standard to the next level – building community capacity through both human skills and efforts aimed at the environment, education and developmental programs.

Involvement with housing and environmental justice has allowed Project Vida to make the neighborhood a cleaner, safer place to live. Community members participate by volunteering to work on Project Vida programs and volunteers are rewarded by service credits (similar to a Time-Dollar program) for their work. These credits can be used in the Thrift Shop, to pay for visits to the Clinic or costs for preschool, and the like. "Clinic visits cost \$6.00... rent for a two bedroom transitional living apartment is \$50/month. [By using the Time-Dollar program], we encourage the community to provide for itself."³⁶

Project Vida's Families

- 1430 families with 1833 adults
- 78% at 100% FPL or less
- 31% (565 adults) below 25% of FPL
- 95% of households are Spanish-only

Best Practices CLAS Language Standards 4-7: Project Vida's Staff are 95% Spanish speaking. The CLAS standards suggest that language needs are best served directly in the patient's first language and without intermediaries. Vida not only meets this standard – but likely exceeds it. Day-to-day operations are carried out in Spanish and English; some supervisors are monolingual Spanish-speaking.

Reducing Emergency Department Visits

“Project Vida's service area represents the highest number of children presented to the Thomason Hospital Emergency Room for non-emergency diagnoses.”³⁷ El Paso has had a community wide goal of lowering Emergency Department visits. This was one of three major goals established through a Kellogg funded plan administered by the El Paso First Health Network.³⁸ Prior to this initiative, Project Vida received a grant from Thomason Hospital³⁹ to initiate a program offering families an alternative to non-emergent Emergency Department care.

³⁶ Skolnik AA: Clinic explores novel approaches to improving health in Hispanic community. *JAMA* 1995;273;1475-76.

³⁷ National Community Development Association award application, 2000

³⁸ Silow-Carroll S, Anthony SE, Seltman PA and Meyer JA: Community Based Health Plans for the Uninsured: Expanding Access, Enhancing Dignity, A Series of Community Voices Publications, November, 2001, prepared for the W.K. Kellogg Foundation. Posted in PDF format at www.communityvoices.org

³⁹ The county's non-profit teaching hospital.

Families from Project Vida's catchment area using the ED are offered the option of being contacted by the project. Approximately 20 families are referred each month by this mechanism. It's clear that once families enroll in Vida's primary care system they no longer use the ED for non-emergent care.

In 1996 HRSA reported that Project Vida had saved over \$150,000 in unnecessary medical costs (FY 1995) by preventing inappropriate ED usage at Thomason Hospital. The program is ongoing; once families are enrolled they become eligible for a wide range of Project Vida programs. Thus with one registration, a family may be able to access emergent food and shelter. This was described in a 1995 interview with Linda Abernathy, MSN, then Thomason Hospital's assistant director of planning. Health needs are thus met in Project Vida's broad, whole systems approach to well being. The effort to obtain needed service extends to arrangements with institutions across the border.

"With this program we are able to address many of the social and economic issues that compound medical problems - like the baby who was brought to the emergency department [ED] three times to be treated for otitis media. Nobody in the ED recognized what was the matter. But the nurse case manager was able to learn the underlying problem: the father had lost his job. The family had no heat and almost no food. Antibiotic treatment alone wasn't going to work." 'Health' for this family included emergency assistance for heat and food. The family was registered at Vida and hasn't used the ED since.

Linda Abernathy quoted in
Skolnik, JAMA, 1995

CLAS Standards 9 and 12 – Organizational self-assessment and Collaborative partnerships.

Project Vida uses outcome measures to analyze the programs it has put in place. These often involve partnerships with other institutions and this is well illustrated by the arrangements with the Thomason Hospital Emergency Room – described in the text. Vida continues to track the number of patients entering their program through this process, the number of families who thereby gain access to care and base line health coverage and the frequency with which members of these same families use the ED for non-emergent reasons. Other programs use simple measures such as weight control and glucose monitoring to track their program success. Response from the city (for example, the El Paso police responding with in-kind support for the environmental clean up) tells Project Vida that the program has positive impact.

Access to Care Across Borders

Project Vida participants have access to primary care at Project Vida's clinic and lower cost secondary care via Hospital de la Familia,⁴⁰ in Juarez, Mexico. This arrangement allows patients in need of specialist care, laboratory testing, radiology and ultrasound to receive affordable quality care. A similar arrangement has been established with a Juarez pharmacy where pharmaceuticals can be purchased at prices well below those in the United States and

⁴⁰ Hospital de la Familia is a nonprofit private hospital operated by FEMAP-SADEC. FEMAP (Federacion Mexicana de Asociaciones Privadas) is an El Paso based foundation and SADEC (Salud y Desarrollo Comunitario de Cd. Juarez, or Health and Community Development of Ciudad Juarez.) SADEC is a private, nonprofit institution organized under the laws of Mexico and created for the purpose of improving the quality of life of individuals in Mexico.

coordinated with Project Vida's health care providers. Project Vida has made every effort to expand the horizons of those living within a poverty-stricken area and maintained the community's sense that it can be self-sustaining. Combined with Vida's Time-Dollar program, families can maintain a sense of self-respect and dignity while participating in a broad range of support systems. These systems include concern for both shelter and employment.

Some Project Vida Community Partners

- Thomason Hospital
- Hospital La Familia (Juarez)
- A Juarez pharmacy
- El Paso Police and Housing
- Community Voices: El Paso (sponsored by the W. K. Kellogg Foundation)
- University of Texas El Paso

Micro-enterprises to Help Build Community Health and Capacity

"We teach and we connect people."

Project Vida applied the concepts of the health promotora model to development of a micro-enterprise program. The nearby community houses more than 250 family-run businesses. The area has been based on a cash economy similar to rural Mexico where bank loans were unheard of. Project Vida works to do outreach and gain the trust of this community one business at a time. Helping with forms and applications, Project Vida provides a bridge to small business development programs. Training is offered in bookkeeping and computers. The project has partnered with small businesses to assist them in obtaining loans. To do this, Project Vida has raised funds by borrowing against its own properties. The program has been a lifesaver for many families.

"They saved my life ... they believed in me. I had a bad past ... alcoholic. Now I have my family, my kids, my business, my wife. They taught us about everything, keeping books and now even computers and Quick Books. I even have two employees and we all have health coverage! Now we are talking about getting a loan and buying a new building! Without Vida we wouldn't be here."

A small business owner and his wife, 2003

The micro-enterprise program is now being expanded with Project Vida playing a greater role in financing, assisting with lines of credit and aligning a number of businesses with banks. It is hoped that this program will provide the basis for improved employment, stability, and safety and thereby health in Vida's surrounding community. When Project Vida began in the 1990's there was no bank in their service area. Businesses and families used check-cashing services with high fees and no savings systems. In 2002, Project Vida partnered with a Credit Union that is now on site and is actively used by Project Vida participants. Project Vida's co-director talks about 'fiscal literacy' as part of Project Vida's focus. This includes helping families and small businesses develop and understand sound financial practices. A credit union was the latest addition to this program.

"We have to tell them, when you get paid for that work, don't put the money in your pocket and go down to the store for groceries. You have to keep records. Write down who paid you for what. It's OK if you have take money from the business and pay yourself, but you have to keep a record of that. If you don't do these things, you won't be able to get a bank loan."

(Manager, Micro-enterprise Program)

Project Vida's Programs

Project Vida's current programs are outlined in the Figure I. A visit to many of these areas finds a mix of volunteers, Americorps employees, community participants and Project Vida workers who live in the community or even across the border in Mexico.

Figure 1 - Project Vida's Programs in 2002

- | | |
|--------------------------------------------------------|-----------------------------------------------------------|
| 1) Primary healthcare and outreach | 13) Daycare and Early Childhood Development |
| 2) Well Child Exams / Immunizations | 14) Home visitations for newborns |
| 3) Support for pregnant teens | 15) Parenting Classes |
| 4) Diabetes Prevention | 16) After school tutors/recreation |
| 5) Chronic Disease Support Groups | 17) Reading programs for children |
| 6) Physical Exercise Activities | 18) Computer labs in after school programs |
| 7) Thrift Shop | 19) Homeless Prevention and Recovery |
| 8) Cooperative Food Buying Program | 20) Transitional Living Center |
| 9) Low Income Housing | 21) Micro-enterprise development, fiscal literacy program |
| 10) Translation, help with documents | 22) Community Council, Neighborhood Watch |
| 11) Environmental cleanup/reporting hazards, offenders | 23) Credit Union |
| 12) Citizenship, GED and ESL classes | |

Vida has discovered that resources may become available from surprising sources. "For example, once we started to clean up the neighborhood the city took an interest. It's clear that less graffiti, removal of crack houses and cleaner vacant lots means less crime." On this basis, the city has contributed to parts of the environmental cleanup. Although Project Vida itself was started by and continues to be supported by the Presbyterian Church less than 7% of its annual funding in 1998 came from that source. "Once you know [clearly] what you want to do, the money comes, ... you are never trapped, and ..we find people who want to do what we want to do, we don't give up." (Bill Schlesinger, Co-Director)

Projects are developed based on community input and need. This message is reinforced by a sense of shared dedication, respect and belonging. 'Helping' has become a byword throughout these project activities: "Every day you come, you really help someone." Respect is maintained through help without handouts. Reciprocity is implied by rewarding effort.

Language, Social and Health Literacy

Many of Project Vida's participants lack 'literacy' in health as well as social systems. Project Vida has provided assistance at multiple levels including 'fiscal literacy' illustrated in

Project Vida's Funding (1998)

- Community Development Block Grants (41.7%)
 - Early Childhood Development
 - Early Education/Gang Prevention
 - Homelessness Recovery
 - Primary Care Clinic Funding
 - Transitional Living Center Construction
 - Clinic Expansion Acquisition/Design
- Americorps (27.5%)
- Community Oriented Primary Care (17.2%)
- Presbyterian Church USA (6.6%)
- Meadows Foundation (4%)
- Maternal and Child Health Services (1%)
- Thomason Hospital (1%)

Source – 1999 Nelson Community Awards Application

the micro-enterprise system described above. Vida's current programs include ESL as well as Spanish language training and this includes assessment of ability to read and write. Programs are tied to local schools and include the capacity to assist individuals with acquiring a GED.

Families in Project Vida's apartment units have learned skills to problem solve around community needs and to maneuver within the city's public works and political systems. Youth volunteers for the environmental justice program have carried disposable cameras and recorded problems such as dumping trash in vacant lots. Youngsters and their families, meanwhile, receive time-dollar awards for these efforts. Project Vida's environmental justice director contacts city inspectors, police or deals directly with the perpetrators. The unspoken lessons taught about community responsibility and participation are inherent, quietly woven into program process. The outcome of these efforts are visible in the neighborhood surrounding Project Vida and local residents are able to describe their own involvement in one or another of these programs.

CLAS Standards 4-7: Defining health in its broadest sense Project Vida has learned that literacy, as a reflection of navigating life's systems and needs, must be addressed. Project Vida teaches fiscal literacy, fundamental language skills, ESL as well as health and social services literacy.

Learning by active participation, Project Vida's families and patients cope and deal with everything from basic health to environmental issues, and community improvement. Project Vida redefines language and literacy broadly and extends the meaning of 'language access' and health access in exciting and meaningful ways for marginalized individuals, families and communities.

"Project Vida encouraged us to testify at the City Council. I'd never done anything like that before. We talked to them about our streets and sidewalks. We went down there two times. That's how we got our street paved! We're really happy about it!"

Elderly woman, living in one of Vida's apartments

Community Congress

Project Vida has come a long way from its beginnings. "When we started in 1989 we held some community coffees. Initially, no one showed up. Residents weren't sure if we were here to sell drugs, to proselytize, or just what!" Having found that no one else was serving the 10,000 people in zip code 79905, they opened a one-room clinic a year later.

Annual Community Congress

- 100 + community participants
- Review strategic plan, program areas
- Community views acted upon
- Community efforts mobilized

With nearly 1500 families enrolled in their programs, Project Vida now holds an annual community congress comprised of 100+ community members. Programs are reviewed, priorities set and community efforts mobilized. Recently, residents of Project Vida's permanent apartment housing units testified at City Hall to persuade the city to pave their street. They succeeded; the street was paved only last year and Project Vida's offices now face across a paved street to a paved parking lot for the apartments.

Key innovations – Direct community input. Project Vida acts on standards 11 and 12 by direct community input and involvement. It's woven into the fabric of their annual cycle as well as their day-to-day work. 'We assure that our services respond to the cultural and linguistic needs of our service area through our annual community congress and our programs. The community congress responds to and drives our strategic plan. It has contributed to many decisions: the need for more space, the development of our early childhood development center and economic development, and in so doing has provided feedback year by year.' (Bill Schlesinger, 2003, paraphrased)

CLAS Commentary and Lessons Learned reflected by Project Vida

Commentary – Relationship in the CLAS standards. Project Vida is about relationships, ties with individuals, with families, with the local community and the El Paso community at large. Relationship building is implied in the CLAS standards but in a segmented fashion. CLAS represents an effort to tie traditional delivery systems to community process; its language, of necessity, describes organizations and communities as distinct entities. Project Vida is one of the health care systems in this report that blurs that distinction.

Project Vida is somewhat unique in that members of the Project Vida program are members of the Project Vida community. This blurs the line between organization and community. At Project Vida, ownership and design of process are shared. Additionally, Project Vida helps broaden the scope and meaning of some of the CLAS standards.

To begin with Project Vida views 'Health' broadly. Community wholeness is seen as essential to personal and family health. This implies that institutional programs directed at health may need to engage concerns beyond biological definitions of wellness and disease.

Regarding relationships: "We think the key components are responsibility, balance and trust. We avoid competition, turf wars and find people that want to do what we want to do. We have partnered with many organizations to accomplish our goals and to meet community needs." Key questions begin to emerge regarding 'relationship' in the design and review of health care systems and issues of continuity, trust, scope of concern, community input and oversight come to the fore.

Special aspects and other lessons from Project Vida's Programs:

- 'One-stop shopping' – Vida's very design makes a variety of services available under one umbrella thereby avoiding what in many programs fall into categorically separate systems.
- Respect, validation and reciprocity are evidenced in the program's fabric
- In its efforts to build a community towards wholeness, Project Vida creates a balance between individual need and family/communal good.
- "You have to be careful about bookkeeping and accountability."

Harborview Medical Center (HMC)

Seattle, Washington

“...A comprehensive health care facility dedicated to the control, promotion and restoration of health.”

History

Harborview Medical Center (HMC) began as a six-bed King County welfare hospital in a two-story South Seattle building in 1877. By 1906, the hospital had moved into a new building in Georgetown with room for 225 patient beds. Another move occurred in 1931, when the center wing of the present hospital was completed, and King County Hospital's name was changed to Harborview. Today, HMC is a world-class trauma and 349-bed patient care center, as well as a teaching and research facility. The hospital serves all patients, regardless of their ability to pay.

| |
|---------------------------------------------------------------------------------------------------------------|
| Harborview Medical Center is owned by King County and managed under contract by the University of Washington. |
|---------------------------------------------------------------------------------------------------------------|

Focus of Work/Philosophy/Patients Served

The mission statement of HMC describes “a comprehensive health care facility dedicated to the control, promotion and restoration of health. Its primary mission is to provide and teach exemplary care and to provide health care for those patients King County is obligated to serve.⁴¹” In addition to serving a broad spectrum of patients the following groups of patients and programs are given priority for care at HMC: persons incarcerated in the King County Jail; mentally ill patients, particularly those treated involuntarily; persons with sexually transmitted diseases; indigents without third-party coverage; non-English speaking poor; trauma, burn treatment, specialized emergency care; victims of domestic violence; and victims of sexual assault.⁴²

Description of Key Programs

The Community House Calls Program

The Community House Calls program at HMC is a nationally recognized program that provides a culturally and linguistically appropriate bridge for limited or non-English speaking patients to help them negotiate their health care. Some of the key components of the program include:

- The use of case worker cultural mediators (CCMs) and community advisors as part of the health care team, allowing access to cultural information and cultural traditions that are in transition, but which strongly influence refugee families.
- Development of an expanded role for interpreters, in which they provide culturally sensitive case management and follow-up, and educate providers, residents and medical students about cultural issues surrounding their patient's care.

⁴¹ Source: HMC Website www.washington.edu/medicine/hmc/

⁴² Source: Harborview Medical Center, Priority Patient and Community Benefits Report 2001, Pg. 3

Through this program patients have greater access to culturally knowledgeable providers and access to health services in their own language; providers receive relevant cultural and social feedback during interpreted patient encounters; medical and pediatric residents have accurate and applicable experiences and explore cross cultural issues in health care. The model encourages more appropriate and effective use of medical services among ethnically and linguistically diverse communities. The CCMs (originally called ICM’s – Interpreter Cultural Mediators) provide a wide range of services including interpretation, cultural mediation, case management, advocacy, follow-up, assistance in accessing ESL and citizenship classes, coordination of patient care, health education and home visits.⁴³

Foreign-born populations

(5-mile radius of HMC selected census tracts/neighborhoods)

Region of Birth

(Seattle’s foreign born)

- Asia 55.8%
- Europe 16.0%
- Latin America 13.2%
- Africa 7.8%

The CCMs at Harborview Medical Center provide services to patients from six targeted communities: the Amharic, Cambodian, Somali, Tigrinya, Spanish, and Vietnamese speaking populations. Community House Calls bridges clinical care and preventative and public health services through a network of community advisors and CCMs. CCMs are bilingual and bicultural case workers chosen in collaboration with community leadership to represent targeted communities. The CCMs interpret for, and help to manage the care of, families who may be more vulnerable due to their

Patient advocacy

“Some of what happens (when an interpreter is present) is that there is a witness, a third eye and that itself ensures that the patient has the best care.”

HMC staff

status as recent immigrants and refugees. While CCMs educate community members about medical and public health concerns, they play an equally important role in educating the medical staff of HMC about healing traditions and social and cultural practices of the target communities.^{44,45}

Key Lessons – The Role of Interpreters and Bilingual Health Workers - Community House Calls is a vital program and raises multiple questions about appropriate roles for interpreters in health care. CCMs take referrals of difficult cases from both Pediatrics and Adult Medicine. They have community advisors who meet quarterly to exchange information on topics of concern to the communities and to Harborview, such as mental health and illness, cancer detection and treatment and youth violence. The CCMs are trained in a variety of skills including health care interpretation. They work to teach patients how to navigate a complex health care system.

⁴³ Jackson-Carroll L, Graham E, Jackson JC; Beyond Medical Interpretation: The role of Interpreter Cultural Mediators (ICMs) in building bridges between ethnic communities and health institutions; (1997)

⁴⁴ Source: http://depts.washington.edu/gim/clinical/clinical_chcisinfo.htm Originally funded for two years in the early 1990’s by Robert Wood Johnson Foundation, the program has grown with support from HMC.

