Tips and Resources

Preface

The U.S. Department of Health and Human Services (HHS) Office of Minority Health (OMH) developed the *National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care* (National CLAS Standards) to provide meaningful and practical guidance on delivering culturally and linguistically appropriate services. The National CLAS Standards, which are targeted toward health and health care organizations, were revised in 2013 to account for the increasing diversity of the U.S. population, the growth in cultural and linguistic competency fields, and the changing landscape with respect to new national policies and legislation, including the Affordable Care Act.

The organizations that are adopting and implementing the National CLAS Standards have taken concrete steps to address health inequities and meet the needs of the vulnerable populations they serve. However, what is less clear is the extent to which these organizations are evaluating the impact of their approach to improve inequities in care.

To help address these questions, OMH commissioned the development of a framework and toolkit to guide efforts to evaluate the National CLAS Standards across four settings: ambulatory care, behavioral health, hospitals, and public health.

This work was sponsored by the U.S. Department of Health and Human Services, Office of Minority Health under contract No. HHSP233201500038I. The research was conducted in RAND Health, a division of the RAND Corporation. A profile of RAND Health, abstracts of its publications, and ordering information can be found at www.rand.org/health.

The RAND Corporation is a research organization that develops solutions to public policy challenges to help make communities throughout the world safer and more secure, healthier and more prosperous. RAND is nonprofit, nonpartisan, and committed to the public interest.

Summary

Among the many contributors to health inequities, the lack of culturally and linguistically appropriate services in health settings has been recognized as one of the more modifiable factors. Improving the availability of such services will not only improve the quality of care provided, but may reduce disparities experienced by racial and ethnic minorities and other underserved populations, who struggle because of language, literacy, or other cultural barriers (Saha, Beach, and Cooper, 2008). To provide meaningful and practical guidance on delivering culturally and linguistically appropriate services, the U.S. Department of Health and Human Services (HHS) Office of Minority Health (OMH) developed the *National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care* (National CLAS Standards). The National CLAS Standards, which are targeted toward health and health care organizations (HCOs), were revised in 2013 to account for the increasing diversity of the U.S. population, the growth in cultural and linguistic competency fields, and the changing landscape with respect to new national policies and legislation, including the Affordable Care Act (ACA) (HHS OMH, 2013).

Successful implementation of the National CLAS Standards requires an organizational commitment. Undoubtedly, the National CLAS Standards have helped to increase awareness and activities related to the need for culturally and linguistically appropriate services. The organizations that are adopting and implementing the National CLAS Standards have taken concrete steps to address health inequities and meet the needs of the vulnerable populations they serve. However, what is less clear is the extent to which these organizations are evaluating the impact of their approach to improve inequities in care.

SUMMARY

To help address these questions, OMH awarded a contract to RAND to develop a framework and toolkit to guide efforts in evaluating the implementation of the National CLAS Standards by HCOs. The resulting report, *Development of a Long-Term Evaluation Framework for the National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health and Health Care*, presents the details of the development of the framework (Davis et al., forthcoming), while this accompanying toolkit distills the elements of the framework and is intended to help guide the efforts of HCOs to evaluate the implementation of the National CLAS Standards across four settings: ambulatory care, behavioral health, hospitals, and public health. This toolkit is thus divided into four sections:

CHAPTER ONE provides information about the toolkit, who should use it, and what it is designed to help you do.

CHAPTER TWO describes seven steps for implementing and evaluating the National CLAS Standards.

CHAPTER THREE provides additional context and details for evaluating specific National CLAS Standards.

CHAPTER FOUR includes relevant resources and information on potential data sources and metrics that may be used in your evaluation.

The National CLAS Standards

The National CLAS Standards were intended to advance health equity, improve quality, and help eliminate health care disparities by providing a blueprint for individuals and HCOs to implement culturally and linguistically appropriate services. The essential goal of the National CLAS Standards is framed in the Principal Standard: **Provide effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs.**

The remaining 14 Standards span the themes of governance, leadership, and workforce; communication and language assistance; and engagement, continuous improvement, and accountability (HHS OMH, 2013).

GOVERNANCE, LEADERSHIP, AND WORKFORCE

1. Advance and sustain organizational governance and leadership that promotes CLAS and health equity through policy, practices, and allocated resources.
2. Recruit, promote, and support a culturally and linguistically diverse governance, leadership, and workforce that are responsive to the populations in the service area.
3. Educate and train governance, leadership, and workforce in culturally and linguistically appropriate policies and practices on an ongoing basis.

COMMUNICATION AND LANGUAGE ASSISTANCE

4. Offer language assistance to individuals who have limited English proficiency and/or other communication needs, at no cost to them, to facilitate timely access to all health care and services.
5. Inform all individuals of the availability of language assistance services clearly and in their preferred language, verbally and in writing.
6. Ensure the competence of individuals providing language assistance, recognizing that the use of untrained individuals and/or minors as interpreters should be avoided.
7. Provide easy-to-understand print and multimedia materials and signage in the languages commonly used by the populations in the service area.

The National CLAS Standards

ENGAGEMENT, CONTINUOUS IMPROVEMENT, AND ACCOUNTABILITY

8. Establish culturally and linguistically appropriate goals, policies, and management accountability, and infuse them throughout the organization's planning and operations.
9. Conduct ongoing assessments of the organization's CLAS-related activities and integrate CLAS-related measures into measurement and continuous quality improvement activities.
10. Collect and maintain accurate and reliable demographic data to monitor and evaluate the impact of CLAS on health equity and outcomes and to inform service delivery.
11. Conduct regular assessments of community health assets and needs and use the results to plan and implement services that respond to the cultural and linguistic diversity of populations in the service area.
12. Partner with the community to design, implement, and evaluate policies, practices, and services to ensure cultural and linguistic appropriateness.
13. Create conflict and grievance resolution processes that are culturally and linguistically appropriate to identify, prevent, and resolve conflicts or complaints.
14. Communicate the organization's progress in implementing and sustaining CLAS to all stakeholders, constituents, and the general public.

More information on the National CLAS Standards and their development can be found on the National CLAS Standards website (HHS, undated[b]).

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Chapter 1
About the Toolkit

Importance of Evaluating the National CLAS Standards

The National CLAS Standards have helped to increase awareness and activities related to the need for culturally and linguistically appropriate services and, as an organizing principle in several instances, they have become a guide for certification and accreditation (e.g., National Committee for Quality Assurance [NCQA] toolkit). The National CLAS Standards have clearly led some organizations to take concrete steps to address health inequities and meet the needs of the vulnerable populations they serve. However, the extent to which the adoption and implementation of the National CLAS Standards occurs across organizations is less clear. Even in the systems that may stand out relative to others, the extent to which the National CLAS Standards are fully implemented across an organization and for different populations and providers is also unclear.

A closely related concern for health organizations, decisionmakers, policymakers, and researchers is that we know relatively little about whether the National CLAS Standards will lead to the desired reduction in health inequities when fully implemented. Nor do we understand whether some of the National CLAS Standards have more impact than others in achieving the goal of reduced inequities.

What This Toolkit Is Designed to Do

This toolkit is designed to support health organizations that are implementing the National CLAS Standards and that wish to evaluate their approach to doing so. The toolkit focuses on translating the overall evaluation framework into elements that can be adopted by individual organizations for their own approach with attention paid to the ways in which the National CLAS Standards may improve quality and reduce disparities. The toolkit also aims to strengthen the capacity of health care organizations (HCOs) to evaluate the awareness, adoption, implementation, and impact of the National CLAS Standards within their organizations.

Because the toolkit focuses on evaluation, it does not include a lot of information on how to identify, design, or implement activities and approaches that your organization may pursue to address the National CLAS Standards. However, there are numerous resources available to address these issues in more detail.

- The **resource library** within the U.S. Department of Health and Human Services (HHS)'s "Think Cultural Health" website can be filtered by resource type and topic to help you identify the most relevant activities and approaches (HHS, undated[c]).
- A Substance Abuse and Mental Health Services Administration (SAMHSA) webinar, **The National CLAS Standards in Action**, explores opportunities for integrating the National CLAS Standards into prevention efforts (SAMHSA, 2016b).
- HHS's **Blueprint** is an implementation guide to help you advance and sustain culturally and linguistically appropriate services within your organization (HHS, undated[b]).

Who Should Use This Toolkit?

This toolkit is designed for individuals responsible for or involved in quality improvement related to or evaluation of the National CLAS Standards within health-related organizations. The toolkit was designed for use in ambulatory care, behavioral health, hospital, and public health settings, although much of the information in this toolkit is broadly applicable to other health providers and settings.

We recognize that HCOs' ability to self-evaluate and their approach to adopting the National CLAS Standards will vary widely. Some organizations will work systematically to implement many of the National CLAS Standards, while others will focus on just a few; likewise, some organizations will have a great deal of experience and organizational capacity to conduct evaluations, while others will have less. This toolkit is interactive to accommodate these differences and to allow users to quickly access the information and material that may be most helpful to them.

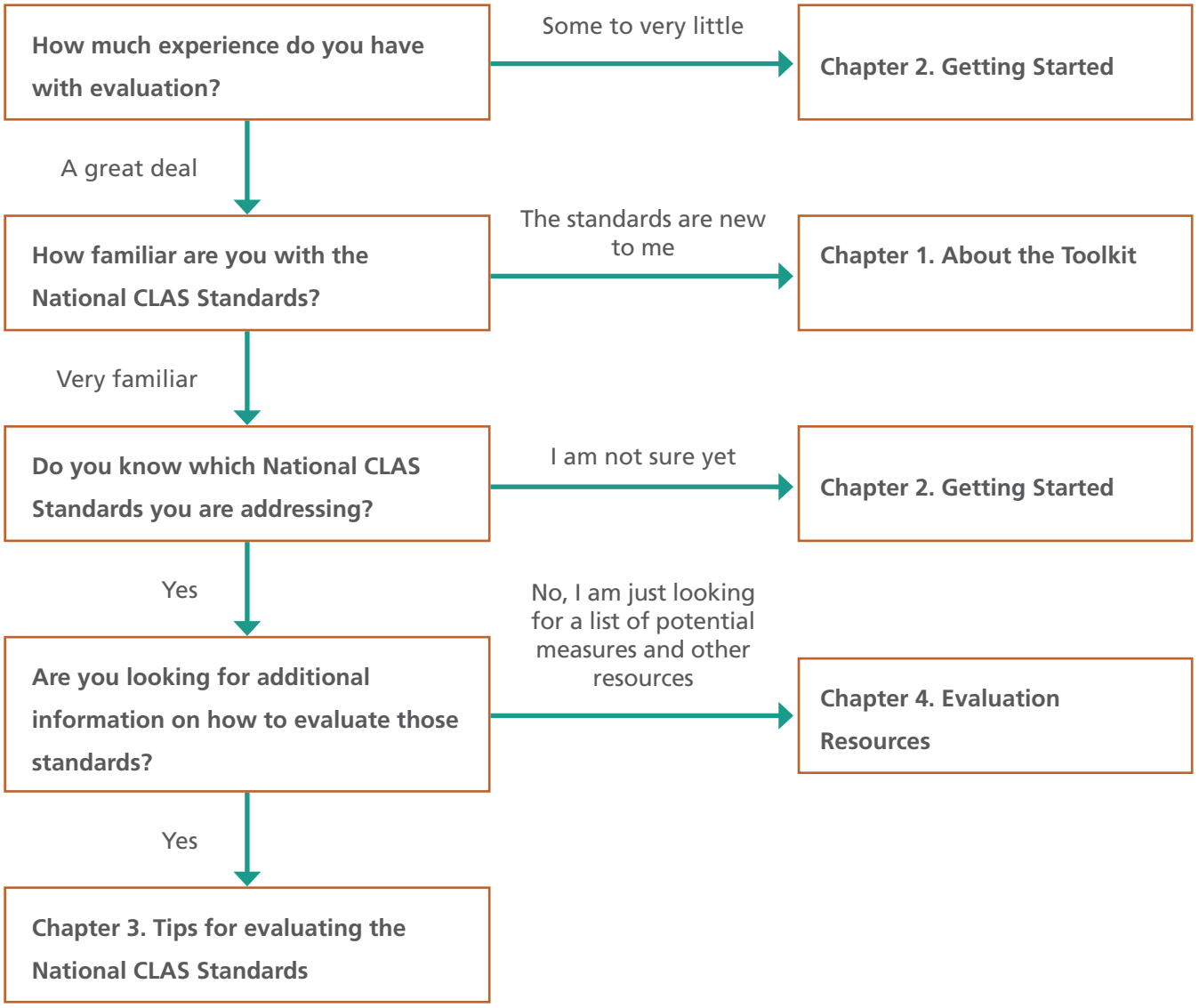
While organizations of all evaluation capacities will find the information within this toolkit useful, we assume that the user has some basic experience with evaluation or continuous quality-improvement initiatives. Individuals and organizations with very little evaluation experience or capacity may benefit from reading some basic evaluation primers either before or in concordance with this toolkit. Examples of evaluation primers are included in Chapter 2.

How the Toolkit Is Organized

As noted, this toolkit is designed to be flexible and interactive so users can quickly jump to the information that is most useful. Here we provide a brief description of each remaining section, followed by a flow chart to help you figure out where to start.

- Chapter 2 describes seven steps for implementing and evaluating the National CLAS Standards. Topics covered include the importance of a needs assessment, setting goals and objectives, developing a logic model, and identifying research questions and the data and measures that can be used to answer those questions. This section is best for individuals newer to evaluation and provides helpful links for more information on many of the steps.
- Chapter 3 builds on the information in Chapter 2, but provides an additional level of specificity depending on the National CLAS Standards being implemented. Information in this chapter is divided into the three main groups of Standards, including (1) governance, leadership, and workforce; (2) communication and language assistance; and (3) engagement, continuous improvement, and accountability. For each group, we provide additional context, suggest refinements to the logic model, and point to measures that may be particularly useful for evaluating each group of Standards.
- Chapter 4 houses the toolkit resources, including detailed information on potential measures and item sets, as well as a compilation of other resources listed throughout this toolkit. While Chapter 3 provides insight into particular measures relevant for each group of standards, this section sorts measures by health setting, as some measures and metrics are already being collected or may be most relevant for one setting.

FIGURE 1. EVALUATION TOOLKIT FLOW CHART: FIGURING OUT WHERE TO START



Chapter 2
Getting Started

Most health organizations have limited resources, meaning that the dollars, resources, and personnel time that organizations use must be allocated to activities and efforts that work. Effective evaluations can help organizations learn about what works to make better decisions about how they spend their resources.

Evaluating the implementation of the National CLAS Standards and their impact can be complicated, but the process can be made easier by breaking it down into steps. Through these steps, your organization will define how to measure progress toward its goals. You will also define how to measure the impact these changes have on your organization, as well as on the individuals you serve. Evaluating the impact of the National CLAS Standards is best thought of as an iterative process that may supplement existing ongoing quality improvement efforts. This allows your organization to make necessary changes along the way.

RESOURCES NEEDED FOR EVALUATION

To complete an evaluation, HCOs will need the following:

- information about the National CLAS Standards they are implementing
- capacity to collect baseline information about the target population
- ability to adapt the evaluation framework to their local context
- understanding of Continuous Quality Improvement (CQI) principles
- a long-term commitment to collect and analyze data.

STEP 1: Assess Organizational and Community Needs

The first step is to assess the needs of the organization and community. An organizational needs assessment can help you identify which of the National CLAS Standards you are already meeting and where there is room for improvement. This step should also include a community needs assessment.

The purpose of a needs assessment is to identify the problems your clients, patients, or their family members have accessing high-quality services. This allows you to prioritize approaches to meeting these needs. The information you draw to define these needs will come from existing data you collect through surveys and other surveillance methods, as well as data collected by outside organizations. You will also want to directly engage patients, community members, and their families through public forums or more directly through focus groups and interviews. Consulting experts may also be important (Wiseman et al., 2007).

SEVEN STEPS FOR IMPLEMENTING AND EVALUATING THE NATIONAL CLAS STANDARDS

1. Assess organizational and community needs.
2. Set goals and objectives.
3. Develop a logic model.
4. Identify evaluation research questions.
5. Choose measures.
6. Design evaluation and collect data.
7. Share findings and make changes as part of CQI.

STEP 1: Assess Organizational and Community Needs

In this section, we provide links to several resources to help you plan and implement a needs assessment. The first link (self-assessment tool) is a comprehensive review of how a needs assessment can be conducted, specifically for planning and implementing the National CLAS Standards. It provides an in-depth review of a methodology for developing a CLAS-specific self-assessment tool. Although needs assessments can be complicated (and expensive), they do not have to be (Wiseman et al., 2007). The second link (toolkit) we provide describes a less-intensive approach that identifies the key steps to a community needs assessment in community-based chronic disease prevention, including

- identifying a community team
- describing the scope of the assessment
- listing the questions to ask
- selecting sites
- determining data collection methods or sources
- identifying key informants
- reviewing and rating data collected from a community needs assessment
- summarizing data
- developing and prioritizing strategies for improvement
- creating a community action plan.

STEP 1: Assess Organizational and Community Needs

More information on needs assessments is provided here:

- **Self-assessment tool** from HHS designed to help local public health agencies assess their culturally and linguistically appropriate services (HHS OMH, 2003). It is also relevant for other health providers.
- **Toolkit** from the Centers for Disease Control and Prevention (CDC) focusing on conducting community needs assessments for chronic disease prevention (CDC, 2013).
- **Article** by Olavarria et al. (2009) describing how to conduct a self-assessment of organizational cultural competence in community health and social service organizations.
- **Resources** from Community Tool Box and its related toolkit containing information about assessing the needs of your community (Community Tool Box, undated[a], undated[b]).

STEP 2: Set Goals and Objectives

After you have completed your needs assessment, you can use the findings to set your goals and objectives. What do you want to accomplish? How can implementation of the National CLAS Standards help you reach this goal? It is important to identify goals for your approach, including identifying the people you will target through implementation of the National CLAS Standards, the desired outcomes, and the objectives. Doing so helps define what will be considered a success. Goals should be broad and define what you intend to improve in the long term. Objectives are also important and should be written in a way that defines how the goals can be measured by describing "what will change, for who, by how much, and by when?" (Chinman, Imm, and Wandersman, 2004).

As you develop your goals and objectives, it may be helpful to draw on this framework that conceptualizes the National CLAS Standards as an innovation to be adopted within health care settings (Figure 2).