⁴⁵ A description of portions of this project is accessible at <http://nnlm.gov/pnr/specproj/resourcelib/uwsub.html>

Interpreter Services

Harborview Medical Center treats patients from over seventy different language groups with the help of interpreter services. Last year there were over 106,000 hours of interpretation provided at HMC. Interpreter Services is primarily funded by the hospital's general funds. Federal Medicaid matching dollars account for a limited portion of the funding.⁴⁶

In addition to serving the refugee population, Interpreter Services coordinates interpretation for all other non-English speaking patients and individuals requiring American Sign Language assistance at the Medical Center. HMC employs a staff of eight interpreters who cover the most frequently requested languages. When staff does not cover a language, HMC draws on its 66 contract interpreters for language services. The institution also has contracts with three language service agencies and one telephonic interpreting agency.

Language services are available 24 hours a day, seven days a week. Interpreters are offered economic incentives for working during the weekends. HMC requires training and certification for all staff and contract interpreters. Staff recommendation for one of the next steps toward service enhancement is the education of providers in the importance of using interpreters in clinical settings.

A few of the clinical providers sometimes prefer to use their own bilingual skills. However, staff recognize that when a non-native speaking provider speaks in the patient's language, valuable cultural cues and linguistic nuances may be lost and for patients it may become challenging if they have difficulty understanding the accent of a non-native speaker. Power differentials come into play and the patient may be reluctant to inform the clinician that communications are failing.

Health Care Interpreting HMC

Hours of interpretation

- 1995 35,000
- 2000 100,000
- 2002 106,000

4 Staff Interpreters

7 CCMs (5.6 FTE)

66 Contract Interpreters

4 Interpreter Agencies

Phone Interpreting Contract

24 hours/day, 7 days a week

Clinicians need information regarding the use of interpreters.... "Getting through a menu in Spanish is not the same as discussing pain with a patient...and no one ever seems to talk about speaking a 'little' Chinese."

- Staff Interpreter

CLAS Standard 4-7 – HMC's interpretation system is one of largest in the country. It is vital to operations at every level and in spite of its availability, long standing presence and maturity there is a clear sense that the providers need further training. Like many programs there is always work to be done. HMC is currently working to improve the hospital's data collection/registration system and to tie language needs to appointments electronically.

⁴⁶ Silva D: More diverse population translates into ER dilemma. Puget Sound Business Journal, 8/6/01. Description of HMC and central Seattle interpreter programs. <http://seattle.biz.com/seattle/stories/2001/08/06/focus7.html>

International Medicine Clinic

“Every single word I say may require a negotiation of meaning.”

Frank Stackhouse, MD, International Clinic

HMC’s International Medicine Clinic “has 13,000 patient visits annually and helps provide services for among others, an estimated 15,000 East African and 30,000 [families from Southeast Asia] living in Seattle.”⁴⁷ The International Medicine Clinic is yet another example of the provision of culturally and linguistically appropriate care at HMC. Providers and staff at HMC’s International Medicine Clinic learn about health beliefs and practices of the communities they serve from multiple sources, chief among them being their patients, interpreters, CCMs, members of the CCM Advisory Board hospital staff. The International Medicine Clinic provides a rich educational opportunity for house staff at HMC to become familiar with the realities of the communities that HMC serves. There is “palpable cross fertilization,” remarks Carey Jackson, M.D., Director, International Clinic and recipient of the Robert Wood Johnson Foundation’s Community Health Leadership Program Award.

“At the International Medicine Clinic, there is palpable cross fertilization across the various disciplines.”

Carey Jackson M.D., Director

EthnoMed: Ethnic Medicine Guide

<http://www/hslib.washington.edu/clinical/ethnomed>

EthnoMed is an internet-based clinical tool that is a database containing medical, cultural and community information about non-English speaking refugees and immigrants living in the Seattle area. Its purpose is to make information about culture, language, health, illness and community resources directly accessible to health care providers when they need it. For example, just before seeing a Cambodian patient with asthma, a provider can use a computer terminal to access EthnoMed and read about how the concept of asthma is translated in Cambodian and what common cultural and interpretive issues surround asthma management in the Cambodian community. A practitioner may also download patient education materials (some in the native language) to give to the patient at the end of the medical visit.⁴⁸ The following information is available for each selected cultural group:

- A brief cultural description
- A section on health and illness
- Information about community resources
- Patient education materials

The content of each profile is researched and reviewed by both health care providers and members of the target community to ensure accuracy and relevancy. The site is frequently updated and includes links to reports, research,⁴⁹ presentations and information produced by HMC’s programs.

⁴⁷ Paulson T: Harborview Doctor Honored for Services for Immigrants. Seattle Post Intelligencer, 5/22/99.

⁴⁸ Jackson-Carroll L, Graham E, Jackson JC; Beyond Medical Interpretation: The role of Interpreter Cultural Mediators (ICMs) in building bridges between ethnic communities and health institutions; pg. 12, (1997)

⁴⁹ See citations under Graham and Jackson in Appendix A.

Key Learning – Research, Training, and Community Involvement. The International Clinic and EthnoMed have helped define a level of excellence in community research. Work is consistently informed and driven by the community voice and this is illustrated by day-to-day work among provider, interpreter and CCM teams as well as by selected research the unit has published and information available on web. These efforts provide model approaches to understanding the impact of differences in meaning in clinical and public health practice.

Patient and Family Resource Center

The Patient and Family Resource Center is available for the use of Limited English or non-English speaking patients and HMC staff. The Center serves as an essential link to social and financial services for families. Patient and family members can also access important health information that is culturally and linguistically appropriate. Community House Calls staff and interpreters from the various ethnic communities share the responsibility for reviewing documents and determining whether they should be included in the Resource Center education collection.

Diabetes Education in Six Languages

The Multicultural Diabetes Project is a work in progress. It has been created by a multidisciplinary team of pharmacists, nurses, dieticians, a librarian, interpreters and certified diabetes educators. The educational materials were field tested in the classroom and are now used in the Adult Medicine clinic and all outpatient clinics. These educational resources are currently available on EthnoMed.

The CCMs review all translated materials for cultural context, identifying food that would and would not work with patients. The team also audio taped and photographed individuals from the communities preparing ethnic specific foods while demonstrating standard food portions. This particular team of professionals and similar teams across the institution have worked again and again with a community process that has had excellent outcomes. “You need people who keep giving you feedback,” says Ellen Howard, Head Librarian, Harborview Medical Library, “and then you need to give them credit. Community members are members of the health care team. An ongoing relationship has to be established that is based on trust. You just can’t do a project, drop it and run.”

“You need people who keep giving you feedback.. Community members are members of the health care team.”

Patient Relations Office

HMC’s Patient Complaint Office interfaces with key programs at the Hospital that have day-to-day contact with patients and families. It works closely with the Interpreter Services program and the Spiritual Care program. A key component of the program is its cadre of patient relations volunteers who come from the community and are often

“If the event is witnessed by a staff person, it is reported to the Patient Complaint Office.”

Kathleen Flaherty
Manager, Patient Relations

former patients of the Medical Center themselves. The volunteers visit patients and families each day to listen, to identify needs or to alert staff to any issues that may need attention.

This office also provides training for staff in direct contact with patients and families. The training is directed towards enhancing direct services and uses the LAST (Listen, Acknowledge, Apologize, Solve the problem together and Thank the patient) model. The office is closely connected to the standards for service excellence of the Medical Center.

“It’s a challenge everyday to stay unbiased, to renew oneself when working with people. I see my primary role as patient advocate.”

Kathleen Flaherty

The HMC Spiritual Care Department

In addition to their regular activity of ministering to patients, families and staff, the department runs a Chaplain Residency Program. This program is designed to train individuals to become ministers in multi-faith settings, as well as certified chaplains, endorsed by their own faith group. The program has trained chaplains from different countries and from multiple faith traditions. The Clinical Director speaks at all new employee orientations to acquaint staff with the diversity of spiritual belief and spiritual care available for our multi-cultural/multi-faith patient and staff population.

Spiritual care is defined differently by each person. "Every spiritual and religious tradition has its own continuum of liberal to conservative. You always need to ask questions to ensure the information is accurate and that the individual is comfortable saying they're religious or not."

Nancy Chambers, Clinical Director
Spiritual Care Department

Employees understand that their own beliefs are valued. They are encouraged to share their traditions and resources. The meditation space has prayer rugs available, as well as a variety of prayer books. Native American and Alaskan Native healers are invited periodically to lead prayers for patients as well as staff. There is a weekly Catholic Mass as well as a weekly Multi-Faith Service, and a monthly Buddhist Meditation led by HMC staff.

CLAS Standard 13. Conflict and Grievance Resolution. Harborview’s spiritual care department offers a focused methodology for grievance resolution program that engages community as well as prior patients. This model system is driven by the voices of individual clientele as well as the voices of staff (who witness problems).

CLAS Commentary and Lessons Learned reflected by HMC

“Harborview has a bumper crop of visionaries, who are passionate about this work.”
Ellie Graham, MD

HMC staff interviewed for this study sees the organization’s leadership being shared and disseminated throughout the hospital. There are many names and many leaders in different sections of the organization. The strength of the institution is apparent in

individuals taking personal responsibility to make the institution work for the community it serves. Significant institutional supports are evident in the form of fair pay, flexible work schedules, benefits, and recognition as well as celebration of staff accomplishments and work place equity. Staff members cite a combination of institutional, co-worker and supervisory support that make things work at HMC and allow for the delivery of services that seek to be culturally competent and linguistically appropriate.

There is room for “bright ideas,” innovation and individualism – it’s part of the institutional culture.

The hallmark of HMC is its committed and innovative staff supported by an institution that is dedicated to its mission. This powerful combination has spawned programs that have been recognized and utilized nationally as models for culturally competent and linguistically appropriate care. This large public institution serves a variety of populations, some of whom may live on the fringes of society and face multiple barriers to accessing health and social services. The barriers that service providers encounter are often just as daunting, but the commitment to quality of service and innovation overrides these challenges.

“It’s good to be here, it’s a large institution and there are opportunities for more learning and for resources.”

Bria Chakofsky-Lewy RN
Community House Calls Program

The Men's Center

East Baltimore, Maryland

History/Location

The Men's Center (TMC) was started in 1995 under the non-profit umbrella of the Historic East Baltimore Community Action Coalition and the Family League of Baltimore City. The Men's Center achieved its own non-profit status in 1999.

TMC is located in one of the more economically depressed areas in East Baltimore and in one of many forgotten alleyways and isolated tenements. The Men's Center offers hope to men through an array of services that address issues in health, parenting, and life skills, with referrals for substance abuse treatment and education/ employment. TMC ensures the hope for health and education while it is caught in the shadow of the imposing buildings of the Johns Hopkins Hospital and University. It is an oasis of hope in the middle of broken concrete, empty and demolished apartment buildings, barbed wire fences and construction equipment. One stark activity visible in broad daylight is the surreptitious drug dealing of out of school youth. A few blocks away, the penitentiary and the juvenile detention home loom over the neighborhood.

"If you do come to visit, don't expect a lavish place, because we are very poor, but we love the work we do..."

TMC staff

Clients/Patients Served

The Men's Center for the most part serves African American men and youth, but no one is turned away if they need services. Over 400-450 clients are served annually. Many of the clients are unemployed or underemployed; others are recovering addicts; and still others have past histories with the criminal justice system. Recently this Center is seeing more women coming in with their partners and accessing TMC's services for themselves. Forty-five percent of men who access services at TMC are on parole or probation. "We do lots of work with the reentry population. We now identify this as part of our work." (Leon Purnell, TMC Director) Therefore, the continuous struggle is to get men hired who have a record. TMC has succeeded in keeping some men out of jail by advocating for the men around modifications of their arrears from failed child support payments. Many come out of jail with another warrant waiting for them for child support. "Support enforcement becomes a weight around their neck" (Leon Purnell). Here in Baltimore, we have been trying to effect change, having payments stopped when a man is incarcerated, thus keeping the arrears from mounting. TMC and its clients see government as being only interested in the money for child support without attempting to assist in establishing meaningful connections between the father and the child. These disconnects often result in juvenile delinquency, teen pregnancies, high drop out rates and violence in the home and on the streets.

East Baltimore in Context

- African American 91.4%
- One in three African American males, 20-29 live under some form of correctional supervision or control (nationally 1995)

In East Baltimore, poverty and disrupted lives lead to broader issues in health:

“Health status indicators for the area surrounding the Johns Hopkins Medical Institutions are among the worst in the city and the entire state. The City Health Department's 1998 statistics show that these neighborhoods have Baltimore's highest age- and sex-adjusted rates of morbidity and mortality from cardiovascular and cerebrovascular disease. Their residents suffer unduly high incidence of diabetes and cancer as well as from some pulmonary diseases, violence, HIV-related illnesses and an epidemic level of substance abuse. The rate of sexually transmitted diseases in East Baltimore is the highest in the country and, in the case of syphilis, the highest of any city in the developed world.”⁵⁰

Work and philosophy

The services offered at TMC focus on the emotional, mental, physical, medical and financial concerns of African American men. TMC efforts include life skills training at the Center and a work re-entry program in West Baltimore's Sandtown-Winchester neighborhood. The work is further accomplished through a variety of projects and programs of the Center including the Rites of Passage Drumming program; Job readiness; the Dad's Duties project, the Health Clinic, the Food Produce Giveaway, Dee's Place and the Rites of Passage program.

TMC funding sources:

(partial list)

- Casey Foundation
- Abell Foundation
- Success by Six
(United Way and Family League of Baltimore)
- TMC Annual Campaign
- Harry and Jeanette Weinberg Foundation
- Public Welfare Foundation

The organization currently has limited funds for program operations and sustainability, let alone disseminating information about their services. TMC is community centered and community driven. It is the community that spreads the word about the Center's work. The

“We address the prejudices that African American men face everyday – we talk about how to cope and not land back in jail.”

-Leon Purnell

community is TMC's greatest asset. The organization receives limited funds from the Casey Foundation, the Abell Foundation, and the Success by Six programs, a private funding program aimed at the betterment of children from birth to six. The United Way, Family League of Baltimore, the Weinberg Foundation, Tobacco and Smoking Cessation Grant, Board donations, and the TMC's annual giving campaign also support the program.

Description of Key Programs

Reentry and Job Training Program

A major focus of the work at the Men's Center is the reentry program for men who have been incarcerated. The reentry program is a six-week program addressing such topics as:

- Delayed gratification
- Budgeting

⁵⁰ Rienzi G: Urban Health Council Sets Priorities. The Gazette Online, The Newspaper of Johns Hopkins University, March 13, 2000, Vol. 29, No. 27

- How to dress for a interview (up or down)
- How not to intimidate the interviewer
- How body language can help or hurt you

This program's success is the result of combining practical skills for job seekers with straightforward discussions about the behavior changes required to enter the job market in today's world, especially if one is an ex-con with a felony record. The program is well accepted by the clients, because it does not attempt to warehouse men. It also satisfies the immediate economic needs of the reentry population. During the past year alone, TMC's pre-employment program has assisted 297 men and 175 of these men have found employment. However, serious transportation barriers in the community have contributed to problems with job retention.

Men who come in are placed into one of three levels of service based on need. They receive need appropriate services which range from a 28-day drug rehabilitation program, pre-employment training, life skills training, parenting training, referrals to GED and employment programs and the health clinic.

The Health Clinic

TMC's Health Clinic started in response to men's health needs that were identified in focus groups. Men were being prepared to enter the workforce, yet there was no means to assess their physical readiness, or health.

This led to the addition of the health clinic as a TMC program. Since the clinic has opened, TMC has been averaging 280-340 new patients annually, with about 2,000 return visits a year. Client demand is consistently growing so currently, the clinic is open one night a week in addition to opening three hours every third Saturday. Many of the patients served have major health related problems such as diabetes, hypertension, sexually transmitted diseases and mental health issues.

Mr. C., a 55 yr. old patient attends the clinic as a follow-up for his blood pressure problem. He lives 8 -10 miles from the clinic and he either walks or catches the bus to reach TMC: "I like the warmth, the service the people give - its like family here. The Men's Clinic is a beautiful place to be."

The Health Clinic operates with three staff members; a volunteer, a physician and a nurse all of whom are African American. Every Thursday evening, an average of twenty-eight patients is seen between the hours of 6:30 and 10:00pm, during which time clients receive baseline primary care.

Referrals are made if necessary to Matilda Kovals Health Clinic or Johns Hopkins Hospital. To date, pharmaceutical companies have donated medications, but the supply is drying up. TMC has links established with the Johns Hopkins School of Public Health, with Friends of TMC and other organizations who have helped do what ever it takes to keep the clinic open.

Dealing with perceived racism: "Providers need to understand how sensitive African Americans are to the dismissive attitudes of providers and staff."
- Leon Purnell

According to Men's Center director, Mr. Leon Purnell, starting the clinic was a battle. Johns Hopkins, a major metropolitan teaching, hospital that looms large only a few blocks away was viewed as a viable source of health care for the neighborhood. However, the

community needed and wanted their own health clinic where they could receive respectful primary care for themselves and for their families. “Many African American men are misunderstood when they go to the hospital and providers often don’t understand that if prescription drugs affect their manhood, compliance may become an issue. The clinic at the

CLAS Standards 4-7 Language and Discourse – At The Men’s Center, respectful interactions between African American patients and providers involves a contextual framework that is mutually shared and understood. Language counts in all provider-patient interactions. In this setting, African American health workers serving African American patients know how deeply, and unconsciously the sub conversation of racism can run through the usual patient-provider interaction. Providers at the Men’s Center combine this knowledge with their own experience as African Americans to call upon common language and common experience, creating the highest quality experience for the clients.

Men’s Center is free and it releases its patients from the threat of unpaid medical bills. It is a place where the staff is sensitive to the issues of African American men.”⁵¹ The fact that patients will wait as long as it takes, sometimes from 6:30pm – 10:00 PM to receive care is ample proof of the success of the health clinic. The clinic provides free health care, nutrition and health education classes as well as HIV/AIDS testing five days a week, Monday through Friday, 5:30- 8:00 PM. Smoking cessation classes are taught several times once a week. TMC works at keeping its community healthy, alive and out of Hospital Emergency Rooms, morgues, dialysis treatments, and long-term hospitalizations.

CLAS Standards 1-3 -Devoted African American staff serving African American clients in the health center and Dee's Place meet the often absent requirement in the discussion of culturally competent care, to serve African Americans respectfully. Understanding the impact of racism on African Americans, this staff consciously provides effective, respectful care in the context of the brutal and fragile day to day existence for the men which the center serves.

Dee’s Place: An all night addiction counseling program

“Dee,” Delois Sparks, a case manager/addictions counselor at TMC was determined to put in place an addiction-counseling program that could operate all night. The all-night, continuous support group meetings at TMC are open to anyone who is seeking NA meetings. Clients arrive from as far away as Delaware, Washington D.C. and Virginia for this night-time program. With a staff of four, all of whom are in recovery and have been trained as counselors, this program serves clients using the 12-step program, 9:00 pm to 9:00 am, seven days a week. During the day, Dee’s Place helps persons get care via one-on-one or group sessions, and in conjunction with The Men’s Center, place people into drug treatment. There are as many 208,000 visits a year and many of the clients are identified as needing mental health services, often with the dual diagnoses of drug addiction and mental illness, all of which need to be addressed. Two physicians provide limited pro-bono mental health services.

"People addicted to drugs need help the most 'when the sun goes down' ... this unique program at TMC has proved its worth."
- TMC Staff Counselor

⁵¹ Leon Purnell, Director of the Men's Center.

The Food Bank

TMC has partnered with Poverty Solution and the Maryland Food Bank to organize a weekly produce distribution. This program supports families in the local neighborhood who have limited resources. At least 7,460 families were served in the last eight months through the program.

“The seniors often have to choose between buying medications, paying bills or buying food each month.”
- Leon Purnell

For senior citizens the Food Bank services can be a critical link to survival. TMC provides hope for their survival in more ways than one.

Rites of Passage

This program was established to help youth be more respectful of elders, of women, of their communities and of themselves. The Rites of Passage program draws its strength from an Afro-centric value system that brings young men through a series of prescribed developmental stages towards manhood. It is offered to males ranging in age from eight to eighteen as an eight week-long program. To date 72 youth have completed the ‘Rites of Passage’ program at TMC.

The content includes a field trip to the Village of Oyutunji in Beaufort, South Carolina, where a Yoruba priest leads the program. The program includes a five mile walk in the community, a two-day food fast, a 21-day sexual fast, learning three drumming songs, undertaking a walk in the bog, the cutting down of a tree, and participating in the evening program. Each person also receives an African name and its meaning. Discussion and teachings include topics such as:

- Mind and manhood
- Drug abuse prevention
- Early childhood pregnancy
- Making the community safe
- Respect for women and elders
- Abstinence
- Staying in school
- Not being arrested

Key Learning:

Rebuilding the Spirit of the Community.

The young men are encouraged to focus on realistic life goals that will build strong individuals, functioning families and a united and caring community.

Participants also list fifty significant problems in their community and make suggestions for solutions.

The young men are encouraged to focus on realistic life goals that will build strong individuals, functioning families and a united and caring community. Men who go through the Rites of Passage continue with valuable community service. They become noticeable and respected individuals and effective change agents in their own communities through their positive influence and involvement. This program trains adult African American men and returns a sense of community pride to them. It regenerates the very spirit of the community

that has been fractured and lost because of economic and social deprivation. The Rites of Passage imbue its participants with a sense of tradition, validation and self-esteem.

The Drumming Program

A traditional drummer and part-time employee at TMC maintains an entire room lined with drums from Senegal. As he runs the Center's drumming program, he teaches drumming songs to teach and sustain a part of the African culture in youth and adults. Fifteen young people participate in his after school Rites of Passage drumming program. He uses drumming to focus young minds on chores and on school work and most importantly on the business of living. The program keeps young people off the streets and away from peddling drugs and other illegal activity – it gives them a healthy alternative. Many of the children who want to be part of the drumming Rites of Passage need transportation to and from the safe haven of TMC. Transportation is provided by TMC staff on their own time and using their own resources, because they believe in the philosophy and goals of the organization. They have full ownership in a program that struggles to do so much with so few resources.

In the last five years TMC has placed over 100 persons in drug treatment. Of these, 60% remain drug free, are gainfully employed and are involved in their children's lives.

CLAS Standard 12 - Community Input - Community is the driving force for the activities of the men's center. The needs are defined and responded to in practical and useful ways. Here the community makes clear that physical and spiritual survival are intertwined--- food to nourish the body coupled with drums and ritual to nourish the soul---are central to creating a healthy people. The identification of these programs, their design and development come directly from the views of the community served.

Reflections of the CLAS Standards in the Programs at the Site

The Men's Center is a program that struggles to accomplish a great deal with limited resources. Success at TMC is personified in many ways. Though located in one of the largest open drug markets of the city, TMC may be one of the reasons according to local law enforcement officers that there has not been a shooting "every week or so". Through respect and understanding TMC maintains an open door policy for marginalized young men from the neighborhood. The program is fully responsive to the need of the populations it serves through the process of rebuilding the spirit of individuals and working to stabilize a shattered community. At the Men's Center, the social context and community relationships shape the interpretation and applicability of the CLAS standards.

Southcentral Foundation/Alaska Native Medical Center

Anchorage, Alaska

"Our whole system is designed around relationships."

History, Demographics, Patients Served

In 2002, Southcentral Foundation (SCF)⁵² celebrated twenty years of providing health and related services to Alaska Natives who are residents of Anchorage, the Matanuska-Susitna Borough and beyond. A non-profit Native-owned health care corporation, SCF has a primary care population of 45,000. While the majority live in the Anchorage area, nearly 10,000 of these patients live in 55 isolated rural villages scattered over a 100,000 square mile catchment that reaches to the tip of the Aleutians and to the Pribilof Islands. SCF manages primary care activities in its clinics and on the campus of the Alaska Native Medical Center (ANMC). SCF and ANMC have over 375,000 visits annually. In remote areas, health care problems and maintenance are in the hands of trained village health aides. ANMC is charged with providing inpatient and tertiary care services to the local SCF population as well as to clinics, village health aides and small hospitals throughout the entire state. In addition, SCF and ANMC support broad based activities focused on issues of health in Alaska Native communities.

The ANMC health care system was transferred from the Indian Health Service to Native ownership in 1999. The move was preceded by extensive preparation. SCF leadership used a combination of community meetings, surveys, and elders' councils to inform its beginnings. Having connections with the Institute for Healthcare Improvement and others since the early 1990's, SCF and ANMC evolved towards a patient and family focused, relationship based program built around a primary care model in pediatrics and family medicine and by the removal of specialty focused teams. Since August 1999, SCF has gone from 25% of patients having a primary care provider to 95%, there has been a major drop off in ER/Urgent Care visits as well as a dramatic drop off in visits to specialists. Each primary care panel includes a nurse case manager and guarantees same day patient and family access to the primary care team.

The Need in Anchorage & Alaska

- 119,000 Alaska Natives Statewide living in urban settings and 229 rural/remote villages
- 45,000 in Anchorage, Matanuska-Susitna Borough and 55 surrounding villages
- Anchorage and Mat-Su Native populations grew by 94% between 1990 and 2000.
- Diabetes has increased 80% 1985-98
- Alaska Native children 2X as likely to live in poverty (26%) as all Alaska (11%)
- 27.3% Unemployment in males >16 years
- FAS* prevalence 7X national rate, 12.3% pregnant women drink during pregnancy
- High death rates from unintentional injury
- High death rates from suicide

From IHS/ANTHC data, 2002

*FAS = Fetal Alcohol Syndrome

Changing the Culture of the Institution

"In 1994 ... there was no primary care system at ANMC. Most area residents got their primary care at the Emergency Room, when they got it at all. The clinics were in hallways; there were no receptionists or waiting rooms, the services were centered on the staff's needs

⁵² The Cook Inlet Region, Inc. (CIRI) native corporation established SCF in 1982. SCF is one of two managing partners of the Alaska Native Medical Center (ANMC) a 150 bed hospital that is the referral resource and tertiary care center for Alaska Native clinics and hospitals around the state and that shares a campus with the SCF primary care center. The Alaska Native Tribal Health Consortium (ANTHC) is the other co-owner of the ANMC.

not the patients ... every department was an island."⁵³ Having decided that "You make decisions based on what's best for your customers," SCF clinics now offer patients same day access to their primary care provider providing they call before 4:00 pm. As a result the use of the Urgent Care Clinic and ER for primary care needs is down 50% and the use of specialists is down more than 60%. Waiting times have decreased throughout the system, patient provider match is 75-80%, and patient satisfaction ratings are very high.

The SCF/ANMC story points out that 'culture' and 'cultural' issues include the culture of the institutions themselves. In this context, for CLAS to be effective it must be reflected at all levels in the fabric of what the institution is and does.

SCF's operating premises are based on Quality Management principles learned through work with the Institute for Healthcare Improvement and others. The ANMC system is patient centered in its approach. "We can't afford to have a team for every disease, and what about people with multiple problems? We put our eggs in a whole person, integrated basket."⁶⁴ Highlights of SCF/ANMC's programs include relationships, health in terms of community wholeness, complete overhaul of an institution's culture, building community capacity through a job progressions program, strong community input and oversight, and community ownership of the system.

SCF and ANMC have centralized care around patients and families. Subspecialty and other support systems have been molded to align themselves to support this operational goal. These efforts are molded by SCF/ANMC's Mission and Core Philosophy:

Mission: To work together WITH the community to achieve wellness. We have a multidimensional vision of wellness. The only programs that have shown long-term sustained improvement in the true underlying issues of health and wellness are those programs with long-term relationship with patient and family. These long-term relationships allow for trust to develop, for consistent messages to be given, for patient knowledge to grow and grow, and for every visit to build on a previous one.

The ties between core philosophy, mission, primary care, inpatient systems and the statewide needs are illustrated (in part) by ANMC's implementation parameters:

- ANMC is a Native place with services delivered in culturally appropriate ways, cultural competence is expected of staff and Native professional development is a priority.
- ANMC will coordinate and integrate with the rest of the Native health system in Anchorage and across the state.
- ANMC's specialty and acute care services will be supportive of the patient's primary care relationships.
- The system is family oriented and relationship based.⁵⁴

SCF and ANMC fold the culture of medicine itself into their program design efforts. They have chosen patient centered care as a fundamental principle. Their subsequent work, like the work of other programs reviewed in this project, suggests that relationship, trust and patient centeredness likely should be clearly articulated in the CLAS Standards.

⁵³ Gordon AB: Success Story: Building Healthy Relationships at Alaska Native Medical Center. 2002, IHI www.ihl.org/resources/successstories/ci1002alaska.asp

⁵⁴ Selected from ANMC Implementation Parameters, received 2/03, Undated

Building Native Capacity and Native Leadership

"We are building Native capacity internally and state-wide."⁵⁵

SCF has vigorous programs focused on staff development. Employees that are entry level are tracked for meeting progress goals at the end of each year. Specific areas such as mental health and social work are prioritized and employees are encouraged to train in these areas. The need for skilled leadership has led to investment in MBA and MPH programs. Of 1,100 employees, 89 are now in master degree tracks or are auditing courses at either Alaska Pacific University or the University of Alaska. Courses run by these educational institutions are held on the SCF/ANMC campus and employees' schedules are adjusted to allow for participation. The program has benefited SCF/ANMC as well as other parts of Alaska as skilled employees from SCF are often placed in health programs elsewhere in the State.

89 of 1100 SCF employees are enrolled in or are auditing an MPH or MBA program.

There is clear evidence of SCF's Job Progressions programs' effectiveness at almost every work site. Employees often comment spontaneously on earlier work at SCF as well as the learning and progression they have experienced. This multifaceted program included the addition of an Employee Development Center (EDC) to an already vigorous Human Resource program. The EDC was formally begun in 2000 with added funding approved in 2002. For SCF/ANMC, capacity building with clearly stated Native preference is a priority.

CLAS Standard 2 - Strategies to recruit and train representational staff

SCF's efforts to 'recruit, retain and promote diverse staff and leadership' are well developed. This includes programs targeting Alaska Native youth.

SCF has also initiated a RAISE program targeting the development of Alaska Native/American Indian youth. The RAISE Graduate Program targets those between ages 17 and 19 years. Combining temporary employment with encouragement to continue training, RAISE partners with organizations like the Haskell Indian Nations University to provide a path to further education. Programs targeting younger teens focus on completion of high school, attainment of

Between 1997-2001 the Summer RAISE program alone had 220 youth participants.

GED and these are tied to summer and winter programs for 14-19 year olds. RAISE activities include cross age tutoring, skill-building, group efforts focused on community service and development of self-esteem carried out through a broad variety of activities that validate youngsters. "We are committed to early recruitment and training of Native Staff to meet our health care needs. Our youth represent tomorrow's Native leadership." (Katherine Gottlieb, CEO)

Additionally, SCF/ANMC have partnered with the family medicine training program at Providence Hospital in Anchorage, which sends trainees in primary care to the SCF site. SCF's traditional healing program is part of the Providence curriculum. Shared efforts have proven effective as the program is a major training site for MDs who have subsequently chosen to practice in rural Alaska as well as for the training of Alaska Native MD's.

⁵⁵ Katherine Gottlieb, MBA, President and CEO of SCF, Southcentral Foundations's RAISE Program Brochure, 2002.

Community Oversight and Input

Southcentral Foundation's Director of Tribal Relations⁵⁶ coordinates meetings with the Village Services Management Team (VSMT) comprised of members from a variety of organizations representing the 55 villages in SCF's area. "The VSMT relays each community's health needs and concerns directly to the SCF Board of Directors."⁵⁷ This pattern has been established in other Alaska Native health care sites. For example, the medical director of Yukon-Kuskokwim Health Corporation's (YKHC) hospital in Bethel describes the annual gathering of tribal representatives in her area: "According to the 1994 settlement, when we compacted with the government, we're required to have community input." The annual meeting (in Bethel) consists of 2 elected representatives from each village. "Representatives of our 58 villages talk about everything from waiting times, to nursing home care, pharmacy refills, community health aides and inhalant abuse in teens." These meetings are held with headsets available for all participants. Both Yup'ik and English are simultaneously interpreted to all participants. These efforts by SCF and YKHC are paralleled by larger efforts that impact Alaska Native Health Care statewide. Wide participation in statewide Native health decision-making is accomplished through the Alaska Native Health Board (ANHB).

"Let me give you an example, the grandfather in a family we know got up at one of the meetings and said; 'that's all well and good, but what about my grandson.' The grandson had an inhalant abuse problem; it's one of our biggest problems with kids here. As far as I know, we've ended up with the only inhalant abuse center in the country."

Jane McClure, MD, Medical Director,
YKHC, interview 10/312/02

The ANHB (established in 1968) plays a unique role in the Native health system. The recipients of the health care system's services own the system. The transfer of health care responsibility to Alaska Natives occurred as a result of the Indian Self-Determination Act⁵⁸ (subsequently amended to allow a process known as compacting). A tribe may 'compact' with the Indian Health Service to operate federal programs in health and education. In 1994, 13 villages, consortiums or corporations representing some 200 tribes in Alaska entered into one compact agreement with the Indian Health Service.⁵⁹

"According to the 1994 settlement, when we compacted with the government, we're required to have community input."

Jane McClure, MD, Bethel, 10/31/02

"Our communities have direct input to leadership."

Katherine Gottlieb, CEO, SCF, 2/03

Coordination is accomplished through an ANHB sponsored 'Mega Meeting' held annually to set priorities and to establish a statewide agreement on the distribution of IHS health care funds among urban centers, the rural communities, and corporations such as SCF and YKHC. Considering the diversity of populations involved, the wide geographic spread and differences in resources among the Native groups, this is an extraordinary accomplishment.

⁵⁶ Dr. Ted Mala has played a lead role in organizing meetings of Circumpolar Indigenous peoples and has encouraged interactions with other health units for indigenous peoples (such as the Maori in New Zealand).

⁵⁷ Mala T: VSMT: SCF's Finger on the pulse of villages. Southcentral Foundation Newsletter, October, 2001

⁵⁸ Public Law 93-638 originally passed in 1975.

⁵⁹ Editorial: Indian Self-Determination: Defining Contracting and Compacting. The IHS Provider, October 1995, pp. 132-3.

CLAS Standard 12 - Reflections on community input and oversight:

SCF's bimonthly meetings with representatives of 55 villages reflect a major commitment to community input. CEO's of both the Alaska Native Medical Center and Southcentral Foundation frequently attend these meetings. Descriptions of systems to meet with village representatives in both the SCF and Yukon-Kuskokwim Health Corporation areas reflect the intent of the Alaska Native Health Board and requirements of the compacting process that began in 1994.

Restoring the Community Spirit

SCF provides a variety of programs that respond to the needs of the service area. The character of these programs, often coordinated with other socially focused efforts of the Cook Inlet Region, Inc., meet a broad spectrum of economic, social and legal needs.

An outline of SCF's programs:

- | | |
|----------------------------------------------------------------------------|-------------------------------------------------------------|
| 1) Primary care to a broad area | 9) Early Head Start (ages 6 weeks to 3 years) |
| 2) Tribal Initiatives (health in 55 Villages) | 10) Head Start (3 to 5 year olds) |
| 3) Mental Health and Counseling Services | 11) Prenatal Support (screens for FAS risk) |
| 4) Supported living for severe persistent mental illness | 12) Elders Program (residential assistance) |
| 5) Residential substance abuse program, (for youth state wide, ages 13-18) | 13) Health Career Promotion (14-18 yr olds) |
| 6) Comprehensive FAS* prevention program | 14) Social Services |
| 7) Men's focused violence prevention and treatment (Wellness Warriors) | 15) Patient Advocates (includes Yup'ik health interpreters) |
| 8) Traditional Healing Program | 16) Home Based Services (includes hospice) |
| | 17) Human resource capacity development |
| | * FAS = Fetal Alcohol Syndrome |

By way of illustration, we have chosen to focus on a selected number of these programs including Traditional Healing, Dena A. Coy, a residential treatment for pregnant women, programs focused on youth and drugs, and village/family violence (#'s 5-7 listed above).

Traditional Healing

"If you want to become healthy and be a healer, you have to learn to open yourself."⁶⁰

SCF and ANMC share a Traditional Healing program in which SCF has used elders to review and certify the skill and training of healers who practice on the campus of the two organizations. This program sees patients on referral from the primary care clinics as well as from the hospital. Additionally, it provides training for health care providers including staff at the Providence Family Medicine Program in Anchorage. Resident trainees in this program learn through talking circles organized, in part, by the Traditional Healing program. To our

⁶⁰ Rita Blumenstein (traditional healer) quoted in Segal B: Alaska Natives Combating Substance Abuse and Related Violence Through Self-Healing: A Report to the People, prepared for the Alaska federation of Natives, Center for Alcohol and Addiction Studies, The Institute for Circumpolar Health Studies, University of Alaska, Anchorage, June 1999, p 18.

knowledge, this program may be one of the first in the country to validate Traditional Healers by formally describing and initiating paid staff positions for them in a primary care/hospital setting.

Dena A. Coy Treatment and Prenatal Support Program

Dena A Coy is a residential treatment program for prevention of Fetal Alcohol Syndrome (FAS). It provides prenatal support as well as care after delivery. Alcohol abusing pregnant women are offered care in a treatment facility during and after their pregnancy. Some are court ordered into care. There is evidence that the program has had success in prevention of FAS. The incidence of FAS in the Alaska Native population is seven times the national average and 12.3% of pregnant Alaska Native women drink during pregnancy.⁶¹

The program allows SCF to make major contributions to the health development and safety of Alaska Native youth as well as alcohol-impacted mothers. Part of SCF's large Behavioral Services division, these represent major efforts focused on youth. Dena A. Coy was one of the country's earliest inpatient FAS prevention programs.

Dena A. Coy's Treatment Program

- Voluntary treatment program
- 148 infants born between 1991 and 1998.
- 2% impacted by the mother's drinking and/or drug abuse vs. 9.6% of infants previously born to these women.
- ANHB estimates: \$1.4 million to raise a FAS impacted child and the program has saved 9.8 million dollars over the period studied.