STEP 2: Set Goals and Objectives

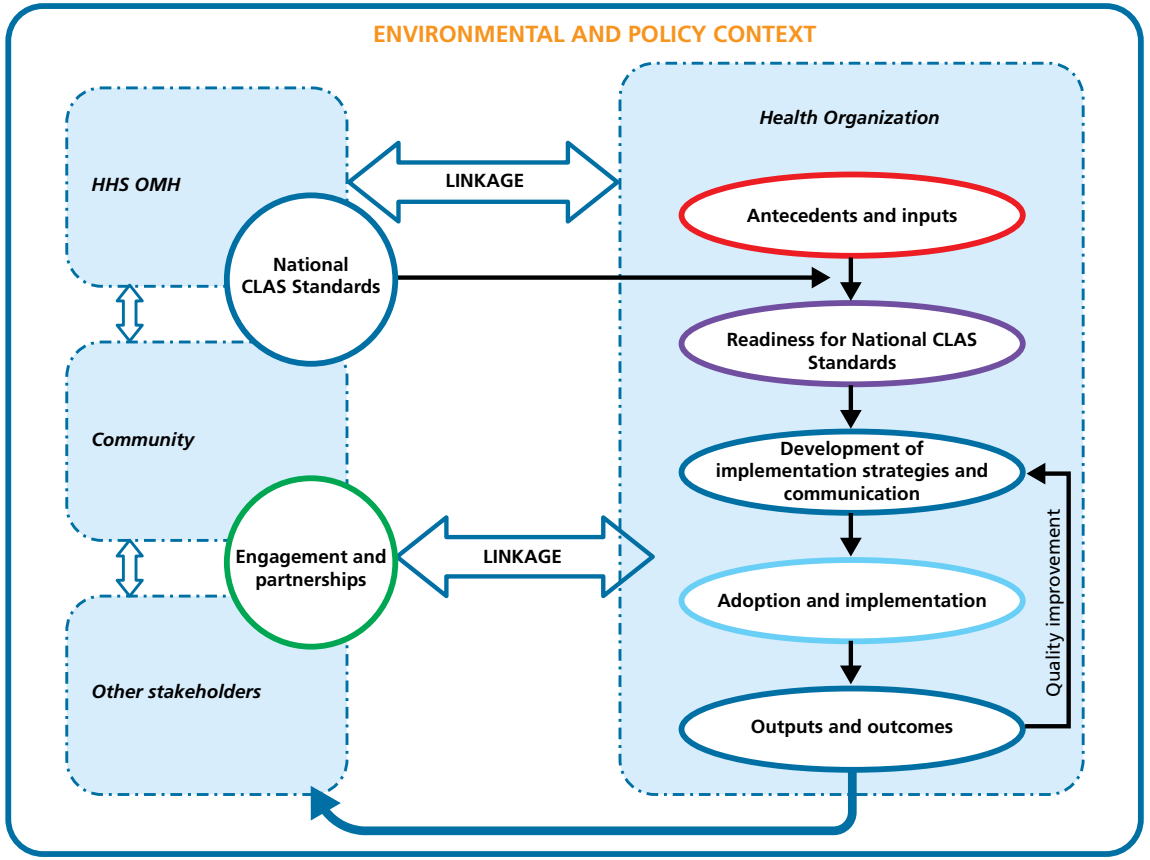
FIGURE 2. CONCEPTUAL FRAMEWORK FOR DIFFUSION OF NATIONAL CLAS STANDARDS

National CLAS Standards
Framework and guide to health care providers and policymakers for ensuring quality of care and needs of diverse populations are met. The overarching goal, or the *Principal Standard*, is "to provide effective, equitable, understandable, respectful, and quality care and services" (Standard 1).

The overall standard has three themes:
- *Governance, Leadership, and Workforce* (Standards 2–4)
- *Communication and Language Assistance* (Standards 5–8)
- *Engagement, Continuous Improvement, and Accountability* (Standards 9–15)

Engagement and Partnerships
Linkages between the health organization, the community, and other stakeholders are present at all stages of National CLAS Standards adoption. They provide relevant inputs and information to help assess need and guide the process; participate in the design, adoption, and implementation of activities; support communication about changes; and are impacted by outputs and outcomes. Linkages evolve over time to include new partners and tasks.

Environmental and Policy Context
Activities depicted in this model occur within a broader environmental and policy context. This includes, for example, the regulatory environment, mandates, and standards of practice. The dashed lines around the organization indicate that this context is likely to influence an organization's readiness for change; whether, when, and how National CLAS Standards are adopted; and the ease at which changes within the organization can be made to meet National CLAS Standards.



Antecedents and Inputs
Includes the organization's structure, internal and external resources, and their capacity and receptivity for change

Readiness
Captures the extent to which an organization recognizes the need for change and has made National CLAS Standards an organizational priority

Development of Implementation Strategies and Communication
Includes development of changes an organization intends to implement to address gaps in culturally and linguistically appropriate care and services as well as strategies to implement those changes. Proposed changes are communicated internally and externally to the community and stakeholders.

Adoption and Implementation
Activities identified to address gaps are implemented (e.g., training and workforce; collection, monitoring, and use of data; changes in procedures, protocols, or physical space; changes to leadership and governance)

Outputs and Outcomes
Captures immediate changes as a result of implemented activities (outputs) as well as short-, medium-, and long-term outcomes for both consumers and the organization

STEP 2: Set Goals and Objectives

Consider these questions as you identify your goals and objectives:

- What were the highest priorities identified in the needs assessment? Which National CLAS Standard(s) can help you to address those needs?
- What broader contexts (e.g., regulatory environment, mandates, standards of practice) might influence what your goals and objectives are and which National CLAS Standards might you adopt first? Are there opportunities to align your goals and objectives with these broader contexts?
- Which stakeholders and community members or groups should you engage to help set your goals and objectives?
- How should you communicate your goals and objectives both internally and externally to community stakeholders?

STEP 3: Develop a Logic Model

The third step for implementing and evaluating the National CLAS Standards is to develop a logic model, sometimes called a theory of change. Logic models help you to map out why you think the activities and efforts you want to implement will result in the goals and objectives you have identified. It can be thought of as a series of "if. . . then" statements. When done well, the logic model provides alignment between activities and outcomes, making it easier to develop or choose metrics and evaluation questions. In the example below, the activities related to staffing changes are aligned with data at the organization level on the composition of the staff as well as their capacity to provide care to a diverse patient population.

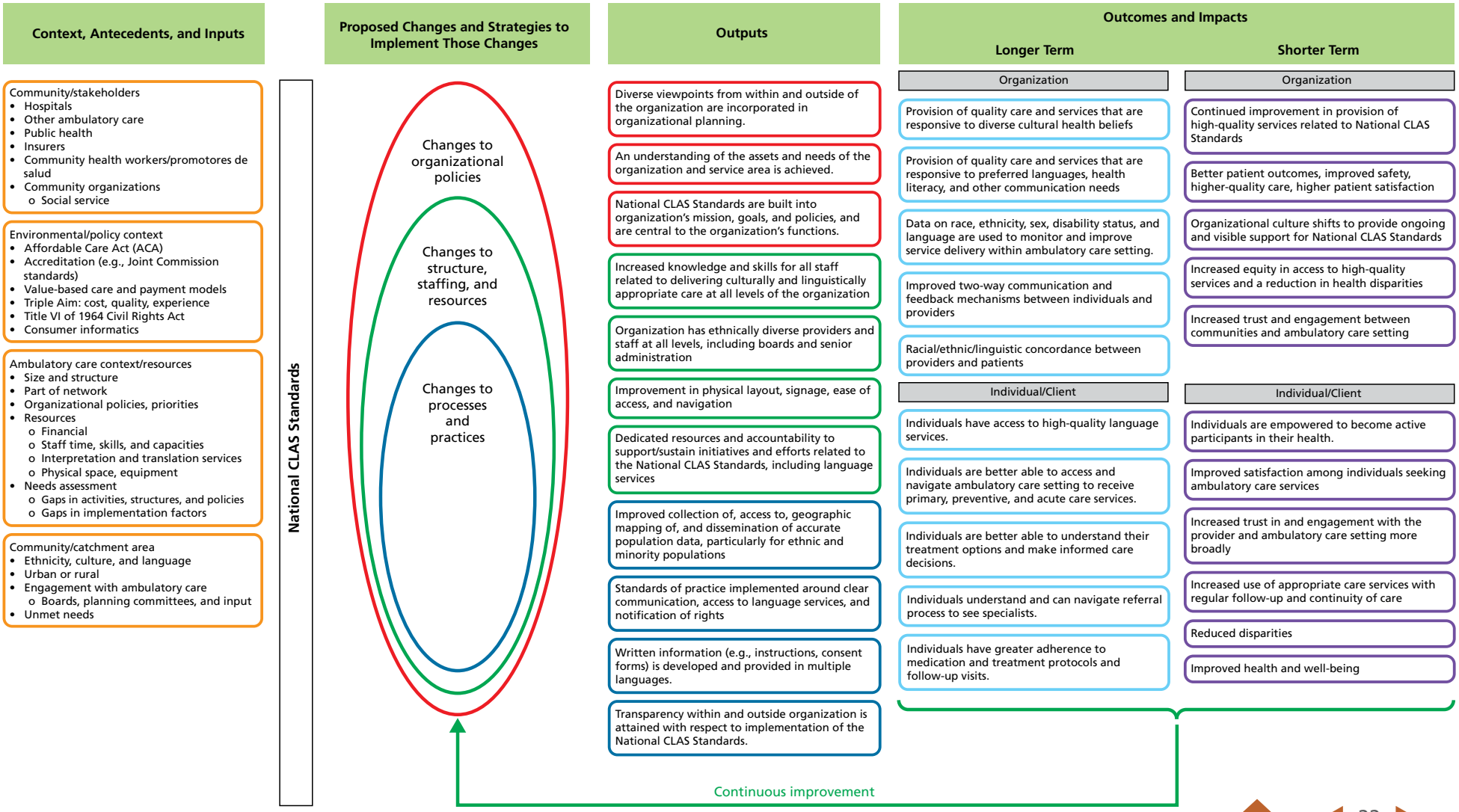
To help you with logic model development, we offer a template for a logic model related to implementation of the National CLAS Standards (see Figure 3). Here, the National CLAS Standards are viewed as a perspective or lens through which context and antecedents are interpreted and help shape the specific Standards the organization chooses to implement to address gaps in culturally and linguistically appropriate care within their setting. More-detailed templates for the ambulatory care, behavioral health, hospital, and public health settings are also available as part of this toolkit. Specific guidance on how to shape your logic model for each of the Standards can be found in Chapter 3.

For more information on developing a logic model, see:

- Guide from CDC on developing and using a logic model (CDC, 2017a)
- Resource list from SAMHSA on developing a logic model to guide program evaluation (SAMHSA, undated).