Source, Kids Count Alaska

<http://kidscount.alaska.edu/1999-98db/Resources.pdf>

The Pathway Home and The Family Wellness Warriors

"The impact of alcohol is the most critical problem facing our villages today."⁶²

SCF also manages the Pathway Home, a residential Therapeutic Community that treats youth from the entire state. Recently moved to a new building, the program provides a vitally needed resource to deal with issues of substance abuse, youth suicide, domestic violence, neglect and abuse. More recently, a second SCF initiative aims at Native adults, men as well as women. Family Wellness Warriors deals with anger management, domestic violence, alcohol and substance abuse, village resource development (especially around issues of domestic violence) as well as the impact of pornography on family and gender relationships. Both of these efforts provide needed focus on the development of healthy families and youth. For SCF and Alaska Native systems statewide, dislocated and troubled youth are seen as key measures of family as well as community health.

⁶¹ Alaska Native Tribal Health Consortium, Division of Information/Technology. *Special Reports: Key Facts - Women*. Key facts about Alaska Natives series. Anchorage, AK: Alaska Native Tribal Health Consortium, Division of Information/Technology and U.S. Department of Health and Human Services, Indian Health Service, 2002. <http://www.ihs.gov/FacilitiesServices/AreaOffices/Alaska/dpehs/ak-dpehs-sp-women.asp>

⁶²Julie Kitka, President of the Alaska Federation of Natives, quoted in testimony to the US Senate Committee on Indian Affairs, Hearing on Alcohol and Law Enforcement in Alaska, 1/4/00, by Ernie Turner, Director, Alaska Division of Alcoholism and Drug Abuse.

While SCF manages the Head Start and Dena A Coy programs, Cook Inlet Region, Inc. (CIRI), SCF's parent organization, has initiatives that fill out the social services programs and needs of the Native populations served by SCF, ANTHC and ANMC. These all impact the health of the community in a broad sense and include the Cook Inlet Housing Authority, an employment and training program (placing an average of 125 applicants/ month), the CIRI foundation (an education-focused program) and the Alaska Native Justice Center.⁶³

CLAS Standard 11- Planning for and implementing services that respond to the cultural and linguistic characteristics of the service area: SCF/ANMC define health and wellness broadly. Programs that focus on primary care and social services are SCF's domains. Combined with and coordinated with other efforts of the Cook Inlet Region, Inc., they serve needs that are economic, social and legal in nature.

CLAS Commentary and Lessons Learned reflected by SCF/ANMC

A number of themes recur in reviewing the work of Southcentral Foundation and the Alaska Native Medical Center: community involvement, building relationships and patient/family centeredness. "We usually like to say – relationship based health care system with patient/ family centered thinking and planning. Our whole system is centered on optimizing relationship – long term, trusting relationship."⁶⁴

The entire Alaska Native Health System is based on participation and collaboration. This fits CLAS Standard 12 that deals with participatory and collaborative partnerships. What has followed at SCF and ANMC is a broad definition of "What's wrong?" and "What needs to be done?" Approximately one-half of their annual budget results from special grants and contracts from a variety of sources. SCF uses grants and contracts to extend its work, to undertake programs in prevention, education, staff and youth development. For example, SCF won a two-year award from the Local Initiative Funding Partners Program⁶⁵ that listed ten additional local funders.⁶⁶ This illustrates the broad extent of SCF's efforts as well as its success.

Relationship is a consistent message in SCF's work. Three other prominent themes appear: To begin with, 'Healing' is defined by broad community needs and programs include a strong focus on making the community whole. Secondly, there is a focus on validating and rekindling community spirit through the recognition of traditional values and efforts aimed at current village realities. Lastly, there is a focus on the future, on the development of Alaska Native youth. These messages are directly woven into programmatic realities. They represent messages that could be applied broadly to health care programs around the country.

⁶³ Alaska Natives comprise 35% of the incarcerated population in Alaska and 50% of the victims of sexual assault in Anchorage.

⁶⁴ Douglas Eby, MD, SCF Vice President for Medical Services.

⁶⁵ A national program of the Robert Wood Johnson Foundation.

⁶⁶ Wells Fargo, The Rasmussen Foundation, Cook Inlet Region, Inc, Providence Health System in Alaska, Alaska Mental Health Trust Authority, United Way of Anchorage, Phillips Alaska, Cook Inlet Housing Authority, BP Exploration and Southcentral Foundation itself. (source: www.lifp.org/html/detail.asp?GN=34954)

V. Oversight by Associations

During the process of this review, it became apparent that major contributions to care, to analysis of the health care system and to health care systems change come from the work of associations and foundations. By way of illustration we have elected to briefly discuss three such organizations (while at the same time making a conscious decision not to attempt highlighting nation-wide foundations that focus on these areas in health).

The **California Primary Care Association's (CPCA)** efforts to promote and recognize excellent work among its membership resulted in a remarkable publication entitled: "Providing Health Care to Limited English Proficient (LEP) Patients: A Manual of Promising Practices."⁶⁷ The CPCA's work exemplifies the critical role that organizations can play in validating and encouraging "best practices" around issues of culture, language and health care access. The manual, funded by the Bureau of Primary Health Care and the California Endowment, highlights 15 community clinic sites in California. The sites reviewed and the practices highlighted offer insights that could be applied by programs in other parts of the country. The manual covers a variety of issues ranging from methods to train interpreters and providers,⁶⁸ to incorporation of traditional practices and healers,⁶⁹ to monitoring compliance, and translation of materials. The appendices of this volume offer working documents such as community surveys, consent forms and language proficiency tests that are used by the clinical practice sites described in the volume. "Providing Health Care" is an excellent guide and should be on the shelf of any practitioner or administrator interested in the development of effective interfaces with LEP communities.

The **National Health Law Program (NHLP)** prepared an extensive overview of the state of linguistic access to health care programs and facilities.⁷⁰ The manual provides an outline of the Office of Civil Rights (OCR) "Bottom Lines for Linguistic Accessibility," and covers a range of federal law, state law, contract language, and language responsibilities in the private sector. NHLP's work clearly outlines the basis on which CLAS standards 4-7 are mandatory under Title VI of the Civil Rights Act of 1964. Additionally, in 2002 NHLP published a study describing current practices in the provision of language services.⁷¹ These two reports are, in our view, essential items for health care administrators and advocates for health care to LEP populations. The NHLP website also provides an example of a recent resolution agreement between the OCR and a hospital in Maine. The agreement (which can

⁶⁷ Mateo J, Gallardo EV, Huang VV and Niski C: "Providing Health Care to Limited English Proficient (LEP) Patients: A Manual of Promising Practices," California Primary Care Association, Sacramento, 1992

⁶⁸ Asian Health Services Language and Cultural Access Program trains health care interpreters in multiple languages and provides interpretation services to six institutional clients.

⁶⁹ Golden Valley Health Center (GVHC) is a large federally funded community health and migrant health center that serves Stanislaus and Merced counties in California. GVHC works in tandem with a training program out of Merced's Healthy House to provide cultural mediation as part of health care interpretation program. Merced was the home of the Hmong child that led to Anne Fadiman's book "The Spirit Catches You and You Fall Down." The learning's that grew from experiences with the Hmong Community in Merced led to the development of Healthy House and its efforts to catalogue the use of traditional healers (working in concert with Hmong healers in the Merced area).

⁷⁰ Perkins J, Simon H, Cheng F, Olson K and Vera Y: Ensuring Linguistic Access in Health Care Settings: Legal Rights and Responsibilities. January 1998, Henry J Kaiser Family Foundation, Menlo Park, Ca.

⁷¹ Youdelman M, Perkins J: Providing Language Interpretation Services in Health care Settings: Examples from the Field. New York, The Commonwealth Fund, Field Report, 2002.

be downloaded) outlines the scope and character of a recent Office of Civil Rights settlement over language-related patient care issues.⁷²

The **National Council on Interpreting in Health Care** (NCIHC), an organization that had its beginnings in 1992 through Kellogg support, has made major efforts to establish a national dialogue about language issues in health care. NCIHC has been funded by OMH to coordinate the evaluation of an interpreter assessment tool developed initially by the Massachusetts Medical Interpreters Association (MMIA). The methodology will be tested on a pilot basis in the states of Massachusetts and California by the MMIA and the California Healthcare Interpreters Association (CHIA). This shared effort will help establish improved methodologies, pointing the way to better training and evaluation of interpreters and trained bilingual health workers who are asked to perform the complex task of medical interpreting. Standards cannot be established in an operative sense without this kind of national collaborative work. Additionally, difficulties associated with interpreter certification were discussed in two commentaries and critiques of Washington State's efforts to certify interpreters^{73,74} and later in a NHeLP review of the Washington State program.⁷⁵

⁷² Office of Civil Rights, USDHHS: Resolution Agreement between OCR, US Dept of Health and Human Services, Region I and Maine Medical Center, July 17, 2000. Posted at http://www.healthlaw.org/docs/OCR_MMC.pdf

⁷³ Roat C: The Certification Blues: Pitfalls and Peaks Along the Road to Certifying Interpreters, Across Cultures, April 1997. Posted on the web at <http://www.diversityrx.org/HTML/MOIPR5.htm>

⁷⁴ Roat C: Certifying Medical Interpreters: Some Lessons from Washington State. *ATA Chronicle* 1999;28(5): 26.

⁷⁵ Youdelman M, 2002, pp. 8-11.

VI. Discussion

The CLAS Standards as a Cultural Perspective

A “society can only be understood through a study of the messages ... which belong to it.” (Norbert Weiner)⁷⁶

The CLAS standards are based on an analysis of practices described over many decades in the language of rule sets, guidelines, published standards and contracts for healthcare systems. As a summation of recommended practices and policies, the standards are themselves a cultural statement. Reflecting on the words of Norbert Weiner the CLAS Standards can be described as messages belonging to health care in the United States in the late 1990’s. We offer the following commentaries, reflections and lessons we have learned during our journey through this effort. The sites we have highlighted exemplify some of the best of the CLAS standards, and simultaneously point to qualities of excellence that deserve explicit statement.

Common Themes

Mission and Programs: CLAS in Action

“You can’t just get a set of standards and start from there – it has to be tied together: it has to relate to providing services.” (Douglas Eby, MD, Southcentral Foundation)

“Once we saw the CLAS standards, we [recognized that] we were doing it and didn’t know there was a name for it.” (Dorcas Grigg-Saito, CEO, LCHC)

Successful programs are clearly mission driven. Mission permeates the design, the organization’s work and often the passion workers bring to the process. "You can't just patch on issues of culture like some add-on ... it's woven into the fabric of who we are, how we do our work," said one of the administrator's at Southcentral Foundation, "everything has to fit together to make it work.”

Programs have responded to multiple rule sets over time, demonstrated by the presence of community boards, a requirement for federally qualified community health centers (FQCHC). Similarly, community input was required under the Compacting Agreements in which Alaska Natives undertook control of their health care systems. Regulatory processes determined the quality and outcome of many of the programs in which parallels with the CLAS Standards were found.

Relationship and Trust

"They saved my life ... they believed in me. I had a bad past ... alcoholic. Now I have my family, my kids, my business, my wife. They taught us about everything, keeping

⁷⁶ Weiner, N: The Human Use of Human Beings: Cybernetics and Society. Doubleday, Garden City, New York, 1954.

books and now even computers and Quick Books. I even have two employees and we all have health coverage!"
(Project Vida Participant)

The themes of relationship and trust came up over and over during site visits. Relationship was seen as key to the community-institution interface and to the provider-patient interface. Relationship and trust are not clearly demonstrated in the language of the CLAS Standards in part because they were derived from contract language, state and federal law and from the language of oversight systems. There is clear evidence that trust and relationships are key components in the design of provider-patient relationships in health care systems.^{77,78,79} Relationship and trust building warrants recognition in any set of standards focused on cultural aspects of health care practices. In fiscally focused thinking, primary care providers become "gate-keepers," a descriptive role that has a major set of bottom line driven implications. Primary care providers are considered essential to building relationships with patients and families, a descriptive role that is relationship driven.

The meaning of 'Health' and 'Healing'

To make a community whole.⁸⁰

All five sites have created programs that deal with major life needs and to varying degrees, each site has worked to contribute to a healing process that impacts the community's health in the broadest sense. Seeing programs focused on employment, fiscal literacy, safety, housing, education, prevention of teen pregnancy, gang prevention, environmental justice, drugs and alcohol, early childhood development and much more, points to a major opportunity for health care systems that truly want to connect to community need and to define 'health' and 'healing' that is essentially community focused and community articulated.

Maximizing Revenue Streams/Cross funding

"We've tied some of our STD monies to gang prevention and the program to prevent teen pregnancies" ... "The lines between programs get blurred sometimes, you can't get the work done if you stay in the box ..." (based on comments from multiple sites)

Money changes everything. Every site we visited was engaged in the struggle to fund the care of diverse communities. The Men's Clinic, the smallest of the organizations we visited, described its work as a struggle to stay alive, to stay open and to make sure that needed help is there for the community. Each of the other organizations, with larger budgets, was engaged in fund raising from multiple sources and characterized the work as an effort to cross fund projects often using targeted categorical funding to keep vital programs alive. For example, over 50% of SCF's operating budget comes from grants and contracts. Patient revenues are

⁷⁷ Weiss LJ, Blustein J: Faithful patients: The effect of long-term physician patient relationships on the costs and use of health care by older Americans. *Am J Pub Health* 1996;86:1742-47.

⁷⁸ Mechanic D: The functions and limitations of trust in the provision of medical care. *J Health Politics, Policy and Law* 1998;23:661-686.

⁷⁹ Bloche MG: Clinical loyalties and the social purposes of medicine. *JAMA* 1999;281:268-274.

⁸⁰ Project Vida's director looks to the Greek word 'iaomai' to define the basis of their work. It has two meanings, to cure or heal and to make whole. We have combined these concepts to describe Vida's concept of 'health.'

not sufficient to support programs that deal with a broad prospect of community needs. Skilled administrators redirect funds across categorical boundaries.

Building Community Skills, Capacity and Leadership

All five of the sites were actively contributing to community capacity and often in arenas that are not traditionally seen as ‘medical.’ These vital programs had a breadth of focus, in each instance uniquely fashioned to meet community realities:

- Moving men in transition to active employment at The Men’s Clinic,
- Building youth and staff capacity in Anchorage,
- Developing business skills and micro-enterprises in El Paso,
- Developing community health workers in Seattle, and
- Partnering with a large community based organization in Lowell.

These selected programs we have listed above illustrate the ways in which community input and community capacity are woven into programs and operations.

Community Driven Programs, Partnership and Control

“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.” (CLAS standard 12)

“Project Vida encouraged us to testify at the City Council. I’d never done anything like that before. We talked to them about our streets and sidewalks. We went down there two times. That’s how we got our street paved! We’re really happy about it!”

(Elderly resident of Project Vida’s Housing program)

CLAS Standard 12 speaks to community relationships using broad language that includes the business aspect of health care, patients as consumers. The sites we visited have strong community relationships, ties, input, oversight, advice and even ownership. In every successful program ‘Healing’ is broadly defined and clearly linked to community realities. And these realities are reflected in everything from patient care, to research protocols, to undertaking a community action to pave the street. Through community congresses, boards, regularly scheduled meetings with community representatives, the working ethic of these programs incorporates the fabric of community realities.

Redefining ‘Linguistically Appropriate Care’

The CLAS standards 4-7 outline linguistically appropriate care for linguistically diverse communities in particular, those that are limited English or Non English speaking. Our inquiry has made it amply clear that ‘linguistically appropriate’ care is equally relevant and critical for native born, English speaking populations. Cultural, historical and contextual diversity finds many forms of linguistic expression. Providers who share the common

realities and the cultural framework of the community they serve provide more than ‘culturally competent care’ they provide ‘linguistically appropriate care’ because language is often about sharing and validating realities. The Men’s Center in East Baltimore truly provides both culturally and linguistically appropriate services to a community that may appear to have access to services elsewhere if access was determined solely by English proficiency. But this community continues to return to the Men’s Center for services because providers and clients alike share a common and powerful understanding of the community’s experience and its history.

VII. Future Directions for CLAS

The introduction to this review includes commentary about the purpose of the standards:

“...These standards for culturally and linguistically appropriate services (CLAS) are proposed as a means to correct inequities that currently exist in the provision of health services and to make these services more responsive to the individual needs of all patients/consumers....”

For the CLAS standards to fully achieve their purpose, the very culture, definition and design of ‘health care’ delivery warrants vigorous examination with questions that are formulated by the experience of these and other successful institutions. The sites profiled in this report bring to life the current CLAS standards in varying degrees. In addition, they demonstrate innovative pathways to health while redefining and informing the reach of CLAS. Several key areas outlined in the previous section, emerge from this study. Incorporated into the CLAS standards they will broaden the standards and maximizes their successful integration into health systems.

VIII. APPENDICES

Appendix A: Bibliography OMH Report

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Appendix B: CLAS-Related Resources

The following is not intended to be a comprehensive cultural competence resource list; instead, the focus is on CLAS-related resources. It includes some in-depth cultural competence bibliographies that the authors saw no reason to duplicate.

1. The Brown University/Memorial Hospital of Rhode Island Department of Family Medicine, Pawtucket, RI.

Transcending Barriers: Teaching Patient Centered Care enhances the teaching skills of family medicine preceptors who work with medical students and family medicine residents, with emphasis on achieving a better understanding of cultural competence and diversity in clinical practice. The training focuses on managing chronic illnesses in hard to reach and underserved populations, and in delivering culturally responsive health care. *The Rhode Island Family Advocacy Program* strives to improve the overall health of Rhode Island children from low-income families through an innovative collaboration of academic, legal, medical and community based organizations. *Interpreter's Aide Program* targets student volunteers to supplement the professional interpreters working at Rhode Island Hospital.

2. Centers for Medicare & Medicaid Services, The M+CO National QAPI Project for 2003. 2 guides and materials from a conference: *Providing Oral Linguistic Services: A Guide for Managed Care Plans; Planning Culturally and Linguistically Appropriate Services: A Guide For Managed Care Plans; Best Practices for Culturally and Linguistically Appropriate Services in Managed Care Conference: June 3 and 4, 2002 in Research Triangle Park, North Carolina.*

<http://www.cms.gov/healthplans/quality/project03.asp>

Baltimore: CMS, Last modified February 4, 2003 as of this writing.

Two guides for helping managed care organizations implement the CLAS standards. These documents are full of ideas and they not only advise but also share results of studies undertaken by the Lovelace Clinic Foundation of Albuquerque, New Mexico involving site visits to various managed care plans. The appendices include numerous tools and documents such as cultural competence assessment tools, patient satisfaction assessment tools, and medical interpreter ethical standards. The reader who wants the whole report with appendices must download many files and carefully assemble them, but the results are worth the trouble. The conference presentations are valuable, too.

3. CHIA Standards and Certification Committee. *California Standards for Healthcare Interpreters: Ethical Principles, Protocols, and Guidance on Roles & Intervention*. Los Angeles CA: California Health Interpreters Association, 2002.
http://www.chia.ws/standards/standards_registration.htm

Standards for healthcare interpreting are now available from MMIA, CHIA and NCIHC.

4. *The CLAS Room*

<http://www.clas-sd.org/index.htm>

Vista, CA: Vista Community Clinic, Updated on February 26, 2003

Web site for Vista Community Clinic's Cultural Awareness Program (CAP), a bilingual/bicultural demonstration grant funded by the Office of Minority Health to institutionalize CLAS-congruent services in San Diego County. Some sections have no content, others content-rich. Includes detailed .pdf versions of workshop agendas. Last updated as of viewing, 2/6/2003

5. Department of Public Health, City and County of San Francisco *Cultural & Linguistic Competency Policy*.

<http://www.dph.sf.ca.us/CLAS/default.htm>.

San Francisco: Department of Public Health, City and County of San Francisco, 2003.

San Francisco Department of Public Health passed a resolution adopting the CLAS standards, and they have posted this web site regarding their activities.

6. Gilbert MJ. *A Manager's Guide to Cultural Competence Training for Healthcare Professionals*. N.p.: The California Endowment, 2002.

Recommends standards for teachers and trainers, provides a cultural competence glossary; the bulk of the document comprises a rich annotated bibliography of resources in a variety of formats which should be useful for trainers looking for materials.

7. Gilbert MJ, ed. *Principles and Recommended Standards for Cultural Competence Education of Health Care Professionals*. N.p.: The California Endowment, 2003.

Too new to be reviewed. "In support of The Endowment's Cultural Competence program, this report provides guidance on content, training methods and modalities, evaluation and qualifications of teachers and trainers. These principles and standards are designed to accompany the Culturally and Linguistically Appropriate Services in Health Care (CLAS) standards, adopted by the Office of Minority Health."—The California Endowment web site, http://www.calendow.org/pub/frm_pub.htm, viewed 5/21/2003. Available on the Internet at http://www.calendow.org/pub/publications/principles_standards.pdf

8. HHS Office of Minority Health, Agency for Healthcare Policy Research, Resources for Cross Cultural Health Care. *Assuring Cultural Competence in Health Care: Developing National Standards and an Outcomes-Focused Research Agenda*
<http://www.diversityrx.org/HTML/RCPROJ.htm>

DiversityRx, 2001.

Proposed topical CLAS-related research agendas. The authors invite comments and participation. As the site states, “With input from a research advisory committee and the public, RCCHC will develop a research agenda intended to examine the research base underlying the field of CLAS in health care, identify issues associated with conducting research in this field, and suggest approaches for developing and implementing a CLAS research agenda. The final document is intended to be a guide for researchers and research funders interested in cultural competence.” Proposed topics include racial and ethnic concordance, cultural competence training, culturally competent health promotion/education, community health workers, integration of traditional healers/practices, and family/community inclusion.

8. Hedrick H, Donini-Lenhoff F, managing ed., American Medical Association. *Cultural Competence Compendium*. Chicago IL: American Medical Association, 1999. Available from the AMA, 515 North State Street, Chicago, IL 60610 www.ama-assn.org/catalog or call 1-800-621-8335.

A variety of resources on cultural competence, diversity and multiculturalism in health.

9. Jacobs CG, Fortier JP, Harris G, Barnhart M, IQ Solutions, Inc., U.S. Department of Health and Human Services, Office of Minority Health. *National Standards for Culturally and Linguistically Appropriate Services in Health Care: Final Report*. Washington DC: U.S. Department of Health and Human Services, Office of Minority Health, 2001. Available on the web at [Http://www.omhrc.gov/omh/programs/2pgprograms/finalreport.pdf](http://www.omhrc.gov/omh/programs/2pgprograms/finalreport.pdf)

The basic text for the CLAS standards. Includes the standards with explanatory text, background and purpose, the individual standards with discussion, a glossary, a bibliography, and contact lists of commentary meeting participants and other related individuals and organizations.

10. Mason JL et al. *An Introduction to Cultural Competence Principles and Elements: An Annotated Bibliography*. Portland OR: Portland State University, 1995. Available from Research and Training Center on Family Support and Children’s Mental Health, Regional Research Institute for Human Services, Graduate School of Social Work, Portland State University, PO Box 751, Portland, OR 97207-0751 (503) 725-4040 or <http://www.rtc.pdx.edu/>

Still worthwhile despite its age, this thoughtfully-annotated collection features sections on cultural self-assessment, dynamics of difference, valuing diversity, adaptation to diversity, and incorporation of cultural knowledge.

11. Massachusetts Medical Interpreters Association
800 Washington Street, NEMC Box 271
Boston, MA 02111-1845
Fax: 617-636-6283 Telephone: 617-636-5479
<http://www.mmia.org/>

A leading organization in the medical interpreting field, MMIA has been instrumental in the professionalization of medical interpreting and the advocacy and establishment of key policy and legal advances in language access.

12. Massachusetts Medical Interpreters Association Education Development Center, Inc. *Medical Interpreting Standards of Practice*. Boston MA: Massachusetts Medical Interpreters Association, 1995.

The National Council on Interpreting in Health Care considered this “the best statement of standards for medical interpreters presently available” as of 1998 (<http://www.mmia.org/sop.html>). \$18.50. For purchase, please send check to MMIA, c/o NEMC Box 271, 800 Washington Street, Boston, MA 02111.

13. Models That Work Campaign
<http://bphc.hrsa.gov/mtw/default.htm>
US Department of Human Services, Health Resources and Services Administration, Bureau of Primary Health Care. No last update date.

Community programs for the underserved with some funding from the Federal Government. Includes searchable database of Models That Work programs.

14. Murray-Garcia J, Herd D, Morello-Frosch R, Smith S. *An Annotated Bibliography: Multicultural Health: Setting the Stage for Innovative and Creative Approaches*. Woodland Hills CA: California Endowment, 1999.
<http://www.calendow.org/pub/publications/annotatedbiblography.pdf>

Extensive collection of thoughtful annotations to articles and other resources. Includes sections on social determinants of health, cultural determinants of health and illness, health services and multicultural health issues, diversity in the healthcare workforce, cultural competency, intervention models and multicultural health, and research and evaluation.

15. Murray-Garcia JL. *Multicultural Health 2002: An Annotated Bibliography*. 2nd Edition. Woodland Hills, California: The California Endowment, 2002.
http://www.calendow.org/pub/publications/2_nd_Ann_Bibliography2002.pdf

A sequel to the previous collection with 180 annotations. Sections include workforce diversity, health disparities, cultural competency, language access, access to health care, and models of community responsiveness.

16. NCIHC-List

National Council of Interpreters in Health Care Listserv
<http://lists.diversityrx.org/mailman/listinfo/ncihc-list>

This busy, lively listserv moderated by Resources for Cross Cultural Health Care provides a forum for medical interpreter issues and language access issues in general. Join or search the archives by visiting the address above at the DiversityRx website.

17. Nerenz DR, Gunter MJ, Garcia M, Green-Weir RR, Wisdom K, Joseph C. *Developing a Health Plan Report Card on Quality of Care for Minority Populations*. New York: The Commonwealth Fund, 2002. Publication #547. One East 75th Street, New York, NY 10021-2692 Publications line: 1-888-777-2744, Fax 212-606-3500 www.cmwf.org, can be ordered from the web site.

The investigators on this study set out to determine whether health plans could collect racial and ethnic data from their members using existing standardized measures of quality and some customized tools and whether the information could be used to create a report card on the quality of care of different racial and ethnic groups. Michigan State University, Henry Ford Health System, Lovelace Clinic Foundation, the University of Texas School of Public Health and eight health plans serving large minority populations collaborated on the project. The project consisted of two phases: development of the health plan report card and pilot testing for data collection; and the demonstration project, in which the health plans' experiences using the various tools to collect data are described. A third section reports a variety of disparity data derived from the demonstration project that the individual health plans produced, involving such subjects as cancer screening, diabetes, and communication. The investigators claim success with this approach and suggest that tracking racial and ethnic information is not only possible with tools readily available today, but that it can be a vital step in the process of assessing health care quality for ethnic minority populations. Some methods may not apply in all situations, such as estimating race/ethnicity by neighborhood and the Spanish surname-recognition software that the report doesn't note might classify large numbers of Asians and other non-Latinos as Latino if used in the wrong place, but for the most part it looks like a practical report on thoughtful, helpful work toward CLAS goals. Relates to CLAS standards 10, 11, 14, and possibly 9.

18. Perkins J, Simon H, Cheng F, Olson K, Vera Y. *Ensuring Linguistic Access in Health Care Settings: Legal Rights and Responsibilities*. Los Angeles: National Health Law Program, 1998. To order a copy, please call Brendan McTaggart in NHeLP's Los Angeles

office at (310) 204-6010 or contact The Henry J. Kaiser Family Foundation at (800) 656-4533 and ask for publication #1362.

Starts by making the case for language access and describing the varied state of language services as of its writing, followed by explanations of legal status and issues based on federal, state and local laws and requirements and the effects of programs such as Medicaid. This is followed by accreditation issues, recommendations, and conclusion. The valuable appendices include sample documents, summary of state law requirements addressing language and cultural needs in health care, other state materials, bibliography, and more. A valuable reference guide.

19. Perot RT, Youdelman M. *Racial, Ethnic, and Primary Language Data Collection in the Health Care System: An Assessment of Federal Policies and Practices*. New York: The Commonwealth Fund, 2001. Publication #492. One East 75th Street, New York, NY 10021-2692 Publications line: 1-888-777-2744, Fax 212-606-3500 www.cmf.org can be ordered from the web site.

CLAS standard 10 calls for collecting and recording data on patients' race, ethnicity, and languages. Such requirements already exist in various contexts at the federal level, yet many providers don't collect this data or are even under the mistaken impression that it is illegal. Perot and Youdelman describe and discuss federal policies and practices and advocate data collection as an essential step for describing, addressing, and eliminating disparities. The investigators also surveyed people in the health care industry to assess their understanding and implementation of data collection laws and regulations. Finally, the authors make recommendations for the future including optimization of current tools and requirements and other suggestions.

20. Rider ME, Mason JL. *Issues in Culturally Competent Service Delivery: An Annotated Bibliography*. Portland OR: Portland State University, 1990. Available from Research and Training Center on Family Support and Children's Mental Health, Regional Research Institute for Human Services, Graduate School of Social Work, Portland State University, PO Box 751, Portland, OR 97207-0751 (503) 725-4040 or <http://www rtc.pdx.edu/>.

21. U.S. Health Resources and Services Administration LTG Associates Resources for Cross Cultural Health Care. *Cultural Competence Works: Using Cultural Competence to Improve the Quality of Health Care for Diverse Populations and Add Value to Managed Care Arrangements*. [Merrifield VA]: US Health Resources and Services Administration, 2001.

The Health Resources and Services Administration sponsored the Cultural Competence Works competition amongst its approximately 5000 service delivery grantees, and this report describes the competition and its winners and nominees. The main section discusses particular concepts or practices that define a culturally competent institution and highlights programs that exemplify those concepts. The authors prefer to term these programs' practices

“exemplary practices” rather than “best practices.” A valuable appendix follows, providing descriptions and contact information for each winner and nominee.

22. U.S. Department of Health and Human Services, Health Resources and Services Administration. *Models that Work: Innovative Health Improvement Programs for Underserved and Vulnerable Populations: Compendium 98*. Rockville MD: U.S. DHHS, HRSA, 1998. <http://bphc.hrsa.gov/mtw/default.htm>

Profiles and contact information of winners and competitors in HRSA’s Models That Work competition. Another source of ideas, examples and contacts.

23. U.S. Department of Health and Human Services, Public Health Services, The Office of Minority Health. *Assuring Cultural Competence in Health Care Recommendations for National Standards and an Outcomes-Focused Research Agenda*.

<http://www.omhrc.gov/clas/>

The Office of Minority Health, “Last updated March 5, 2003.”

Spanish CLAS site:

<http://www.omhrc.gov/CLAS/ESPmi.htm>

The CLAS Standards web site. Includes the OMH’s Final CLAS Standards in HTML and .pdf versions, the draft standards and commentary, the Comprehensive Final Report in .pdf form, A Practical Guide for Implementing the Recommended National Standards for Culturally and Linguistically Appropriate Services in Health Care, and more.

Not reviewed

24. Leicher ES. *Interpreter services: Analysis of various models*. Worcester, MA: University of Massachusetts, 1997.

25. Torres B. *Best Practice Recommendations for Hospital-Based Interpreter Services*. N.p.: Commonwealth of Massachusetts, Massachusetts Department of Public Health, Executive Office of Health and Human Services, n.d. Obtain from The Commonwealth Fund, One East 75th Street, New York, NY 10021-2692, 212-606-3800, www.cmwf.org.

Cultural competence assessment tools:

1. Andrulis D, Delbanco T, Avakian L, Shaw-Taylor T. *Conducting a Cultural Competence Assessment*. Brooklyn: SUNY/Downstate Medical Center. N.d., viewed 5/21/2003.

<http://erc.msh.org/provider/andrulis.pdf>

or go to

<http://erc.msh.org/mainpage.cfm?file=9.1g.htm&module=provider&language=English>

and scroll to the .pdf file.

Builds upon the Georgetown University Child Development Center's Continuum of Cultural Competency.

2. Child Welfare League of America. *Cultural Competence Self-assessment Instrument*. Washington DC: Child Welfare League of America, 1993. <http://www.cwla.org/pubs/202-638-2952>. ISSN 0-87868-840-4, \$16.95.

This assessment tool specifically addresses the organization as a whole. Most questions ask for a 0-2 rating and a few lines to suggest ideas for improvement.

3. Goode TD. *Promoting Cultural and Linguistic Competency: Self-assessment Checklist for Personnel Providing Primary Health Care Services*. Washington, DC: National Center for Cultural Competence, Georgetown University Center for Child and Human Development, 1989, last revision 2000. <http://www.georgetown.edu/research/gucdc/nccc/nccc11.html>

Thirty-question checklist with a 1-3 scale of "things I do[frequently/occasionally/never]."

4. Johnson, Bassin & Shaw, Inc. U.S. Department of Health and Human Services, Administration for Children and Families, Administration on Children, Youth and Families, Family and Youth Services Bureau. *A Guide to Enhancing the Cultural Competence of Runaway and Homeless Youth Programs*. Silver Spring MD: U.S. DHHS, Administration for Children and Families, Administration on Children, Youth and Families, Family and Youth Services Bureau National Clearinghouse on Runaway and Homeless Youth, 1994. PO Box 13505, Silver Spring, MD 20911-3505, 301-608-8098.

The detailed tools included in this book utilize open-ended questions, Likert-type scales and diversity matrices, and are geared for staff, management, clients, and many aspects of organizations.

5. Mason JL, Williams-Murphy T. *Cultural Competence Self-assessment Questionnaire: A Manual for Users*. Portland OR: Portland State University, 1995. Research and Training Center on Family Support and Children's Mental Health, Regional Research Institute for Human Services, Graduate School of Social Work, Portland State University, PO Box 751 Portland, OR 97207-0751 <http://www.rtc.pdx.edu/pgPublications.shtml> 503-725-4040. \$8.00.

This respected instrument includes individual and administrative versions, a demographic questionnaire, as well as instructions and background. Most questions ask for a 1-4 rating that may be labeled "not at all/seldom/sometimes/often". Both the individual and

administrative versions contain varied content useful for assessing organizational cultural competence.

6. Tirado, MD. *Final Report to the Office of Planning and Evaluation, Health Resources and Services Administration on the Project Entitled Tools for Monitoring Cultural Competence in Health Care*. San Francisco CA: Latino Coalition for a Healthy California, 1996. 1535 Mission Street, San Francisco, CA, 94103, 431-7430.

Features a variety of questionnaires, question styles, and content, plus explanations of the logic behind every question. Also contains background information and suggestions for working with patients from Latino and Chinese backgrounds as produced by Latino and Chinese American physician panels.

7. Vancouver Ethnocultural Advisory Committee of the Ministry for Children and Families. *Cultural Competency Assessment Tool*. Vancouver, British Columbia: Vancouver Ethnocultural Advisory Committee of the Ministry for Children and Families, n.d., viewed 5/21/2003.

http://www.mcf.gov.bc.ca/publications/cultural_competency/assessment_tool/tool_index1.htm

Several worksheets of questions with 1-5 scales

8. Weiss CI, Mnsky S. Multicultural Services Advisory Committee, New Jersey Division of Mental Health Services. *Program Self-assessment Survey for Cultural Competence: A Manual*. Trenton NJ: New Jersey Division of Mental Health Services, 1996. May be out of print, but their phone # is 1-800-382-6717.

Somewhat short test consists of checklists and multiple choice questions whose choices lay along a continuum, along with instructions for administration and evaluation.

Not reviewed

9. Bernal H, Froman R. The confidence of community health nurses in caring for ethnically diverse populations. *Journal of Nursing Scholarship*. 1987;19:201-203.

&

Bernal H, Froman R. *Influences on the cultural self-efficiency of community health nurses*. *Journal of Transcultural Nursing*. 1993;4:24-31.

10. La Frontera, Inc. *Building Bridges: Tools for Developing an Organization's Cultural Competence*. Tucson, AZ: La Frontera Center, Inc., n.d., 2nd edition since 1995.

\$2.50, Order from Director of Communications, La Frontera Center, Inc., 502 W. 29th St. Tucson, AZ 85713. <http://www.lafrontera.org/competence-tool.asp>

La Frontera, Inc. is a non-profit behavioral health agency in Pima County, Arizona.

10. Roizner M. *A Practical Guide for the Assessment of Cultural Competence in Children's Mental Health Services*. Boston, MA: Technical Assistance Center for the Evaluation of Children's Mental Health Systems, Judge Baker Children's Center, 1996. May be out of print, but their contact information is 3 Blackfan Circle, Boston, MA 02155, 1 800-779-8390 x 2109, info@jfcc.harvard.edu. <http://www.jbcc.harvard.edu/>

11. Warda, M. *Development of a Measure of Culturally Competent Care*. PhD Dissertation, University of California San Francisco, 1997. Try interlibrary loan at a public or medical library or buy through Proquest (UMI or University Microfilms is now here) <http://www.umi.com/hp/Products/Dissertations.html>.

Appendix C: Literature Review

The investigators decided to present their literature review as an annotated bibliography. As described under “Methodology for this Report” in the Introduction, a literature search and review was conducted to search for programs that might reflect best practices. Numerous bibliographic sources were utilized including MEDLINE, CINAHL, OCLC WorldCat, Dissertations Abstracts, HRSA Models That Work, Cochrane Library, CDC Wonder, NTIS, PsycINFO, Sociological Abstracts, Social Work Abstracts, National Library of Medicine, University of Washington Libraries, CRISP, general Internet search engines such as Google, and others. Query terminology included but was not limited to variations on and combinations of CULTURAL COMPETENCE, CULTURAL DIVERSITY, BEST PRACTICES, PROGRAMS, INSTITUTIONS, ORGANIZATIONS, LANGUAGE ACCESS, LINGUISTIC ACCESS, INTERPRETER SERVICES, MULTICULTURALISM, ETHNICITY, MINORITY, QUALITY, RACE, DISCRIMINATION, PATIENT EDUCATION, COMMUNITY, and similar terms. MESH Headings were used in MEDLINE. The search was date-limited to recent years depending on what options were available in a particular search tool. A large volume of results was pared down for review, and the following are some of the more notable materials encountered and read.

Most works included here were chosen because they document a program that attempts some activity or activities that could potentially be a best practice. This list is not exhaustive by any means.