STEP 3: Develop a Logic Model

FIGURE 3. LOGIC MODEL TEMPLATE



STEP 4: Identify Evaluation Research Questions

The following evaluation questions, developed in partnership with HHS OMH, were designed to capture important short- (1–2 years) and longer-term (3 or more years) outputs and outcomes for health organizations and the individuals they serve. In the short term, it is more likely that an organization can develop a set of activities that improves the outputs. This might involve providing services that are responsive to preferred language and other communication needs. But it will take much longer to achieve and measure changes in outcomes with populations that have these communication needs. While not all questions may be relevant to your efforts, and you may wish to add supplemental questions specific to your efforts, HHS encourages the use of a consistent set of evaluation research questions across a range of providers and settings for several reasons:

1. Using similar questions ensures that organizations are capturing short- and longer-term outcomes that are of the highest importance for improving access to culturally and linguistically appropriate health care services.
2. It allows for more-direct comparisons of findings across settings and systems to identify particularly effective models or approaches that may be shared more broadly.
3. It allows for a collective look at the impact of implementing the National CLAS Standards on organizations and individuals accessing care and services.

Chapter 3 provides additional resources and information to help shape your evaluation questions. Next, we provide examples of important short- and long-term outcomes.

STEP 4: Identify Evaluation Research Questions

SHORT-TERM OUTCOMES (1–2 YEARS)

For organizations

- To what extent has the implementation of the National CLAS Standards led or contributed to
  - the use of data on race, ethnicity, sex, disability status, and language to monitor and improve health service delivery?
  - improved two-way communication between providers and clients?
  - increased knowledge of culturally and linguistically appropriate care and buy-in from staff?
  - better and earlier detection of health care concerns through appropriate screening?

For clients/individuals

- To what extent has the implementation of the National CLAS Standards resulted in
  - improved access to high-quality language services for ethnic and minority populations?
  - consumers being better able to access and navigate health care services? If so, in what ways?
  - increased consumer understanding of health care treatment options and to more-informed care decisions?
  - greater adherence to medication, treatment protocols, and follow-up visits?

STEP 4: Identify Evaluation Research Questions

LONGER-TERM OUTCOMES (3 OR MORE YEARS)

For organizations

- To what extent has the implementation of the National CLAS Standards led to a cultural shift in the organization toward greater awareness of and workforce buy-in of culturally and linguistically appropriate care and services?
- To what extent has the implementation of the National CLAS Standards led or contributed to
  - improvements in the provision of high-quality health care services for diverse populations?
  - improved health outcomes for ethnic and minority populations?
  - increased trust and engagement between patients and providers?
  - increased trust and engagement between the community and HCOs?
  - increased equity in access to health services?
  - reduction in disparities in health outcomes?
  - increased capacity of the HCO or health system to address the needs of a diverse population?

STEP 4: Identify Evaluation Research Questions

LONGER-TERM OUTCOMES (3 OR MORE YEARS)

For clients/individuals

- To what extent has implementation of the National CLAS Standards led to
  - individuals feeling empowered to become active participants in their health care?
  - improved satisfaction among individuals seeking health care?
  - increased trust and engagement between individuals seeking care and treatment providers?
- To what extent has implementation of the National CLAS Standards contributed to
  - increased use of appropriate health care services with regular follow-up and continuity of care?
  - increased equity in outcomes of health services?
  - improved health, family, and social functioning, and overall well-being?

STEP 5: Choose Measures

You can use the logic model you created in Step 3 and the evaluation questions in Step 4 to help you think about what types of data you will need. You do not need to measure everything. Think about what measures might capture the most-important processes or outcomes related to the specific National CLAS Standards you are implementing. Given that data collection can be a resource-intensive process, you should also think about what types of measures you already use and what types of data you already collect that may be helpful for your evaluation.

More information on metrics and methods for assessing each Standard can be found in Chapter 3, and the appendixes provide tables of measures that may be helpful for your evaluation. For each measure, you can see its description, area of focus (e.g., cultural competency, language services), the source and item number, notes, and references. In some cases, the measure listed in the table is an item set or a grouping of measures. Clicking on the name of the item set will give you the topic area and specific wording of each of the items in that set. Measures are grouped by setting for quick reference to measures that may be most relevant to you.

STEP 6: Design Evaluation and Collect Data

Once you have identified your research questions and the measures that will help you answer those questions, the next step is to formally design your evaluation and to think in particular about your plan for collecting data.

- Who are you involving in your evaluation (e.g., consumers, stakeholders, staff)? How will you recruit them? How many individuals from each group are you including?
- Will you have a comparison group?
- When are you collecting data? Are you assessing changes over time? At what time points?
- How are you collecting data? What are your mode(s) of data collection (e.g., survey, interview, focus group)?

The following resources provide additional information on evaluation design and implementation, which can help you to determine the most-appropriate data-collection approaches for your evaluation:

- CDC's **Introduction to Program Evaluation for Public Health Programs: A Self-Study Guide** provides useful introductory information (CDC, 2012).
- The Substance Abuse and Mental Health Services Administration (SAMHSA) has a **list of evaluation tools and resources** that can help with planning and management, implementation, and analysis of data and evaluations (SAMHSA, undated).
- RAND's **Getting to Outcomes** toolkits help communities and organizations implement and evaluate their prevention programs (RAND Corporation, undated).

STEP 7: Share Findings and Make Changes as Part of CQI

The last step in the process is to analyze the data you collected and to use those findings to inform your next steps. Given the importance of the community, stakeholders, and partners to the implementation of the National CLAS Standards and the ongoing assessment of providing culturally and linguistically appropriate services, sharing the findings with the community is essential. Findings should also be shared within your organization, where successes can be celebrated and continued gaps can be reassessed.

As noted earlier, implementation of the National CLAS Standards is not a one-time effort, but rather an important component of your organization's CQI efforts. While many health organizations have quality-improvement processes in place, additional resources on the importance of ongoing quality improvement and how to develop and implement a quality assurance plan can be found here:

- The Health Resources and Services Administration's **Quality Improvement** and **Developing and Implementing a QI Plan** (HHS, Health Resources and Services Administration, 2011a; HHS, Health Resources and Services Administration, 2011b)
- New York State Office of Mental Health's **Quality Improvement Plan Template** (2005)
- CQI in the **Electronic Health Record Implementation Lifecycle** (National Learning Consortium, 2013).

Chapter 3
Tips for Evaluating the National CLAS Standards

Chapter 2 provided an overview of seven steps for implementing and evaluating the National CLAS Standards. However, for an evaluation to be effective, it must be specific to the planned activities, processes, and outcomes relevant to the National CLAS Standards that are being implemented. Therefore, this chapter provides additional context and considerations that may be helpful for evaluating specific sets of Standards. We provide additional information on each set of Standards, note what the expected outcomes of successful implementation should be, discuss how your logic model could be shaped to reflect the specific Standards you are implementing, and provide potential measures that are particularly relevant for each set of Standards.

This section is divided into four parts:

- Principal Standard (Standard 1)
- Governance, Leadership, and Workforce (Standards 2–4)
- Communication and Language Assistance (Standards 5–8)
- Engagement, Continuous Improvement, and Accountability (Standards 9–15).

PRINCIPAL STANDARD: Standard 1

Provide effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs.

WHY IS THIS STANDARD IMPORTANT?

STANDARD 1 is the Principal Standard of the National CLAS Standards and encompasses many practices and policies related to providing equitable, effective, and quality care to culturally and linguistically diverse populations. Thus, by successfully implementing activities to address the other standards (summarized in the following sections, navigable via the sidebar), your organization will achieve Standard 1. Standard 1 names several important components: (1) *effective and equitable care and services*, including health promotion, disease prevention, diagnosis, treatment, mental and behavioral health, emergency care, and more, focuses on reducing the burden of illness and injury based on race, education, age, religion, language, gender, and income to improve the health of all people; (2) *respectful services* fosters an environment where all individuals feel comfortable discussing their needs with staff members; (3) the *recognition of cultural beliefs* and practices and acknowledgment of patients' *preferred language* ensures that staff consider culturally informed health beliefs and use appropriate communication techniques.

PRINCIPAL STANDARD: Standard 1

By addressing this Standard, you will

- ensure that consumers with limited English proficiency or other communication needs receive equitable access to services
- help consumers understand their health care and service options and allow them to participate in health care decisionmaking
- increase satisfaction with care
- improve adherence to recommendations and treatments
- improve consumer safety and reduce miscommunications that contribute to medical errors
- aid in compliance with requirements, such as Title VI of the Civil Rights Act of 1964, the Americans with Disabilities Act of 1990, and other relevant policies.

PRINCIPAL STANDARD: Standard 1

HOW COULD I SHAPE MY LOGIC MODEL TO REFLECT THIS STANDARD?

In Chapter 2, the idea of a logic model was introduced. Logic models can help you think through your evaluation in greater detail to ensure that you measure what is important. Standard 1 is the Principal Standard because the adoption of the remaining Standards would achieve Standard 1. Standards 2–15 represent the activities, outputs, and outcomes (elements of the logic model) intended to be the building blocks of culturally and linguistically appropriate services that will help you achieve the Principal Standard. For this reason, ways of shaping your logic model specific to Standard 1 are not listed here. If activities that support each of Standards 2–15 are implemented and maintained, organizations will be better positioned to achieve the desired goal.

In Table 1, we provide some example metrics you can use to assess your progress toward implementing practices that align with Standard 1, as well as the impact of those processes on your organization and those you serve. The metrics highlighted for Standard 1 focus on delivering equitable and high-quality services and will supplement those you may collect to assess the other National CLAS Standards. This is not a comprehensive list, but it will help you get started and may complement metrics you already collect. Additional information on the measures, including links to survey documents, can be found in Chapter 4.

TABLE 1. METRICS AND WAYS OF ASSESSING STANDARD 1

EXAMPLE METRIC	DESCRIPTION
Communication Climate Assessment Toolkit (C-CAT), all domains	The C-CAT provides assessments of consumers, staff, and organizational leadership to comprehensively measure the implementation and outcomes of providing language services. C-CAT has been validated in diverse health care settings nationwide. C-CAT scores are calculated on nine domains. All C-CAT domains are relevant for this Standard. Specific items related to equitable, high-quality care assess • whether staff have communicated with one another effectively to ensure high-quality care • whether clinical quality measures are compared across patient demographic groups • sharing of communication quality assessments with staff • patient perceptions of quality of care • patient perceptions of whether the organization serves the community well.
Cultural Competency Implementation Measure: Commitment to Serving a Diverse Population and Quality Improvement subdomains	The Cultural Competency Implementation Measure is an organizational survey designed to assist health care organizations in identifying the degree to which they are providing culturally competent care and addressing the needs of diverse populations. The Cultural Competency Implementation Measure was designed for use in diverse health care settings. Scores are calculated for 12 subdomains. The Commitment to Serving a Diverse Population and Quality Improvement subdomains are most relevant for this Standard and include items assessing • whether a vision statement, goals, and mission have been developed and/or revised to ensure they reflect a commitment to providing high-quality, culturally competent care for diverse populations • development of an action plan that includes explicit expectations and measurable objectives relating to culturally competent care • whether, based on national benchmarks, organizational targets and benchmarks were set for performance measures • whether information on patients' race, ethnicity, and primary written and spoken language were used to design and/or inform quality improvement strategies and projects focused on providing more culturally competent care and eliminating health care disparities in access, outcomes, or patient experiences with care.

GOVERNANCE, LEADERSHIP, AND WORKFORCE: Standards 2–4

Standard 2. Advance and sustain organizational governance and leadership that promotes CLAS and health equity through policy, practices, and allocated resources.

Standard 3. Recruit, promote, and support a culturally and linguistically diverse governance, leadership, and workforce that are responsive to the populations in the service area.

Standard 4. Educate and train governance, leadership, and workforce in culturally and linguistically appropriate policies and practices on an ongoing basis.

WHY ARE THESE STANDARDS IMPORTANT?

The implementation of culturally and linguistically appropriate services is a systemic responsibility, requiring the investment, support, and training of all individuals within an organization. **Standard 2** emphasizes the importance of advancing and sustaining governance and leadership that promotes the National CLAS Standards and health equity through policies, programs, and resource allocation. The National CLAS Standards are applicable to all of the work your organization does, and traditionally, cultural competency efforts have proceeded from the bottom up. However, the culture of an organization is really established through its leadership and governance through the policies, expectations, and actions performed. Your organization should not only be culturally and linguistically diverse in its leadership, but should also put forth policies and procedures that make a commitment to cultural competency and equity visible to your staff and those you serve.

GOVERNANCE, LEADERSHIP, AND WORKFORCE: Standards 2–4

Standard 3 illustrates that it is important for organizations to ensure that their leadership and workforce are culturally and linguistically diverse in order to be responsive to the populations they serve. Evidence shows that organizations with a more racially and ethnically diverse workforce are better able to provide high-quality care, improved communication, and greater patient satisfaction, and this is becoming increasingly important as the United States becomes more diverse. Unfortunately, this diversity is not represented in many health-related professions. Therefore, it is essential that organizations develop focused strategies to recruit, promote, and support a culturally and linguistically diverse workforce, from front desk staff to senior leadership to external contractors and partners. However, diversity alone is not sufficient to achieve cultural competency: All members of your organization should also be trained in cultural and linguistic competency skills.

Standard 4 summarizes the importance of providing ongoing education and training for professionals. Cultural and linguistic competency concepts—including effective communication and patient-, family-, and community-based practices—should be incorporated not only into all formal educational curricula but also into new and existing staff training and curricula. Ongoing education and staff training ensures that your governance, leadership, and workforce are equipped with adequate knowledge, tools, and skills to appropriately manage cross-cultural encounters with the consumers you serve. While principles of cultural competency should carry through all education, training, policies, and procedures, specific opportunities exist for training your staff on such subjects as health disparities or the effect of current and historical

GOVERNANCE, LEADERSHIP, AND WORKFORCE: Standards 2–4

events on medical mistrust experienced by the populations you serve. Consistently reinforcing your commitment to cultural and linguistic competency creates buy-in within your workforce. Culturally competent practices have also been shown to have positive impacts for consumers, including services efficiency, satisfaction, and outcomes.

Your organization can use a variety of approaches for addressing Standards 2–4, depending on the type of services you offer. As is discussed for all of the National CLAS Standards, it is important to monitor the quality and use of services.

By addressing these Standards, you will:

Standard 2

- ensure the provision of appropriate resources and accountability needed to support and sustain initiatives
- model an appreciation and respect for diversity, inclusiveness, and all beliefs and practices
- support a model of transparency and communication between your organization and the populations you serve.

Standard 3

- create an environment in which culturally diverse individuals feel welcomed and valued
- promote trust and engagement with the communities and populations you serve
- infuse multicultural perspectives into planning, design, and implementation of CLAS
- ensure diverse viewpoints are represented in governance decisions
- increase knowledge and experience related to culture and language among staff.

GOVERNANCE, LEADERSHIP, AND WORKFORCE: Standards 2–4

Standard 4

- prepare and support a workforce that demonstrates the attitudes, knowledge, and skills necessary to work effectively with diverse populations
- increase the capacity of staff to provide services that are culturally and linguistically appropriate
- assess the progress of staff in developing cultural, linguistic, and health literacy competency
- foster an individual's right to respect and nondiscrimination by developing and implementing education and training programs that address the impact of culture on health and health care.

GOVERNANCE, LEADERSHIP, AND WORKFORCE: Standards 2–4

HOW COULD I SHAPE MY LOGIC MODEL TO REFLECT THESE STANDARDS?

In Chapter 2, the idea of a logic model was introduced. Logic models can help you think through your evaluation in greater detail to ensure that you measure what is important. In this section, we provide some ideas for how you might think about building out a logic model to evaluate your implementation of Standards 2–4. Every organization is different, but we provide some examples of things to consider as you tailor your logic model to implement and assess activities that aim to meet standards related to governance, leadership, and workforce.

Consider, for example, the *context*, *antecedents*, and *inputs* that highlight the cultural and linguistic factors that should inform changes to policies and practices:

- cultural and linguistic characteristics of the population(s) you serve
- current workforce demographics and promotion demographics
- current training procedures, opportunities for new training, and availability of cultural competency training resources in your area (including live and web-based resources) for all senior leadership, management, staff, and volunteers.

GOVERNANCE, LEADERSHIP, AND WORKFORCE: Standards 2–4

Implementation of the National CLAS Standards often requires changes to or the development of new policies, procedures, and staffing. Your logic model should include the *activities that you have adopted and implemented*. Some examples related to Standards 2–4 are listed below. We have organized the examples to highlight the outputs named in our sample logic model: changes to organizational policies; changes to structure, staffing, and resources; and changes to processes and practices.

Changes to organizational policies

- A written policy that reinforces the organization's commitment to
  - consumers' rights to respect and nondiscrimination
  - a diverse workforce at all levels of leadership
  - mentorship and promotion opportunities for a diverse staff
  - ongoing training for governance, leadership, and staff in culturally and linguistically appropriate practices.

IMPLEMENTATION IN ACTION: Organizational Changes at Woodhull Medical and Mental Health Center (Standard 4)

At Woodhull Medical and Mental Health Center, in Brooklyn, N.Y., the leadership sought to make sweeping changes to its practices related to cultural competency. Framed as a patient safety and customer service issue, leadership changed the organization's mission to affirm their commitment to cultural competency. Staff now collect data on language preferences and interpretation needs and use staff interpreters, with a telephone language line vendor as backup. Cultural competency training is incorporated into the organization's required in-depth orientation for new hires.

GOVERNANCE, LEADERSHIP, AND WORKFORCE: Standards 2–4

Changes to structure, staffing, and resources

- Strategies to recruit, retain, and promote a diverse set of leaders at all levels that reflect the demographics of those you serve
- Informed and committed champions for cultural competency
- Staff responsible for identifying opportunities, resources, and processes for leadership and staff training and mentorship
- Changes in budget to support the development of new policies and procedures, staff training, and related costs
- Allocating resources to train current staff as interpreters if they express interest and meet qualifications; and to support mentor relationships.

Changes to processes and practices

- Advertising job opportunities and recruiting potential employees in targeted foreign language and minority health professional associations, publications, and convenings
- Relationships with businesses, public schools, and other stakeholders to create a pipeline for diverse staff and provide them with the support and resources necessary to meet job requirements
- Processes that encourage dialogue about meeting the needs of diverse populations and preventing discrimination
- Changes to staff training, both for new hires and existing employees, that uses adult learning principles (e.g., exploration of one's own cultural background and the cultural backgrounds of the populations you serve), elements of effective cross-cultural communication and use of language services, and strategies for cross-cultural conflict resolution

GOVERNANCE, LEADERSHIP, AND WORKFORCE: Standards 2–4

- Strategies for collecting race, ethnicity, sex, language, and disability status data in a sensitive manner
- Evaluation
  - ongoing assessment of staff demographics and promotion demographics
  - evaluation of education and training, including pre- and post-assessments
  - changes to staff performance evaluation to assess cultural and linguistic competency.

Finally, your logic model should list the anticipated *outputs and outcomes* of these activities. For Standards related to leadership, governance, and workforce, these may include

- a culturally and linguistically representative workforce at all levels
- organizational leadership and staff exhibiting nondiscriminatory and culturally/linguistically competent attitudes, knowledge, and skills
- database of race, ethnicity, sex, language, and disability status of consumers.