Literature reviews and documents that profile multiple sites for “best practices” in culturally and linguistically appropriate services.

1. Anderson LM, Scrimshaw SC, Fullilove MT, Fielding JE, Normand J, Task Force on Community Preventive Services. Culturally competent healthcare systems: a systematic review. *American Journal of Preventive Medicine* 2003;24(3S)68-79.

Reviews culturally competent interventions of five types: recruiting and retraining staff that reflect the community, interpreter or bilingual services, cultural competency training for providers, culturally and linguistically appropriate health education materials, and culturally specific healthcare settings. Few articles gathered in the initial search qualified for review because they didn't conform to the authors' analytic framework and/or didn't feature a control group and an experimental group. This leaves zero to a handful of articles in each category, and even when the authors found the remaining programs' evidence sound and sufficient, there were too few left and each category was pronounced as having “insufficient evidence” as if there was no point discussing the good programs they just described. The authors may be correct about the need for more analytical study of culturally competent services, but their suggested approaches may need to be broadened. As evidenced by the many articles featured in the present review/bibliography, there are numerous programs that appear to be making a difference in care, but the construct of experimental/control groups may be a difficult or impossible evaluative method to apply, or a one-issue focus may be too narrow to capture what is happening in culturally competent services.

2. Association of Asian Pacific Community Health Organizations. *Addressing the Nation's Mental Health Issues for Asian American Communities: Three Mental Health Program Models*. Oakland: AAPCHO, 2000.

Profiles three programs that provide improved access to mental health services for Asian Americans. The Bridge Program of New York City's Chinatown Health Clinic provides culturally competent mental health services primarily for Chinese Americans at a primary care facility. Integrating mental health care into a primary care facility significantly reduces patients' stigma with attending a stand-alone mental health clinic. Asian American Community Services in Columbus, Ohio reduces language and cultural barriers to mental health services by providing interpreter training and cultural competence training, developing publications, and providing interpreter services to area hospitals and agencies. At Social Adjustment Program (SAP) for Southeast Asian Refugees, in Saint Paul, Minnesota, staff attempt to coordinate holistic treatment that addresses numerous areas of concern including family and spiritual issues and practical aspects of navigating life in the United States. The report describes program evaluation processes and includes contact information, "lessons learned", and "recommendations for replication" sections for each program. Addresses aspects of CLAS standards 1, 2, 3, 4, 6, 7, 11, and 12, and possibly 5, 8, 9, and 10.

3. Betancourt JR, Green AR, Carrillo JE. *Cultural Competence in Health Care: Emerging Frameworks and Practical Approaches*. New York: The Commonwealth Fund, 2002. Obtain from The Commonwealth Fund, One East 75th Street, New York, NY 10021-2692, 212-606-3800, available on the web at www.cmwf.org, choose "minority health" under "publications."

Reports on a project which had three goals: evaluate current definitions of cultural competence and identify benefits to the health care community through reviewing the literature and interviewing health care experts in a variety of settings, identify models of culturally competent care, and determine key components of cultural competence and develop recommendations for improving health care quality. After setting the stage with a literature review, the report profiles the four programs the investigators visited including the White Memorial Medical Center Family Practice Residency Program in Los Angeles (academic); Language Interpreter Services and Translations, Washington State (government); Kaiser Permanente, San Francisco (managed care); and Sunset Park Family Health Center in Brooklyn (community health). The fairly short profiles include key lessons learned and contact information. The report closes with recommendations drawn from the investigators' research and some appendices. CLAS Standards: Various, depending on the site.

4. Brach C, Fraser I. Can cultural competency reduce racial and ethnic health disparities? A review and conceptual model. *Medical Care Research and Review* 2000;57 Supp. 1:181-217.

This review attempts to use evidence-based best practices found in the cultural competency literature and the health disparities literature to produce a conceptual model for reducing

health disparities. The general conclusion is that based on related literature cultural competency should reduce disparities but it has rarely been directly tested. The authors demonstrate the lack of rigorously evaluated practices but present both proven and promising techniques that have been either suggested or used, breaking them into nine major categories: 1) interpreter services, 2) recruitment and retention policies, 3) training, 4) coordinating with traditional healers, 5) use of community health workers, 6) culturally competent health promotion, 7) including family/community members, 8) immersion in another culture, and 9) administrative and organizational accommodations. The one exception the authors stress is interpreter services, for which there is evidence of reduction in disparities when adequate services are available. The articles reviewed address numerous CLAS standards.

4. Guitierrez-English J, Le A. Assessing needs and planning, implementing and evaluating health promotion and disease prevention programs among Asian American population groups. In: Huff RM, Kline MV, eds. *Promoting Health in Multicultural Populations: A Handbook for Practitioners*. Thousand Oaks, CA: Sage;1999:357-373.

Discusses methodology and issues specific to conducting health promotion with Asian American populations. These include inter- and intracultural groups and demographics, intergenerational differences, and the tendency for statistical information to be either nonexistent or aggregated into less meaningful categories. By way of illustration, the authors then profile, describe and compare two model programs. The first program is Suc Khoe La Vang! (Health is Gold!), a mostly media-based anti-smoking campaign aimed at Vietnamese men. The program incorporated Vietnamese-language health education materials including a video broadcast on tv, a calendar, bumper stickers, several brochures and other materials and a Vietnamese anti-tobacco counter-advertising campaign in numerous media, all tailored to a Vietnamese market, continuing education for Vietnamese doctors, and more (CLAS standards 7, 12). The second program was Pathways to Early Cancer Detection for Vietnamese Women, a smaller-scale, more personal neighborhood intervention that utilized the social advantages of lay health workers to help increase preventive care and screening for breast and cervical cancer (12). While the first program reports significant changes in tobacco use and behavior relative to a control community, the second program hadn't progressed enough to report results as of the chapter's writing. Both programs utilize current demographic and health data and community needs assessment (CLAS standard 11) in determining and addressing health issues of particular import in the Vietnamese community.

3. Horowitz CR, Davis MH, Palermo AS, Vladeck BC. Approaches to eliminating sociocultural disparities in health. *Health Care Financing Review* 2000;21:57-74.

This literature review presents an overview of approaches to addressing health disparities followed by recommendations for prospective programs. The overview breaks down into provider-targeted programs, patient and community targeted programs, and health system approaches and policy, using specific examples in each category. Many of these projects address issues corresponding to specific CLAS standards, typically but not limited to standards 1, 2, 4, 5, 7 and 12. Community House Calls at Harborview Medical Center in

Seattle, for example, uses community health workers (standards 2 and 12) who carry hand-held computers to access records on the spot when working with refugee families (standard 10). The authors found a trend of programs lacking evaluation for various reasons. The recommendations section that followed emphasized evidence-based approaches that incorporate evaluations, and multi-sector collaborations and networking.

4. Isaacs MR, Benjamin MP. *Towards a Culturally Competent System of Care Volume II: Programs Which Utilize Culturally Competent Principles* - Washington DC : CASSP Technical Assistance Center, Georgetown University Child Development Center, 1991.

An ambitious companion to Volume I, this volume profiles eleven programs utilizing Cross's principles of culturally competent care. These include the Asian/Pacific Center for Human Development in Denver; Black Family Development, Inc. in Detroit; Roberto Clemente Family Guidance Center in New York; The Indian Health Board of Minneapolis, Inc.; Ada S. McKinley Intervention Services in Chicago; Progressive Life Center, Inc. in Washington DC; Roybal Family Mental Health Services in Los Angeles; Santa Clara County Mental Health Bureau in San Jose, CA; South Cove Community Health Center in Boston; Three Rivers Youth in Pittsburgh; and Indian Health Service, Yakama Indian Reservation, Toppenish, WA. The report contains extensive additional information including background, lessons learned, priorities for the future, and appendices that include, among other things, short profiles of 72 surveyed sites.

5. Loudon RF, Anderson PM, Gill PS, Greenfield SM. Educating medical students for work in culturally diverse societies. *JAMA* September 1, 1999; 282:875-880.

This brief UK article analyzes and compares 17 cultural diversity training programs in medical schools in the United States, Canada, Australia and the United Kingdom, identified following a broad literature search and specifically focusing on ethnic and racial diversity. Areas discussed include motivation for program development, teaching methods, program content, student assessment, and evaluation. Several of these programs are discussed elsewhere in this literature review [CLAS reviews]. Such programs tend to exist in departments of family medicine, preventive medicine, educational development and mental health. Some programs were initiated by students; these tended to have a view of diversity that went beyond ethnicity. The article includes a handy table where the reader can quickly compare the programs'/articles' settings, program length, teaching staff, basic content, cultural and/or racial/ethnic group addressed, course evaluation and other details.

6. Mateo J, Gallardo EV, Huang VY, Niski C. *Providing Health Care to Limited English Proficient (LEP) Patients: A Manual of Promising Practices*. Sacramento: California Primary Care Association, [2001].

This book describes how innovative community clinics in California serve limited English proficient populations. The clinics are divided into three categories: rural/frontier, migrant

and urban community clinics. Throughout the clinic profiles section are references to program examples of OCR's Keys to Compliance, "four elements generally found in programs that provide 'meaningful access.'" The authors have ostensibly chosen one exemplary practice from each clinic on which to focus, but most descriptions include more. Many of the clinics feature mostly bilingual staff and provide trained interpreters for languages not represented by staff. Though the main focus of the book is language access, in their efforts to provide appropriate services these clinics illustrate practices congruent to various CLAS standards including but not limited to the language access standards. Standout programs include Salud Para la Gente in Watsonville, La Clinica de La Raza in Oakland, and Asian Health Services in Oakland, with its intensive involvement in interpreter training and a local language bank, translations, tracking of patient language on its Patient Data System and other activities to numerous to list. Also included is a section on state policies, describing activities of several states that have developed programs that pay for providers' access to language services, including Washington, Hawaii, Minnesota, Utah, Maine, Massachusetts and California. The book concludes with appendices providing excerpts from the OCR's guidance on Title VI and examples of profiled programs' materials.

7. National Advisory Council on Nurse Education and Practice. *A National Agenda for Nursing Workforce Racial/Ethnic Diversity: Report to the Secretary of Health and Human Services and Congress*. [Rockville, Md.]: U.S. Dept. of Health and Human Services, Health Resources and Services Administration, Bureau of Health Professions, Division of Nursing, 2000.

Section I is an introduction, Section II is an overview of federal efforts to address diversity issues in nursing, dating back to the 1960s. The reader may want to seek out original reports referenced in this section for more details. Section III discusses issues related to diversity in nursing education and practice, drawn together and supported by numerous references though not an exhaustive literature review. Educational issues identified include inadequate pre-nursing guidance, financial restraints, restrictive admissions policies, lack of mentoring systems, few minority faculty, and barriers to the pursuit of or lack of awareness of the higher levels of nursing education. Leadership was identified as an issue for both education and practice. Practice issues included underrepresentation, minority nurse contribution to care, workplace diversity, educational mix, the aging of the minority nursing workforce, and cultural competency. In Section IV NACNEP formally sets forth issues, policy goals, and action items on education, leadership, and practice/workforce and cultural competency, which make reference to the CLAS Standards. This section lays out ideas that in practice might contribute well to CLAS Standards 2 and 3 particularly, and probably others, though when they mention the CLAS Standards at the end, they give the impression that they haven't read them yet since they don't draw any connection. This reviewer is unable to estimate the influence of NACNEP, but its efforts in writing this report are laudable.

A related item is the Division of Nursing's *Nursing Initiatives to Increase Ethnic/Racial Minority Representation*. US Department of Health and Human Services, Public Health Service, Health Resources and Services Administration, Bureau of Health Professions, Division of Nursing, no place, no date. The document describes nearly 30 programs sponsored by the Division of Nursing at nursing schools around the country. Of

interest for finding out what is going on and where, but each project is described at too early a stage to include results. Based on content, the publication date is late 1990s.

8. Mateo J, Gallardo EV, Huang VY, Niski C. *Providing Health Care to Limited English Proficient (LEP) Patients: A Manual of Promising Practices*. Sacramento: California Primary Care Association, [2001].

This book describes how innovative community clinics in California serve limited English proficient populations. The clinics are divided into three categories: rural/frontier, migrant and urban community clinics. Throughout the clinic profiles section are references to program examples of OCR's Keys to Compliance, "four elements generally found in programs that provide 'meaningful access.'" The authors have ostensibly chosen one exemplary practice from each clinic on which to focus, but most descriptions include much more. Many of the clinics feature mostly bilingual staff and provide trained interpreters for languages not represented by staff. Though the main focus of the book is language access, in their efforts to provide appropriate services these clinics illustrate practices congruent to various CLAS standards including but not limited to the language access standards. Standout programs include Salud Para la Gente in Watsonville, La Clinica de La Raza in Oakland, and Asian Health Services in Oakland, with its intensive involvement in interpreter training and a local language bank, translations, tracking of patient language on its Patient Data System and other activities to numerous to list; and Excerpts and explains legislation and traditional interpretations. Also included is a section on state policies, describing activities of several states that have developed programs that pay for providers' access to language services, including Washington, Hawaii, Minnesota, Utah, Maine, Massachusetts and California. The book concludes with appendices providing excerpts from the OCR's guidance on Title VI and examples of profiled programs' materials.

9. Youdelman M, Perkins J. *Providing Language Interpretation Services in Health Care Settings: Examples from the Field*. [New York City]: The Commonwealth Fund, 2002.

This study by the National Health Law Program was funded by the Commonwealth Fund. It describes 14 examples of practices around interpretation programs around the country. These are categorized as follows (the number of programs in each category is in the parentheses following the category): Statewide Medicaid/SCHIP Reimbursement (2), State and Local Government Initiatives (2), Managed Care Programs (2), Hospitals (3), Community Based Organizations (2) and Educational Models (3). Appendices include: a) a matrixed presentation of Federal Programs, State Medicaid/SCHIP Fee-for-Service programs, b) State and Local Laws/Ordinances, and c) the names and brief descriptions of 58 specific interpreting programs in 23 states and the District of Columbia.

Literature about programs with promising “best practices” and a few other relevant items:

1. Affonso DD, Korenbrot CC, De AD, Mayberry LJ. Use of care, outcomes and costs of a culturally-based perinatal program for Asian American and Pacific Islander Women in Hawaii. *Asian American and Pacific Islander Journal of Health*. 1999;7:10-24.

This description of a perinatal program on the Island of Hawaii includes an extensive review of pertinent background information. The program included a community advisory board of local businessmen, a neighborhood women’s group that partnered with nurses and patients, provider training in care “congruent with Asian-Pacific Islander cultural values of harmony and balance,” traditional healers, transportation, home visits, group activities, incentives for participation, content gleaned from focus groups, and traditional practices. The study includes estimates of costs and outcomes and projects positive savings from a community program. Participants experienced fewer adverse birth outcomes and had better perinatal care. Additionally, the article implies that the program affected outcomes in non-participating women that received care in the same catchment area. This well-constructed program has been adapted to wider use in Hawaii and is being studied for broader research and model applications are under consideration by AHCPH and HRSA. On the downside, the article does not present enough follow-up on money saved (if any) in post-natal care because of the program. Program addresses elements of CLAS standards 1, 3, 11, 12 and possibly others.

2. Akau M et al. Ke Ala Ola Pono: the Native Hawai’ian community’s effort to heal itself. *Pacific Health Dialog*. 1998;5:232-238.

This article opens with a quick history of Native Hawai’ian health status dating to the 18th and 19th centuries, culminating in the passage of the Native Hawai’ian Health Care Improvement Act of 1988 and the simultaneous formation of Papa Ola Lokahi from representatives of 25 public agencies and private organizations to implement the Act’s objectives. Papa Ola Lokahi is a focal point for advocacy, research, training, and technical assistance for the state and its accomplishments include the Native Hawai’ian Health Scholarship Program and the innovative Native Hawai’ian Health Care Systems. The 5 Native Hawai’ian Health Care Systems operate independently on Oahu and most of the neighbor islands, serve 25,000 Native Hawai’ian clients annually, and utilize a strategy based on relationship building, culturally competent outreach and services, access to primary care, collaboration with existing providers, and disease prevention, health promotion, and health education. The rest of the article details Native Hawai’ian health statistics and needs and social issues, the revival of and world-wide interest in their arts and healing traditions, and hopes for the future. Aspects of CLAS Standards 1, 2, possibly 8, 11, 12.

3. Andrulis D, Goodman N, Pryor C. *What a Difference an Interpreter Can Make: Health Care Experiences of Uninsured with Limited English Proficiency*. Boston: The Access Project, 2002.

The authors surveyed over 4,161 uninsured respondents who sought care at hospitals in 16 cities, distinguishing respondents as “no interpreter needed,” “interpreter needed/available,” or “interpreter needed/unavailable.” Respondents were asked about perceptions of hospital attitudes toward the uninsured, satisfaction with medical and support staff encounters, understanding of medication instructions and payment for prescription drugs, payment for general medical care, availability of signs and written materials in respondents’ native language and effects of financial experiences on likely future use of the facility. Clearly, the “interpreter needed/unavailable” group had the worst experiences. For all questions asked, the least number of positive responses came from this group. For example, over one quarter of the “interpreter needed/unavailable” group didn’t understand their medication instructions, and another 7% weren’t given instructions. A discussion session follows the results, presenting implications for access to care and quality, business, research, and urban hospitals. A curious trend that might have benefited from discussion is that on many questions there was a greater number of positive responses from the “interpreter needed/available” group than from the “no interpreter needed” group. CLAS standards 4, 7.

4. Avery MPB: The role of the health care interpreter: an evolving dialogue. National Council on Interpreting in Health Care, Working Paper Series, April, 2001, available at <http://www.ncihc.org>

This paper summarizes nearly ten years of national dialogue on the role of the interpreter. It is well written and summarizes the views of a broad collective of individuals who have studied these issues, provided input and are experienced in linguistics, health care and health care interpreting.

5. Balcazar H, Valdez E, Tafoya-Barraza H, Guevara J. Proyecto Unidos: A Latino health coalition to empower professionals and para-professionals for community health actions. *Journal of Health Education*. 1998;29:144-148.

An Office of Minority Health-funded project that organized a coalition that enabled an Arizona county to begin systematically, collaboratively, and sensitively addressing its Latino population’s health needs. A small staff and a steering committee composed of seven Latino community organizations involved in health issues developed and implemented an action plan to address eight areas of concern: 1) coalition membership, 2) network systems development to connect Latino health expertise, 3) leadership training for Latino health professionals and paraprofessionals, 4) dissemination of information of Spanish and Latino-targeted health promotion material, 5) cultural competence and language certification to start down the road towards interpreter and cultural competence training programs, 6) coalition documentation, 7) needs assessment survey to determine most pressing Latino health issues, and 8) grant writing to find further funding sources to keep the coalition viable. As the authors point out, the article and project are limited by lack of evaluative measurements and empirical evidence of enhanced access to health care by Latinos, but the project’s grant-seeking activities led to a three-year demonstration project called “Unidos En La Salud”/”United in Health” to be implemented as a follow-up initiative. Unidos En La Salud

is described as a tailored, culturally sensitive, community-based screening, access, outreach, and treatment program focused on cardiovascular disease and diabetes and may be worth checking out. Addresses aspects of CLAS standards 1, 2, 6, 7, 11, and 12, at least.