IMPLEMENTATION IN ACTION: Staff Diversity at the Great Brook Valley Health Center (Standard 3)

The Great Brook Valley Health Center (GBVHC) in Worcester, Mass., is very diverse, with a staff that speaks 29 languages and comes from 36 countries. When GBVHC was having difficulty finding Hmong interpreters, leadership contacted the school system in a community where there was an existing Hmong population to obtain qualified applicants. Leadership is also committed to sharing knowledge and resources with the surrounding community and other providers.

GOVERNANCE, LEADERSHIP, AND WORKFORCE: Standards 2–4

	CONTEXT, ANTECEDENTS, AND INPUTS	PROPOSED CHANGES AND STRATEGIES FOR IMPLEMENTATION	OUTPUTS	OUTCOMES AND IMPACTS	
				SHORT TERM	LONGER TERM
Governance, Leadership, and Workforce (Standards 2–4)	A mismatch between the cultural and linguistic characteristics of the population(s) served and the current workforce demographics and promotion demographics	Organization makes changes to its staff recruitment process, such as advertising job opportunities in targeted foreign languages and minority health professional association publications	A more culturally and linguistically representative workforce	Organizational leadership and staff exhibiting non-discriminatory and culturally/linguistically competent attitudes, knowledge, and skills	Improved access to care among culturally diverse consumers

GOVERNANCE, LEADERSHIP, AND WORKFORCE: Standards 2–4

HOW CAN I SHAPE MY EVALUATION TO ASSESS IMPLEMENTATION AND EFFECTIVENESS OF THESE STANDARDS?

In Chapter 2, we discussed a set of overarching evaluation questions that will help you to assess the impact of the National CLAS Standards on your organization and the populations you serve. As you review these questions, think about what they mean in the context of Standards 2–4, which relate to governance, leadership, and workforce.

In the short term, for example, think about how infusing cultural competency throughout your workforce and leadership would increase consumer engagement with care and follow-up visits. Or think about how implementing training processes would increase staff knowledge of culturally and linguistically appropriate care. In the long term, how have changes to processes and policies produced greater awareness of and workforce buy-in of culturally and linguistically appropriate care and services? How has the infusion of cultural competency and health equity principles improved trust and engagement between individuals seeking care and your staff over time? These pathways may help you to think about important process, implementation, and outcome measures you wish to capture in your evaluation.

In Table 3, we present some example metrics you can use to assess your progress toward implementing practices that align with the governance, leadership, and workforce Standards, as well as the impact of those processes on your organization and those you serve. This is not a comprehensive list, but it will help you get started and may complement metrics you already collect. Additional information on the measures, including links to survey documents, can be found in Chapter 4.

GOVERNANCE, LEADERSHIP, AND WORKFORCE: Standards 2–4

TABLE 3. METRICS AND WAYS OF ASSESSING STANDARDS 2–4

EXAMPLE METRIC	DESCRIPTION
CAHPS Cultural Competence Item Set: patient-provider communication, complementary and alternative medicine, experiences of discrimination, and linguistic competency measures	CAHPS Cultural Competence items are a set of supplemental items for the CAHPS Clinician/Group Survey that ask consumers about their experiences with the cultural competence of an organization that provided them services. CAHPS Cultural Competence items were designed for medical practices and clinics, but questions could be applied to diverse health care and public health settings. Scores are calculated for five item sets. The patient-provider communication, complementary and alternative medicine, experiences of discrimination, and linguistic competency items are most relevant for this group of Standards and assess such measures as • understanding of provider instructions based on providers' communication style • communication with provider about use of acupuncture, natural herbs, and the like • patient experiences with discrimination • whether language services were offered.
C-CAT workforce development, leadership commitment, cross-cultural communication, and performance evaluation domains	The C-CAT provides assessments of consumers, staff, and organizational leadership to comprehensively measure the implementation and outcomes of providing language services. C-CAT has been validated in diverse health care settings nationwide. C-CAT scores are calculated on nine domains. A number of domains are relevant to this group of Standards (e.g., workforce development, leadership commitment, cross-cultural communication, and performance evaluation) and include items assessing • written policies on culturally appropriate communication • senior leadership encouragement of discussions with consumers about cultural and spiritual beliefs • staff training on asking patients about their racial/ethnic background in a culturally appropriate way • effectiveness of staff training for improving patient communication • patient perceptions of staff understanding their culture • performance evaluation system's capacity to assess staff's cross-cultural communication skills.

GOVERNANCE, LEADERSHIP, AND WORKFORCE: Standards 2–4

TABLE 3. METRICS AND WAYS OF ASSESSING STANDARDS 2–4

EXAMPLE METRIC	DESCRIPTION
Cultural Competency Implementation Measure, commitment to serving a diverse population, leadership diversity, dedicated staff and resources, reward systems, and clinical encounter subdomains	The Cultural Competency Implementation Measure is an organizational survey designed to assist health care organizations in identifying the degree to which they are providing culturally competent care and addressing the needs of diverse populations. The Cultural Competency Implementation Measure was designed for use in diverse health care settings. Scores are calculated for 12 subdomains. A number of subdomains are relevant to this group of Standards (e.g., commitment to serving a diverse population, leadership diversity, dedicated staff and resources, reward systems, and clinical encounter) and include items assessing • organization's mission, vision, and goals for a commitment to cultural competency • documentation of fiscal support for culturally competent policies and practices • strategies for recruiting, retaining, and promoting a diverse staff at all levels of the organization, including upper management • job performance evaluation criteria for cultural competence improvement goals • collection of patient information on cultural beliefs (e.g., religion, nationality, ethnicity)
Screening for preferred spoken language for health care measure	The screening for preferred spoken language for health care measure is used to assess the percentage of patient visits and admissions where preferred spoken language for health care is screened and recorded. It relies on administrative claims, electronic health records, or other records of consumer visits. The measure was designed for use by hospitals and outpatient clinics, but could be applied across health care settings where patient records are kept. It is calculated by determining the number of hospital admissions, visits to the emergency department, and outpatient visits where preferred spoken language for health care is screened and recorded and dividing that number by the total number of hospital admissions, visits to the emergency department, and outpatient visits.

COMMUNICATION AND LANGUAGE ASSISTANCE: Standards 5–8

Standard 5. Offer language assistance to individuals who have limited English proficiency and/or other communication needs, at no cost to them, to facilitate timely access to all health care and services.

Standard 6. Inform all individuals of the availability of language assistance services clearly and in their preferred language, verbally and in writing.

Standard 7. Ensure the competence of individuals providing language assistance, recognizing that the use of untrained individuals and/or minors as interpreters should be avoided.

Standard 8. Provide easy-to-understand print and multimedia materials and signage in the languages commonly used by the populations in the service area.

WHY ARE THESE STANDARDS IMPORTANT?

Language assistance services are mechanisms used to facilitate communication with individuals who do not speak English, those who have limited English proficiency, and those who are blind, deaf, or with hearing loss. These services include on-site interpreters, bilingual staff, or use of remote interpreting systems, such as telephone or video interpreting for both spoken languages and sign languages, as well as the translation of written materials or signage, or braille material. **Standard 5** highlights that the provision of these services is critical to ensuring consumer satisfaction, safety, quality of care, and improved outcomes. By using quality language services, your organization will facilitate effective and accurate communication between your staff and consumers, regardless of their language proficiency. Language assistance also improves the qual-

COMMUNICATION AND LANGUAGE ASSISTANCE: Standards 5–8

ity of services you provide and promotes patient safety by facilitating conversations regarding prevention, symptoms, diagnosis, treatment, and other issues. Additionally, your organization may be required to offer language assistance services in order to receive some federal funds.

Standard 6 summarizes the importance of notifying consumers that language services are available to them at no cost. Because many consumers may not be aware that services exist, staff may inform consumers of language services speaking to people in-person or over the phone, using language identification tools ("I speak" cards), or publishing multimedia materials. Since staff are crucial conduits of information about language services to consumers, all members of the organization should be fully aware of the communication and language assistance services available, and all related organizational policies and procedures, and should be offered training and continuing education about these services.

Standard 7 illustrates that it is important for organizations to ensure that staff or contractors tasked with interpretation and language services have the ability and skills to provide high-quality services to your consumers. These qualifications often extend beyond language ability to include knowledge of health concepts, cultural competency, and skills in applying interpreter standards, protocols, and ethics. Doing so can minimize the risk of miscommunication and the potential for medical errors and poor quality of care when ad hoc interpreters or family members are used to interpret. Using ad hoc interpreters and family members may also violate consumers' preferences for confidentiality and privacy and may be distressing to family or friends tasked with interpretation.

Standard 8 focuses on the availability of print and multimedia materials that help to ensure that the people you serve—including those with limited English proficiency (LEP) and low health literacy—can read, comprehend, and act on written materials. Unfortunately, most clinical

COMMUNICATION AND LANGUAGE ASSISTANCE: Standards 5–8

and health promotion information is written at too high a level for the average person to understand. Those with health literacy challenges are disproportionately represented in minority populations, which may lead to worsening health disparities. Your organization can become more "health literate" by designing and distributing print, audiovisual, and social media content that is easy to understand and act on. Such materials use culturally appropriate graphics, employ user-friendly design, focus on providing clear directions to the consumer, and do not use jargon. They should also be available in common non-English languages spoken in the community. Health materials, including signage, should supplement in-person communication to reinforce the messages your staff conveys, rather than replacing in-person communication.

Your organization can use a variety of approaches for addressing Standards 5–8, depending on the type of services you offer. Further, your organization may choose to create different types of materials, forms, and signs depending on the type of services you offer. As is discussed for all of the National CLAS Standards, it is important to monitor the quality and use of services.