6. Brown SA, Garcia AA, Kouzekanani K, Hanis CL. Culturally competent diabetes self-management education for Mexican Americans: The Starr County Border Health Initiative. *Diabetes Care*. 2002;25:259-268.

Brown and associates have written several articles profiling aspects of a multi-faceted diabetes program for Mexican Americans in Starr County, Texas. Starr County is the poorest in Texas and one of the poorest in the U.S., and has Texas' highest unemployment rate. The population is 97.7% Mexican American. The intervention was carefully researched with a sample size of 256. The control group received the same intervention a year after the experimental group. The intervention incorporated numerous culturally competent methods such as bilingual staff, use of family support congruent with the culture, demonstrations of ways to adapt the local diet to diabetes care, much involvement with community workers, and focus groups to find out what participants preferred and what was realistic and practical for them in a diabetes self-management program. The course of each intervention was extensive, lasting 12 months and consisting of 52 contact hours. At the end of the study, the experimental group showed statistically significant improvements in diabetes knowledge scores and metabolic control, the latter enough to theoretically reduce diabetes complications. No other variables measured, such as weight loss, significantly changed. CLAS standards 1, 2, 3, 4, 6, 7, 11, 12 are addressed.

7. Carol R. Taking the initiative: by breaking down cultural barriers to health care and providing preventive education, nurses of color are helping to close minority health disparity gaps one patient at a time. *Minority Nurse*. Fall 2001;24-27.

This article discusses minority nurses' special advantages in helping diverse patients and dealing with culture-specific issues. Several Latino nurses and a Native American nurses describe how their cultural backgrounds came in handy on the job and the barriers they have helped breach to improve the health of their patients. The nurses stress communicating in the patient's first language is purportedly a critical factor in providing quality care. Addresses aspects of CLAS standards 1, 2, 4.

8. Cross TL, et al. *Towards a Culturally Competent System of Care Volume I: A Monograph on Effective Services for Minority Children Who Are Severely Emotionally Disturbed*. Washington DC : National technical Assistance Center for Children's Mental Health, Georgetown University Child Development Center, 1989.

A foundational work on culturally competent care, this document provides a "philosophical framework and practical ideas for improving service delivery" and includes Cross's popular, thought-provoking and practical "cultural competence continuum." Areas addressed include

values and aspects of the culturally competent system of care, developing cultural competence at all levels, service adaptations, and planning for cultural competence. As many readers already know, its usefulness is not limited to children's services.

9. Culhane-Pera KA, Reif C, Egli E, Baker NJ, Kassekert R. A curriculum for multicultural education in family medicine. *Family Medicine*. 1997;29:719-23.

Describes and evaluates 3 years of a multicultural education curriculum held in the St. Paul-Ramsey Family Practice Residency Program at Regions Hospital, St. Paul, Minnesota, an institution serving a culturally diverse inner-city population. Bennett's structure of five stages of cultural competence was used as a model for students' development⁸¹. Each resident attended a full day of content-rich seminars and grand rounds which included participatory exercises and case discussions, experienced one-on-one teaching sessions with faculty reviewing videotapes of clinical encounters, and participated in a community medicine project such as designing a brochure about HIV for Latinos. Thirty-three residents were evaluated for cultural competence before and after the curriculum by themselves and faculty, and were found to have improved. While the residents rated the curriculum as 4.26 on a 5 point scale with 5 as the highest rating, interviews revealed several negative opinions and in the discussion the authors reveal that residents' resistance to a perceived political agenda basic to the curriculum and to its self-exploratory demands presented a major challenge at every stage. There is no attempt to quantify this and the reader is left wondering how many residents harbored these objections. It is unclear if this program was elective or fulfilled a diversity requirement. Aspects of CLAS standard 3 and possibly others.

10. Donini-Lenhoff FG, Dedrick HL. Increasing awareness and implementation of cultural competence principles in health professions education. *Journal of Allied Health*. 2000;29:241-245.

This optimistic article describes proposed and implemented cultural competence-related standards amongst individual professional and accreditation bodies in medical and allied health education. The authors suggest "next steps" that include caveats about the depth and analysis necessary for making real impact.

Fields evidencing the most progress toward cultural competence training requirements tend to be in general health care and primary care, mental health or counseling, and other specialties that involve significant patient contact. Descriptions of standards are general, with more innovative or notable details extracted for description.

With only brief introductions, it's hard to be sure which CLAS standards these fields' self-imposed standards address. Standard 3 is most likely, though somewhat implicit, since the CLAS standards don't explicitly address professional education.

⁸¹ Bennett MJ. Toward ethnorelativism: a developmental model of intercultural sensitivity. In: Paige RM, ed. *Education for the Intercultural Experience*. Yarmouth, ME: Intercultural Press;1993.

11. Doty BJ, Pastorino R. Cultural competency training in a new-start rural/frontier family practice residency: a cultural immersion integrated model. *Journal of Rural Health* 2000;16:278-279.

This summary report describes the Alaska Family Practice Residency, founded in 1997 and affiliated with the University of Washington School of Medicine Affiliated Family Practice Residency Network. Located in Anchorage, Alaska, the program graduated its first class of eight in 2000. The cultural curriculum consists of “Transcultural Medicine” (TCM) in the first and third years and a six-week immersion experience in the second year, and emphasizes self-discovery and progressive learning. TCM includes diverse, participatory course content on working with indigenous cultures in a physically adverse, very isolated, subsistence-living environment, and includes two month-long rural practicum blocks. The immersion experience places residents in an isolated hospital unreachable by road, serving 50 rural villages in an area the size of Oregon. The program was implemented to serve a highly specialized training need, but the depth of training, experience and subject matter described suggest that the program may be worth investigation by other professional education programs and other individuals interested in designing intensely culturally-involved training programs. CLAS standards 1, 3, 12.

12. Downing B, Roat CE. *Models for the Provision of Language Access in Health Care Settings*. N.p.: The National Council on Interpreting in Health Care, March 2002.

Describes the range of models, viable and not, for communication in health care when providers and patients/consumers do not share the same principal first language. The descriptions proceed with an order and logic that clearly and simply leads the reader to an understanding of the complexity of language access, the merits and shortcomings of each model, their complementary nature, and an appreciation for the great skill, knowledge, and commitment necessary on the part of interpreters, providers, administrators, and other staff for providing appropriate linguistic access. The paper easily puts to rest notions that knowing “a little Spanish” or using family members as interpreters will do the job. An appendix called “Models in Action” follows, detailing exemplary programs that use viable models. These programs include SeaMar Community Health Centers in Seattle (Bilingual Provider Model), Kaiser Permanente in California (Ad-Hoc Model, non-clinical staff used to interpret), Mercy Medical Center in Des Moines, Iowa (Community Service Agency Staff Model), Harborview Medical Center in Seattle (Dedicated Interpreter Models—staff, contract and agency interpreters), and Yale New Haven Hospital in Connecticut and Primary Children’s Hospital in Salt Lake City (Dedicated Interpreter Model --Volunteer Interpreter Model). CLAS standards 4-7.

13. Dreachslin JL, Hunt PL, Sprainer E. Workforce diversity: Implications for the effectiveness of health care delivery teams. *Social Science & Medicine* 2000;50:1403-1414.

Nursing teams at two hospitals participated in focus groups to discuss perceptions of race’s effect on inter-staff communication, and a grounded theory was derived from the results.

Team role tended to fall along racial lines, with most RNs being white and most support staff African American. Most staff thought their team's communication was bad and those that didn't thought their team was unusual. Though opinions varied widely, more African Americans identified race as a factor in staff conflict and communication difficulties while white staff more often attributed problems to team role and status. Different perspectives and alternative realities emerged as common themes, with people frustrated by and discounting each other's perceptions. Reinforcing factors, also discussed in the focus groups, included social isolation, selective perception, and stereotyping. The one mitigating factor identified was leadership style; specifically, communication was perceived as best when team leaders and patient care managers were open to and encouraged discussions about differences and validated alternative realities and differing perspectives, which then went beyond mitigation to mining the advantages of a diverse workplace for patient care. The authors call this "diversity leadership," a major focus of Dreachslin's work. The article's examples and theories are explicit eye-openers and inform on some of the dynamics behind the immediate appearance of communications in a diverse workplace. Unlike many articles, the authors take the time to explain their methods instead of just stating them by concept, so if the reader doesn't know what a focus group is, now they will. Dreachslin has published much on workplace diversity and further investigation of her work is recommended. Doesn't address any particular CLAS standard but relevant to standard 2 at least.

14. Fahrenwald NL, Boysen R, Fischer C, Maurer R. Developing cultural competence in the baccalaureate nursing student: a population-based project with the Hutterites. *Journal of Transcultural Nursing* January. 2001;12:48-55.

Describes a semester-length student nursing project to develop cultural competence in students while benefiting South Dakota's Hutterites. The instructors chose Campinha-Bacote's multi-part model of culturally competent care to guide the students.⁸² The article staged the project under headings drawn from Campinha-Bacote's model to illustrate student development toward cultural competence. Each stage was designed to be culturally competent for the Hutterites. Students assessed priority health needs of Hutterite colonies and planned, implemented, and evaluated health programs such as first aid classes for children, education about heart disease, and blood lipid level testing for colonies' adults. The authors acknowledge bearing the responsibility to ensure continuation of programs started by leaving students. This project sounds sufficiently in-depth to make a difference in both the professional lives of the students and the health of the target population, but the article does not report an evaluation of the students' cultural competence or their projects' effects on the Hutterites' health. Addresses CLAS standards 1, 11, 12.

15. Gettleman L, Winkleby MA. Using focus groups to develop a heart disease prevention program for ethnically diverse, low-income women. *Journal of Community Health*. 2000;25:439-453.

⁸² Campinha-Bacote J. A model and instrument for addressing cultural competence in health care. *Journal of Nursing Education*. 1999;8:203-207.

Describes the exploratory stage of a project aimed at heart disease prevention for ethnically diverse, low-income women. The project used a focus group methodology to sample equal numbers of low-income white, African American and Hispanic women from urban and agricultural communities in Northern California. The women's voices and opinions spoke to possible effective interventions in their communities and to broader concerns they had about achieving healthy lifestyles. The authors found commonalities across ethnic groups, such as lack of safe places to exercise and difficulty finding healthy food, a preference for visual rather than written formats, and the desire for personal medical knowledge regarding effects of lifestyle choices and behaviors on health. This article's use of community data and community and consumer involvement in service design illustrate examples of CLAS standards 11 and 12. However, it is unclear whether an actual program was built in response to the work.

16. Godkin MA, Savageau JA. The Effect of a global multiculturalism track on cultural competence of preclinical medical students. *Family Medicine*. 2001;33:178-86.

The article describes a 2-year elective medical school track intended to increase students' cultural competence, consisting of multiple visits to a local family of a different ethnicity (who received \$400 for participation), a 6-week language and cultural immersion experience abroad, a domestic community service project, and a seminar series. A detailed, validated cultural competence measurement tool was used to compare students before and after the track and to compare them to non-track students. Students showed improvements as well as intriguing, often unpredictable changes in many areas and attitudes after the courses. Comparison between track and non-track students was not ideal because track students were self-selected and showed higher levels of cultural competence and differing opinions than non-track students to begin with. Although the authors point out limitations including the lack of a true control group and qualitative analysis of student journals, this work reflects an in-depth and impressive medical-education cultural competence training effort. Addresses aspects of CLAS standards 2, 11, and 12.

17. Gordon AB. Success story: building healthy relationships at Alaska Native Medical Center. *Continuous Improvement* no. 19, October 2002.

<http://www.ihl.org/resources/successstories/ci1002alaska.asp>

This "Success Story" from the Institute for Healthcare Improvement describes how Alaska Native Medical Center in Anchorage was transformed from an impersonal federally-owned hospital where "primary care" was conducted in urgent care or emergency room settings and few patients had a primary care provider into a Native-owned, Native-directed patient-centered system providing same-day access to care. The hospital's operations were entirely rearranged according to the new owners' values and tools learned through IHI's Quality Management Network program, producing a system tailored to its clients needs and desires, and involving community input, annual planning, and Native healing. According to Vice-President Douglas Eby, the most important concept for making it work and effecting change

in insidious health problems is relationships. “Relationships are really what it's all about.” The article links to impressive statistics. CLAS standards 1, 8, 9, and 12.

18. Hatch J, Moss N, Saran A. Community research: partnership in Black communities. *Community Research*. 1993 Nov-Dec;9(6 Suppl):27-31.

Describes and discusses the utility of four models for conducting community research in Black communities, then presents additional challenges and issues relevant to forming research partnerships in Black communities. The models described demand progressively more intimate community involvement by researchers and entail progressively more active, empowered, and formative involvement by community members, with the fourth model, in which the community collaborates on every aspect of research including problem definition and research design, held as the best. Two examples of model three involving hypertension and diabetes control and one example of model four involving cardiovascular fitness are briefly described. Additional issues discussed include the distrust held by some members of the Black community toward scientific research directed at Black people, problematic data interpretation concerns, the need for researchers to choose issues and research that have strong potential to directly benefit the community, rather than just policy or scientific interests, philosophy of science issues, and partnerships particularly with African-American women. A thoughtful article that concisely and meaningfully introduces and addresses these fundamental concerns. CLAS standard 12.

19. Heins HC Jr., Nance NW, Ferguson JE. Social support in improving perinatal outcome: The Resource Mothers Program. *Obstetrics and Gynecology* August 1987;70:263-266.

Pregnant teenagers tend to be socially isolated, have less prenatal care than other mothers, and more adverse pregnancy outcomes. The Resource Mothers program pairs rural teenaged pregnant women with nonprofessional women who provide a combination of social support and highly structured guidance and education and practical assistance throughout the pregnancy and the infant's first year of life. The present article compared 575 Resource Mothers participants with a control group, both in rural North Carolina, and found significantly higher percentage of small-for-gestational age babies in the controls, and fewer low birth weight babies in the Resource Mothers participants. Eighty-nine percent of the teen mothers were African American. The article and program come from an era before the popular emergence of cultural competence and the article says nothing about cultural issues in the Resource Mothers' six-week training period or about recruiting Mothers that reflect the target population. Still, some CLAS standards are implicitly addressed, particularly 11, 12 and possibly aspects of 1.

20. Hodge FS, Pasqua A, Marquez CA, Geishirt-Cantrell B. Utilizing traditional storytelling to promote wellness in American Indian communities. *Journal of Transcultural Nursing*. 2002;13:6-11.

A California health promotion program that uses traditional storytelling as a major component. The authors provide an informative introduction to the educational role of storytelling in American Indian culture and traditions, a convincing argument for its potential efficacy in health education. This is followed by some explanation of how the storytelling and conventional health education methods were combined, other factors such as communication issues were dealt with in culturally competent ways, and barriers such as transportation and location issues were solved. This may be a fine example of culturally appropriate services (CLAS standard 1) involving community members as facilitators and using community locations (standards 12 and 2). Despite reference to “project findings” early in the article, the work is limited by a lack of statement or discussion of outcomes.

21. Holland L, Courtney R. Increasing cultural competence with the Latino community. *Journal of Community Health Nursing*. 1998;15:45-53.

Presents a variety of suggestions for improving nursing care to Latinos. These include rhetorical suggestions and descriptive examples of culturally-recognized health terms and syndromes; creative activities devised by one clinic’s staff to bring its nurses out of the clinic and acquaint them with the local Latino community and efforts to put the nurse in the patient’s or community’s shoes included participation in the activities of the clinic’s Latino community workers and a one-week cultural immersion trip to Mexico that included seeing formal and informal health systems in action. There’s some generalization about “the Latino culture.” No evaluative process of these educational practices was undertaken. Addresses aspects of CLAS standards 3 and 12.

22. Jackson-Carroll LM, Graham E, Jackson JC: Beyond Medical Interpretation: the role of Interpreter Cultural Mediators (ICMs) in building bridges between ethnic communities and health institutions. Community House Calls Program, Harborview Medical Center, Revised edition, January, 1998.

This manual, published by Harborview Medical center, describes The Community House Calls program, originally funded by the Robert Wood Johnson Foundation. House Calls utilizes bilingual, bicultural workers trained to work as case managers, interpreters and culture brokers. They carry out independent assessments on patients and families referred from the Pediatrics and Internal Medicine clinics at HMC. The program includes community input, oversight and advisors who are community elders. The program’s success (it began in 1995) led to HMC adding workers and language groups to their initial project. It touches on CLAS standards 1-8 and 12.

23. Jezewski MA. Culture brokering in migrant farmworker health care. *Western Journal of Medicine*. 1990;12:497-513.

Describes and analyzes culture brokering, a means to bridge the gap between patients and providers of disparate cultures, socioeconomic and power status, in the care of migrant

farmworkers in New York State. Data was drawn from formal, informal, and semi-structured interviews with staff and migrant farmworkers and observation of clinic sessions. A three-stage model illustrates the brokering process: first, the need for brokering is perceived when a breakdown occurs between the patient/provider; second, intervention in which brokering strategies such as advocating, mediating, negotiating, intervening, sensitizing, and innovating; are used; and third, outcome, in which if there is resolution to the problem, facilitation of health care happens. The article also describes providers learning culturally appropriate care on the job, and an informal network of care in which providers and patients knew and shared with each other which providers were open to, trusted, and skilled at serving the migrant community. Provides examples of aspects of standards 1, 12, and especially 13 at work.

24. Jones ME, Bond ML, Cason CL. Where does culture fit in outcomes management? *Journal of Nursing Care Quality* 1998;13:41-51.

This article explores various approaches to culturally competent care by reviewing the literature and looking briefly at a few examples from ongoing projects in the Parkland Health and Hospital System in Dallas, Texas and other sites. None are systematically evaluated. This effort is a rare attempt to address organizational culture and the need to implement cultural competence measures at the level of organization mission, strategic planning, and administration. CLAS standards 1, 8, 10.

25. Larson K et al. Maternal care coordination for migrant farmworker women: program structure and evaluation of effects on use of prenatal care and birth outcome. *The Journal of Rural Health* 1992;8:128-133.

Describes a perinatal care program for migrant farmworker women in North Carolina, at the University of North Carolina Migrant Health Project, that utilizes bilingual nurses, outreach to camps, volunteer translators to assist migrant women in labor, lay health advisors, home visits, a van for transportation, and perhaps most notably a multistate, multiclinic tracking system that makes it possible for migrating women to have continuing care. Prenatal service use improved over the 5 year study period, including an increase in first-trimester entry and an increase in women receiving nine or more prenatal visits. These successes inspired the National Migrant Resource Program, Migrant Clinicians Network, and National Perinatal Association to collaborate on promoting coordination of perinatal services for migrant women. Aspects (perhaps somewhat limited) of CLAS Standards 1, 2, 4, 6, and 11.

26. MacAvoy S, Lippman DT. Teaching culturally competent care: nursing students experience rural Appalachia. *Journal of Transcultural Nursing*. 2001;12:221-227.

Describes two courses, Health in Rural Appalachia and Clinical Practice in Appalachia, developed by one of the authors to increase students' cultural competence. The classes include a one-week immersion experience in Eastern Kentucky. Coursework integrated

issues of class, race, gender, environment, and poverty, utilized a variety of literature resources, and encouraged discussion and exploration. The article also describes Appalachian culture to some extent. Quotes from participants convey a sense of personal growth and cultural learning in response to the immersion experience. The comments tend to lack the transformative depth toward cultural competence conveyed in the journals shared in St. Clair and McKenry, 1999. (see # 17, p 7)

27. Meade CD, Calvo A. Developing community-academic partnerships to enhance breast health among rural and Hispanic migrant and seasonal farmworker women. *Oncology Nursing Forum*. 2001; 28:1577-1584.

This article details a partnership between the federally qualified Suncoast Community Healthcare Center and the H. Lee Moffit Cancer Center and Research Institute at the University of South Florida in Tampa. It includes a literature review of preferred practices/pitfalls of community-academic partnerships providing for the underserved. Though it's not clear what quantifiable impact the program has had on the health of the target population, it reaches hundreds of people and incorporates practices congruent with several CLAS standards. The program has been in operation for seven years reaching 800 women per year. The program now offers screenings and care applicable to the whole family. CLAS standard related practices include utilization of culturally relevant approaches (1), translated patient education materials and written notices (5 and 7), community involvement at every stage of the projects (12), regular "reality checks" to make sure goals are on track and find what new messages, initiatives, or activities would improve the program (9), partnerships with local church organizations and governments (12) and bilingual/bicultural lay outreach workers (4). Outside of the CLAS standards were numerous notable aspects: program experience generated research questions; the program was mobile and taken where people lived; outreach workers appeared in salons, stores and other community locations; and the program eventually partnered with numerous additional organizations including, the CDC, and the Avon Breast Care Fund.

28. Nora LM, Daugherty SR, Mattis-Peterson A, Stevenson L, Goodman LJ. Improving cross-cultural skills of medical students through medical school-community partnerships. *Western Journal of Medicine*. 1994;161:144-147.

Describes and evaluates a session of Rush Medical College's Spanish Language and Hispanic Cultural Competence Project, an extensive three-part curriculum developed through collaboration with two outside organizations. Spanish language courses constitute the first part of the curriculum. The second is cultural competence training consisting of 20 two-hour weekly sessions based on a syllabus developed by the Hispanic Health Alliance, a non-profit community-based organization concerned with improving the health status of Chicago-area Hispanics. Community experts lead the sessions. Course content emphasized Hispanic demographic facts, cultural information, and health concerns rather than more philosophical and self-exploratory themes of cultural competence. The third component is an 8-day trip to

Mexico, an international seminar with programming developed in partnership with the Center for Global Education at Augsburg College, which maintains a facility in Mexico.

After the courses, students were tested on Spanish translation, Hispanic health and cultural issues, Sullivan and Adelson's misanthropy scale, and a survey about the Mexican trip. Predictably, students showed improvement in Spanish skills and Hispanic knowledge, and the misanthropy scale also showed changes suggesting signs of students becoming more open and tolerant towards difference. Comments on the immersion experience were mostly positive. The authors don't present a definition of cultural competence for their purposes and it's not clear that cultural competence is what these tests collectively measure. Addresses aspects of CLAS Standards 1, 3, and 12, at least.

29. Rust G, Taylor V, Morrow R, Everett J. The Morehouse Faculty Development Program: methods and 3-year outcomes. *Family medicine*. 1998;30(3):162-7.

In response to the disproportionately low number of minority family physicians in the United States and even lower number of minority medical school faculty in the US and on its own faculty, the Morehouse School of Medicine, a historically Black institution, developed a program to increase minority representation among medical school instructors. Seven to 10 trainees participate each year, including a fourth-year fellow, community-based preceptors who are usually family physicians practicing in the area, and new faculty who need training. Trainees learn a variety of practical and professional skills through hands-on work in a culturally supportive setting which has a mission to train physicians for underserved populations. In the first three years, 35 participants completed the program and Morehouse filled its two vacant family practice faculty positions and changed its faculty from 30% to 85% African American (it doesn't say what happened to the others). By comparison, in 1992 only 52 African-American full-time family medicine faculty could be identified in the entire country! Participant feedback has been quite positive. The authors describe areas for improvement and note that replicating this success will be harder in non-ethnic minority institutions.

To achieve CLAS standard 2, there has to be someone to hire, and there is a need for "role models, mentors, broadening experiences, and a nurturing environment" in order to train providers (p. 167).

30. Shaw-Taylor Y. Culturally and linguistically appropriate health care for racial or ethnic minorities: analysis of the US Office of Minority Health's recommended standards. *Health Policy*. 2002;62:211-221.

Introduces and comments on the CLAS standards, providing background on their impetus, describing the U.S.'s changing ethnic makeup, listing the standards, analyzing their potential impact on health care organizations, and describing a few notable programs that represent particular CLAS standards at work. The standards are analyzed based on structural requisites, process requirements, and outcome expectations, with a foundation in a variety of cultural competence, diversity, public health, and health care quality literature. Amongst other comments, the author writes that the standards lean heavily toward process requirements to

the neglect of structural requisites and outcome expectations and that the standards particularly overlook the role of public health agencies. To illustrate public health agencies' contributions to CLAS standards' requirements, the paper briefly describes HRSA's *Cultural Competence Works* (2001), Massachusetts Department of Public Health's outreach education training program, and Multnomah County (Oregon) Health Department's "Manager's Strategic Plan for Developing Cultural Competence."

31. Smith S, Gonzales V. All health plans need CLAMS (culturally and linguistically appropriate materials). *Healthplan*. Sept/Oct 2000 45-48.

Discusses health plans' legal and mission-related obligation to communicate effectively with plan members, problems and approaches to dealing with language barriers when presenting patient education information, and describes a process for translating English materials into other languages and then evaluating them. The University of Washington Center for Health Education and Research's process consisted of three steps: 1) Select good source materials—materials reviewed for scientific accuracy, developed specifically for a diverse population with a wide range of literacy skills, 2) Translate and pretest—with members of the intended audience, and revise as necessary, and 3) Pilot test. The article is not entirely clear here, but it appears that the pilot test is the evaluation, and the authors go into some detail about an evaluation process, Reader Verification and Revision Interview Process. Despite the authors' concern with low-literacy levels, the Spanish translations produced by the project were best understood by people with an average nine-year education. The article refers to studies but does not provide references. CLAS standard 7.

32. Shaw-Taylor Y, Benesch B. Workforce diversity and cultural competence in healthcare. *Journal of Cultural Diversity*. 1998;5:139-146.

This article presents a detailed framework for achieving culturally competent institutions and service provision, with a particular focus on workforce diversity and the patient-provider relationship. The authors draw this framework together from literature, and while it's difficult to tell for certain, it appears more theoretical than experience-based. Addresses CLAS standards 2, 3, 4, 8, 9.

33. Smith L. Evaluation of an educational intervention to increase cultural competence among registered nurses. *Journal of Cultural Diversity Summer*. 2002;8:50-63.

In response to the lack of empirical research on cultural competence interventions, the author applied two measures to RNs who participated in the author-designed continuing education "Culture School" class and a control group of RNs who took a nursing informatics class to determine if their levels of cultural competence had changed since before the courses. The two measures used are Bernal and Froman's Cultural Self-Efficacy Scale (CSES)^{83 84} and

⁸³ Bernal H, Froman R. The confidence of community health nurses in caring for ethnically diverse populations. *Image: Journal of Nursing Scholarship*. 1987;19:201-203.

knowledge base questions by Rooda.⁸⁵ Concepts measured by the tools were then analyzed by transcultural nursing experts for their congruence with the Giger and Davidhizar Transcultural Assessment Model/Theory (GDTAMT).⁸⁶ Culture School participants were found to score significantly higher than the control group. The article focuses on the research methods, not the intervention. This article serves as an example of possible testing procedures for before and after cultural competence interventions. Aspects of CLAS Standard 3.

34. St. Clair A, McKenry L. Preparing culturally competent practitioners. *Journal of Nursing Education*. 1999;38:228-234.

Describes, but not very clearly, a study of 80 nursing students' development towards cultural competence through two- to three- week immersion experiences in Jamaica, Ghana, Northern Ireland, or England. Quantitative analysis found marked improvement over baseline measurements, and qualitative analysis of the immersion students' journals focused on the immersion experience's advantages in students' overcoming ethnocentrism and developing attitudes of ethnorelativism. Students frequently described the experience as life-changing. The authors present the immersion experience as superior to merely studying anthropology and cultural diversity in school and working with diverse patients based on comparison to a control group's journals. However, the article lacks sufficient information about the control group to draw conclusions.

35. Standards, Training and Certification Committee of the National Council on Interpreting in Health Care. *Models for the Provision of Health Care Interpreter Training*. N.p.: The National Council on Interpreting in Health Care, February 2002.

With the same clear style that characterized the Downing and Roat publication, this paper describes major models of health care interpreter training in use today, categorized as 1.) Academic training programs, 2.) Bilingual health care employee training programs, 3.) Community training programs, 4.) Intensive training of at least 40 hours, and 5.) Agency training programs. Advantages and disadvantages are listed and the wildly variable nature of trainings within categories is discussed. The paper ends with criteria for evaluating a training program's adequacy and the National Council's work plan for creating standards for training. Relevant to CLAS standards 1, 4, and especially 6.

36. Stork E, Scholle S, Greeno C, Copeland VC, Kelleher K. Monitoring and enforcing cultural competence in Medicaid managed behavioral health care. *Mental Health Services Research*. 2001;3:169-177.

⁸⁴ Bernal H, Froman R. Influences on the cultural self-efficacy of community health nurses. *Journal of Transcultural Nursing*. 1993;4:24-31.

⁸⁵ Rooda LA. Knowledge and attitudes of nurses toward culturally diverse patients. Unpublished doctoral dissertation, Purdue University, West Lafayette, IN, 1990.

⁸⁶ Giger JN, Davidhizar RE. *Transcultural Nursing: Assessment and Intervention* 2nd ed. St. Louis: Mosby;1995.

An exploratory look at the implementation of cultural competence in Medicaid managed behavioral health care that includes studying the contract language and plan requirements and interviewing responsible officials of five fairly representative states--Nebraska, Pennsylvania, Texas, Washington, and Wisconsin—that have cultural competence provisions for these services. Provisions generally consist of contract language and oversight and monitoring mechanisms. The researchers found that the contract language tended to be vague or easily interpreted to mean a requirement is optional, with language like “should consider” or “should recognize,” and while some oversight mechanisms had potential, such as systems that tracked useful information like language and ethnicity, this lack of well-defined standards makes enforcement extremely difficult.

37. Tervalon M, Murray-Garcia J: Cultural Humility Versus Cultural Competence: A critical distinction in defining physician training outcomes in multicultural education. *Journal of Health Care for the Poor and Underserved*. 1998;9:117-123.

Describes the underlying philosophy of cultural humility in healthcare training (this process that has been built into a training program at Oakland’s Children’s Hospital). The article covers fundamentals such as Self-Reflection and the Lifelong learner model, patient-focused interviewing and care, community based care/advocacy and institutional consistency. This later issues frames fundamental questions about the training environment, institution community relationships, work-force diversity, etc. The fundamentals outlined by Tervalon and Murray-Garcia, if carried through across the patient-care and training boundaries of an institution – would meet the CLAS standards across the board and carry them a step further.

38. Thompson M, Curry MA, Burton D. The effects of nursing case management on the utilization of prenatal care by Mexican-Americans in rural Oregon. *Public Health Nursing*. 1998;15:82-90.

Describes an attempt to improve prenatal care utilization among low-income rural Mexican American women with a traditional public health nursing effort that included a bilingual, bicultural case outreach worker acting as case manager, cultural broker, interpreter, and advocate for pregnant women recruited for the program. As described, the Rural Oregon Minority Prenatal Program (ROMPP) lacks evidence of community oversight and participation. The authors report that the program had little if any impact on birth outcomes, ER visits, screening efforts, low birth-weight or preterm births, though a small sample size made the results difficult to interpret and statistically insignificant. The researchers noted major barriers not addressed by the project, including problematic provider attitudes, financial issues, transportation issues and language barriers. Uses some aspects of CLAS standard 11, 12.

39. Velde BP, Wittman PP. Helping occupational therapy students and faculty develop cultural competence. *Occupational Therapy in Health Care*. 2001;13:23-32.

Describes an ongoing home-based evaluation and intervention program provided by occupational therapy students and faculty in a low-income, rural, mostly elderly African American community. Through qualitative evaluation over successive years, the investigators wish to gain a better understanding of cultural competence, design better curriculum and training for students and provide better service to the residents. In class and through clinical visits, students studied and reflected on the cultural, historical, and geographic/community planning differences between the residents and themselves and their own expectations. The authors, presumably the leads on the project, start with a good basis in cultural competence, citing landmark work on the subject, but their student and faculty sample size is small and time spent with the African American residents is limited to a few hours per student.

40. Warda, MR. Mexican Americans' perceptions of culturally competent care. *Western Journal of Nursing Research*. 2000;22:203-224.

This article goes to the source, a target population, to find out what patients consider culturally competent care. The researcher utilized carefully constructed research methods involving focus groups to produce qualitative results from a small sample of Mexican Americans, mostly lay people plus several registered nurses. Responses were organized into patterns of culturally congruent versus culturally incongruent care, corresponding respectively to "valuing" factors on the part of the health care system, leading to "enabling" the respondent to access and receive quality care, versus "discounting" factors which lead to "hindering" respondents' ability to receive quality care.

The authors thoroughly outline culturally congruent and culturally incongruent values identified by the patients. The Mexican American nurses identified family support as one of the most important factors to be aware of when caring for Mexican Americans, and the author emphasizes the importance of trust and intimacy in the client/provider relationship as a top priority when caring for this population. The article and the issues discussed arguably relate to all CLAS standards, but most directly 1, 3, 4-7, and 12.

41. Weaver HN. Indigenous people and the social work profession: defining culturally competent services. *Social Work*. 1999;44:217-225.

This qualitative research paper is similar to the Warda article (#22 above), but in a social work setting. Respondents are all Native American social services providers, not clients. Knowledge, skills, and values are three areas commonly identified as necessary for culturally competent social work. The population-specific themes that arose in the data were classified into these areas, providing a framework for culturally competent care with Native American clients. Examples include knowledge of U.S./Native American history, culturally competent communication skills, and humility and willingness to learn as values. The author notes the need for empirical studies of indigenous clients' beliefs and the actions of social workers. CLAS standard 1, perhaps 3.

42. Weitz TA, Freund KM, Wright L. Identifying and caring for underserved populations: experience of the National Centers of Excellence in Women's Health. *Journal of Women's Health & Gender-Based Medicine*. 2001;10:937-952.

A review of Centers of Excellence (CoEs) activities serving underserved populations at 18 sites around the U.S. Several. The CoEs are social-justice oriented and their agenda calls for a one-stop-shopping approach to healthcare to defragment services amongst various specialties, and provide comprehensive care throughout the life span. The article introduces current understandings of the roles of socioeconomic status and race and ethnicity on health outcomes and disparities before describing how various CoE programs address such needs as research, access, quality improvement, special needs of racial and ethnic minority women, lesbians, and women with disabilities. The authors conclude with a discussion of the analysis' limitations. Several sites discussed incorporate activities congruent with a few CLAS standards, particularly standards 12, usually in the form of focus groups with community members, 4, providing bilingual staff or interpreters, and 7, translated patient education material.

43. Wessling, S. CLAS Action. *Minoritynurse.com* [Jan 2003?]
<http://www.minoritynurse.com/features/other/01-08-03a.html>

Nurses from a variety of racial, ethnic, and cultural backgrounds share their experience and advice regarding the CLAS standards. Many stress that few people are aware of the standards.

44. Wolf EJ. Providing culturally appropriate care: a tale of two hospitals. *Healthcare Executive*. Mar/Apr 2001:12-17.

This informal article describes, briefly, approaches to culturally appropriate care taken by The New York Hospital Medical Center of Queens and Howard University Hospital in Washington, DC. The author's introduction to cultural competency implies that culture and language related challenges are brought by the patient, rather than including the provider. Whether or not the hospitals scientifically planned, implemented, evaluated and documented their work is unclear, but their activities parallel several of the CLAS standards.

In order to better serve a community that was 47% Chinese and Korean, NYHQ sought extensive, ongoing, organized community input and implemented a variety of new practices, including staff training, recruitment of Asian staff, language services, Korean and Chinese hospital food, and integration of traditional practices (CLAS standards 1, 2, 3, 4, 11, 12 and perhaps other language standards). Outcomes included increased service utilization by the Asian American community, including a notable change in the rate of Asian American mothers returning for subsequent births.

Though traditionally serving African Americans, Howard University Hospital's surrounding neighborhood has recently become increasingly Latino, and the hospital saw the need to expand services in order to better serve the changing community. Through a

partnership between the hospital and Howard's medical school, and La Clinica del Pueblo, a free clinic for the Latino population, the hospital, clinic, residents and medical students, and the community at large benefited. CLAS standards addressed include aspects of 3, 4, 11, 12.

The article also lists organizational cultural competence recommendations from Stephen Mills, president and chief executive officer of The New York Hospital Medical Center.

45. Zambrana RE. The underrepresentation of Hispanic women in the health professions. *Journal of the American Medical Women's Association*. 1996; 51:147-152.

Reviews statistical data on Hispanic women in the health professions, followed by a discussion of barriers to their entry into health professions and finally recommendations for improving their representation in the health professions. The extensive information ranges from notes on early childhood education rates to medical school faculty percentages. Notable statistics include Hispanics' 1991 high school dropout rate of 35% and that Hispanic women constitute only 2% of the female medical school population though the percentage of women in medical school increased by 25% from 1990-1993. Barriers include lack of role models, support services, family support, and financial resources; poor-quality, discriminatory education; pressures of being forced to represent their communities in higher education; and cultural gaps between their roots and their studies. The authors recommend increased availability of math and science education for Hispanic girls, targeted recruitment by associate degree programs that may lead students eventually to advanced studies, partnerships between health institutions, health professional schools and the Hispanic community, financial assistance and changes in the medical school climate and faculty attitudes. Encouragingly, the authors note that health careers rank third among career choices of college-bound Hispanic high school students. Relates to standards 2 and 12.

46. Zweifler J, Gonzalez AM Teaching residents to care for culturally diverse populations. *Academic Medicine*. 1998;73:1056-1061.

The article promotes caring for culturally diverse populations by using the tools present in the best of 1) community-oriented primary care (COPC), which it describes as a worthy British concept that hasn't caught on in this country; 2) cultural competency; and 3) public health. Though its introduction conveys the complexity of culturally competent care of diverse populations and the psychosocial side of the "art of medicine", it suggests little beyond emphasizing public health and a focus on access.

The article describes the UCSF-Fresno Family Practice Residency Program. The Fresno program focuses on 3 areas: cultural competency, community-oriented primary care, and public health. Includes four essential components: 'longitudinal experience' in training sites (two are community health centers), four to six academic sessions/year focused on key anthropologic facts regarding three populations served, one month community resource exposure (includes public health dept), and a requirement that each resident complete and report on a community project. Addresses aspects of CLAS standards 1 and 3.