COMMUNICATION AND LANGUAGE ASSISTANCE: Standards 5–8

By addressing these Standards, you will:

Standard 5

- ensure that consumers with LEP or other communication needs receive equitable access to services
- help consumers understand their health care and service options and allow them to participate in health care decisionmaking
- increase satisfaction with care
- improve adherence to recommendations and treatments
- improve consumer safety and reduce miscommunications that contribute to medical errors
- comply with requirements, such as Title VI of the Civil Rights Act of 1964, the Americans with Disabilities Act of 1990, and other relevant policies.

Standard 6

- inform individuals with LEP in their preferred language that language services are readily available at no cost to them
- facilitate access to language services.

Standard 7

- provide accurate and effective communication between individuals and providers
- reduce misunderstanding, dissatisfaction, omission of vital information, misdiagnoses, inappropriate treatment, and patient safety issues because of reliance on staff or individuals that lack interpreter training
- empower individuals to negotiate and advocate on their own behalf for important services via effective and accurate communication with health and health care staff

COMMUNICATION AND LANGUAGE ASSISTANCE: Standards 5–8

Standard 8

- ensure that readers of other languages and individuals with various health literacy levels are able to access care and services
- provide access to health-related information and facilitate comprehension of and adherence to instructions and health plan requirements
- offer an effective way to communicate with large numbers of people and supplement information provided orally by staff members.

HOW COULD I SHAPE MY LOGIC MODEL TO REFLECT THESE STANDARDS?

In Chapter 2, the idea of a logic model was introduced. Logic models can help you think through your evaluation in greater detail to ensure you measure what is important. In this section, we provide some ideas for how you might think about building out a logic model to evaluate your implementation of Standards 5–8. Every organization is different, but here are examples of things to consider as you tailor your logic model to implement and assess activities that aim to meet standards related to communication and language assistance.

IMPLEMENTATION IN ACTION: Healthcare Interpreter Certificate Program (Standard 7)

Kaiser Foundation Health Plan in Oakland, Calif., established a college-level training program with didactics and fieldwork designed to provide accreditation standards for interpreters serving LEP members and the community at large. Through national dissemination of the program, more than 100 college-level instructors across the country and numerous staff have been trained and certified. Evaluation results suggest that providers who used trained interpreters overwhelmingly preferred them over untrained interpreters (e.g., family members and bilingual staff), and patients could differentiate between trained versus untrained interpreters, favoring trained interpreters significantly.

COMMUNICATION AND LANGUAGE ASSISTANCE: Standards 5–8

Consider, for example, the *context*, *antecedents*, and *inputs* that highlight a need for language assistance with the population you serve:

- interpretation and translation needs at various points of contact between staff and consumers
- availability of printed materials to aid in translation and interpretation (e.g., handouts for patients, signage for waiting rooms, legal forms) and appropriate content
- availability of materials or language services in the region, including bilingual staff or dedicated language assistance (e.g., a contract interpreter or video remote interpreting).

Implementation of National CLAS Standards often requires changes to or the development of new policies, procedures, and staffing. Your logic model should include the proposed changes and strategies to implement those changes that you have identified and implemented. Some examples related to Standards 5–8 are listed below.

Changes to organizational policies

- Development of a written policy that requires the use of qualified language services (e.g., prohibits the use of family members or friends as interpreters)
- Development of a policy around plain language and the creation of documents that demonstrate best practices in clear communication and information design
- Development of a written policy that describes your organization's approach to informing consumers of language services.

COMMUNICATION AND LANGUAGE ASSISTANCE: Standards 5–8

Changes to structure, staffing, and resources

- Changes to staff responsibilities, ensuring that appropriate staff have ownership over materials development, needs assessment, and dissemination
- Changes in budget to support translation of materials, development of plain language forms, printing and production of materials, and related costs
- Addition of technology required to efficiently support interpretation services (e.g., video remote interpretation)
- Use of signs, materials, and multimedia resources to reflect the languages regularly encountered by your organization at various points of entry and intake or areas where clinical or educational work is performed. Include culturally appropriate visuals to convey messages at low literacy levels.

IMPLEMENTATION IN ACTION: Remote Video Voice Medical Interpretation Project (Standard 5)

Contra Costa County, Calif., Health Services initiated a partnership among four local hospitals to develop a remote and mobile voice system supported by voice call centers that provide services in two languages. This partnership tripled the number of translations per day. This has generated a cost savings to the hospitals of $0.80 per minute, which in one month totaled $25,000.

COMMUNICATION AND LANGUAGE ASSISTANCE: Standards 5–8

Changes to processes and practices

- Changes to workflow, including how preferred language will be assessed and recorded (e.g., in patient charts, client service records), processes for sending for or contacting interpreters (on-site or remote), and location of translated materials
- Changes to employee and/or contractor assessments to ensure language proficiency and interpreting skills of individuals providing language services (e.g., use language-proficiency scales from the American Council on the Teaching of Foreign Languages or Interagency Language Roundtable and a valid and reliable tool to assess interpreting skills)
- Create forms that are easy to fill out and offer assistance in completing forms
- Test materials with target audiences (e.g., with focus groups, community partners)
- Establish processes for periodically reevaluating and updating materials.

Finally, your logic model should list the anticipated outputs and outcomes of these activities. For Standards related to communication and language assistance, these may include:

- availability of high-quality interpretation services, including
  - consumer awareness of the availability of no-cost interpretation
  - frequency of use of interpretation services
  - wait times for consumers to receive interpretation services
- staff knowledge of how to access communication and language assistance
- availability of professionally translated written consumer materials.

COMMUNICATION AND LANGUAGE ASSISTANCE: Standards 5–8

Table 4 illustrates an example of how to align the elements of the logic model using the just-mentioned points, which makes it easier to develop or choose metrics and evaluation questions.

TABLE 4. ALIGNING THE LOGIC MODEL

	CONTEXT, ANTECEDENTS, AND INPUTS	PROPOSED CHANGES AND STRATEGIES FOR IMPLEMENTATION	OUTPUTS	OUTCOMES AND IMPACTS	
				SHORT TERM	LONGER TERM
Communication and Language Assistance (Standards 5–8)	Population(s) served have a clearly identified need for language services at various points of contact	Workflow changes are implemented that improve the capacity to identify when a language service need is present	Organization provides equitable, effective, and high-quality services to consumers with language service needs	Improved two-way communication between consumers and health care staff	Improved patient health outcomes

COMMUNICATION AND LANGUAGE ASSISTANCE:
Standards 5–8

HOW COULD I SHAPE MY EVALUATION TO ASSESS IMPLEMENTATION AND EFFECTIVENESS OF THESE STANDARDS?

In Chapter 2, we discussed a set of overarching evaluation questions that will help you to assess the impact of the National CLAS Standards on your organization and the populations you serve. As you review these questions, think about what they mean in the context of Standards 5–8, which relate to communication and language services.

In both the short and the long terms, you should be able to observe changes within your organization and among the consumers you serve. In the short term, for example, think about how access to interpreters would help consumers with language-service needs navigate the services you provide. Or think about how implementing language services would contribute to improved two-way communication between consumers and your staff. In the long term, how would offering interpretation and translated materials contribute to the capacity of your organization to serve a diverse population? How has providing language services impacted consumer satisfaction over time? These pathways may help you think about important process, implementation, and outcome measures you wish to capture in your evaluation.

Table 5 presents some example metrics you can use to assess your progress toward implementing practices that align with the communication and language Standards, as well as the impact of those processes on your organization and those you serve. This is not a comprehensive list, but it will help you get started and may complement metrics you already collect. Additional information on the measures, including links to survey documents, can be found in Chapter 4.

COMMUNICATION AND LANGUAGE ASSISTANCE: Standards 5–8

TABLE 5. METRICS AND WAYS OF ASSESSING STANDARDS 5–8

EXAMPLE METRIC	DESCRIPTION
CAHPS Cultural Competence Item Set, access to language services measure	CAHPS Cultural Competence items are a set of supplemental items for the CAHPS Clinician/Group Survey that ask consumers about their experiences with the cultural competence of an organization that provided them services. CAHPS Cultural Competence items were designed for medical practices and clinics, but questions could be applied to diverse health care and public health settings. Scores are calculated for five item sets. The linguistic competency (access to language services) items are most relevant for this group of Standards and assess: • respondent English proficiency • whether language services were offered free of charge and how long consumers had to wait for services • frequency of use of language services • satisfaction with language services.
CAHPS Item Set for Addressing Health Literacy, all item sets	CAHPS Addressing Health Literacy items are a set of supplemental items for the CAHPS Clinician/Group Survey that ask consumers about their experiences with receiving materials and instructions that were easy to understand. CAHPS Addressing Health Literacy items were designed for medical practices and clinics, but questions could be applied to diverse health care and public health settings. Scores are calculated for five item sets. There are items in all five item sets relevant to these Standards that assess: • use of pictures, drawings, models, or videos to convey information • consumer ability to understand and fill out forms • consumer ability to understand information about elements in health care, such as disease management and medicines.

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EXAMPLE METRIC	DESCRIPTION
Communication Climate Assessment Toolkit (C-CAT), language services domain	The C-CAT provides assessments of consumers, staff, and organizational leadership to comprehensively measure the implementation and outcomes of providing language services. C-CAT has been validated in diverse health care settings nationwide. C-CAT scores are calculated on nine domains. The language services domain is most relevant for this group of Standards and includes items assessing • existence and awareness of policies and processes governing the use of interpreters • availability and frequency of use of language services (translated materials and interpreters) • frequency of miscommunication between staff and consumers • whether language services were offered free of charge • satisfaction with language services • perceptions of communication skills of staff • overall satisfaction with care.
Cultural Competency Implementation Measure, language access subdomain	The Cultural Competency Implementation Measure is an organizational survey designed to assist health care organizations in identifying the degree to which they are providing culturally competent care and addressing the needs of diverse populations. The Cultural Competency Implementation Measure was designed for use in diverse health care settings. Scores are calculated for 12 subdomains. The language access subdomain is most relevant for this group of Standards and includes items assessing • whether language services policies have been reviewed and updated • whether language services are available in different areas of the organization • existence of procedures for effective language assistance communication via multiple modes (telephone, in-person).

COMMUNICATION AND LANGUAGE ASSISTANCE: Standards 5–8

EXAMPLE METRIC	DESCRIPTION
Patients receiving language services supported by qualified language services providers measure	This measure is used to assess the percentage of LEP patients receiving both initial assessment and discharge instructions supported by assessed and trained interpreters or from bilingual providers and bilingual workers/employees assessed for language proficiency. It relies on administrative claims, electronic health records, or other records of consumer visits. This measure was designed for use in medical practices and clinics, but questions could be applied to diverse health care and public health settings. It is calculated by determining the number of LEP patients with documentation that received the initial assessment and discharge instructions and were supported by trained and assessed interpreters and dividing that number by the total number of patients that stated a preference to receive their spoken health care in a language other than English.
Screening for preferred spoken language for health care measure	The screening for preferred spoken language for health care measure is used to assess the percentage of patient visits and admissions where preferred spoken language for health care is screened and recorded. It relies on administrative claims, electronic health records, or other records of consumer visits. The measure was designed for use by hospitals and outpatient clinics, but could be applied across health care settings where patient records are kept. This measure is calculated by determining the number of hospital admissions, visits to the emergency department, and outpatient visits where preferred spoken language for health care is screened and recorded and dividing that number by the total number of hospital admissions, visits to the emergency department, and outpatient visits.

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Standard 9. Establish culturally and linguistically appropriate goals, policies, and management accountability, and infuse them throughout the organization's planning and operations.

Standard 10. Conduct ongoing assessments of the organization's CLAS-related activities and integrate CLAS-related measures into measurement and continuous quality improvement activities.

Standard 11. Collect and maintain accurate and reliable demographic data to monitor and evaluate the impact of CLAS on health equity and outcomes and to inform service delivery.

Standard 12. Conduct regular assessments of community health assets and needs and use the results to plan and implement services that respond to the cultural and linguistic diversity of populations in the service area.

Standard 13. Partner with the community to design, implement, and evaluate policies, practices, and services to ensure cultural and linguistic appropriateness.

Standard 14. Create conflict and grievance resolution processes that are culturally and linguistically appropriate to identify, prevent, and resolve conflicts or complaints.

Standard 15. Communicate the organization's progress in implementing and sustaining CLAS to all stakeholders, constituents, and the general public.

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WHY ARE THESE STANDARDS IMPORTANT?

To fully integrate CLAS, you may need to rethink the way you work, from your front desk to your leadership team; the principles that guide your organization; which outside organizations you partner with to implement CLAS; and the ways in which you measure success. Standard 9 illustrates that establishing goals, policies, and management accountability that promote CLAS throughout your organization will ensure that your organization is culturally and linguistically competent at every point of contact. Doing so will also help to tie CLAS to your organizational priorities, such as consumer satisfaction, safety, and outcomes, which will be key to ensuring that the Standards are fully implemented over time. This integrated approach also demonstrates that cultural and linguistic competency is integral to the way you run your organization.

Standard 10 highlights the importance of assessing progress toward your organization's CLAS goals. A key element of successfully implementing the National CLAS Standards for cultural and linguistic competency involves a continuous quality-improvement process, including an assessment phase, a planning phase, an implementation phase, and an evaluation phase. These assessments can range in intensity from relatively brief organizational checklists to in-depth assessments with structured and formal input from stakeholders, consumers, and/or staff. Methods can range from informal interviews to using validated surveys across the organization. In general, integrating measures related to cultural and linguistic competency into your existing assessment efforts and CQI programs will help you learn whether CLAS delivery processes are producing the desired results. Absent these measures, you may not be able to demonstrate the effectiveness of CLAS delivery nor will you be able to identify ways to improve CLAS implementation.

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Standard 11 focuses on understanding the population you serve to plan your implementation appropriately. The availability of demographic data, particularly on race and ethnicity, is the first step for your organization to be able to demonstrate the effectiveness of CLAS in reaching your goal of delivering quality, equitable services and, ultimately, in reducing disparities and improving health equity. Your organization should train staff in cultural and linguistic competency to collect key data from consumers in a sensitive manner, including demographic information such as race, ethnicity, sex, language, and disability status. You should also consider the ways in which you plan to share data across departments and throughout the continuum of services you provide. These data will help you to establish the foundation for cultural and linguistic competency, become more responsive to cultural preferences, tailor services to diverse needs, and use your resources more cost-effectively. Thus, one purpose of collecting and maintaining accurate demographic data is to link the data with other measures you collect and use them in ongoing monitoring, evaluation, and CQI activities. For example, you might track use and satisfaction with different services by race/ethnicity to make staffing decisions or target quality-of-care improvement efforts.

Standard 12 highlights the value of conducting regular assessments of community health needs and assets. Knowing your community—including its needs, already-available resources, and service gaps—will help you to understand how to provide the best service and value. Needs assessments can help your organization gain cultural knowledge about community health beliefs and attitudes, as well as the specific interventions that would be of help to community members. By assessing existing resources in the community, your organization can avoid duplication of services and better connect consumers to those resources. It is important to partner with key

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stakeholders from the populations you serve to collect information for your needs and resource assessments and to help promote the culturally and linguistically competent services you plan to implement. Over time, your organization can use the information gained from ongoing assessment to develop appropriate services and evaluate access to and use of those services, including disparities in care and the potential for improving health equity.

Standard 13 builds on the idea of conducting community needs assessments to creating meaningful partnerships with community members in your service area. Community partnerships are essential to help your organization be culturally and linguistically competent: Only through meaningful community partnerships can your organization truly understand the needs of the diverse populations you serve, appropriately allocate resources, and develop an accountable system that provides equitable culturally and linguistically appropriate care and services. When it comes time to conduct planning activities, quality improvement assessments, or evaluations, seeking community input will help you to understand your organization's reputation and the best ways to expand the reach and impact of your services. It will also prevent your staff from recommending activities that are culturally inappropriate or infeasible for consumers. Community involvement can take many forms, from forming community steering committees and coalitions, to conducting key interviews and focus groups, to collaborating with cultural brokers and lay community health workers.

Standard 14 addresses the importance of creating conflict- and grievance-resolution processes that are culturally and linguistically appropriate. One of the reasons that health disparities exist today is the existence of discriminatory and inequitable practices by health organizations, although often unintentional and unconscious. These inequitable practices may be embedded in

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systems' policies and procedures. Discrimination based on race, ethnicity, sex, age, socioeconomic status, sexual orientation, gender identity, and other characteristics make it difficult to provide quality care and services, which means that culturally and linguistically competent conflict prevention and resolution are vital parts of advancing health equity. Even if your organization makes a commitment to cultural and linguistic competency (e.g., through adoption of other National CLAS Standards), it is inevitable that individuals will have conflicts and grievances, including differences related to informed consent and advance directives to difficulties in accessing services or denial of services to discriminatory treatment. Your organization should anticipate and be responsive to the differences that arise among individuals and your staff. You can institutionalize this thinking through implementing training for staff and leadership on how to listen and respond in conflict situations (as described in more detail in Standard 4), by incorporating cultural sensitivity into existing feedback procedures, and by actively seeking input from community members (as addressed in the other Standards in this group).

Standard 15 emphasizes the need to communicate your organization's progress in implementing and sustaining the National CLAS Standards to all stakeholders, constituents, and the public. Communicating about progress can serve many purposes when it comes to developing a more culturally and linguistically appropriate organization. It can allow your organization to share its accomplishments and identify areas for improvement; it can help you to institutionalize CLAS by prompting your organization to think critically about, or better yet, formally evaluate, the extent to which you have implemented each Standard; it will help hold you accountable to the communities you aim to serve; and it also helps organizations learn from one another about new ideas and promising practices for implementing CLAS in different communities and settings. There are several ways in which you can communicate about your

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organization's progress, all of which build on the other Standards in the engagement, continuous improvement, and accountability category. You can report results of evaluations (Standard 10), describe the data collected and communities served (Standard 11), share the results of community health assessments (Standard 12), or describe the partnerships you have built with community members (Standard 13).

Your organization will choose to set different goals, create your own policies, and collect different types of data in different ways depending on the populations you serve and the type of services you offer. As is discussed for all National CLAS Standards, it is important to monitor the quality and use of services.

By addressing these Standards, you will:

Standard 9

- make CLAS central to your organization's service, administrative, and supportive functions
- integrate CLAS throughout your organization (including the mission) and highlight its importance through specific goals
- link CLAS to other organizational activities, including policy, procedures, and decisionmaking related to outcomes accountability.

Standard 10

- assess and improve the extent to which health care services are provided equitably
- assess the value of CLAS-related activities relative to the fulfillment of governance, leadership, and workforce responsibilities
- ensure equal allocation of organizational resources
- improve service planning to enhance access and coordination of care.

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Standard 11

- assess performance and monitor progress in implementing the Standards
- accurately identify population groups within a service area
- tailor and improve services based on the people you serve
- monitor individual needs, access, use, quality of care, and outcome patterns.

Standard 12

- determine the service assets and needs of the populations in your service area (needs assessment)
- identify all of the services available and unavailable to the populations in your service area (resource inventory and gap analysis)
- determine what services to provide and how to implement them based on the results of the community assessment
- ensure that your organization obtains demographic, cultural, linguistic, and epidemiological baseline data (both quantitative and qualitative) and updates the data regularly to better understand the populations in your service area.

Standard 13

- provide responsive and appropriate service delivery to a community
- ensure that services are informed and guided by community interests, expertise, and needs
- increase use of services by engaging individuals and groups in the community in the design and improvement of services to meet their needs and desires
- create an organizational culture that leads to more-responsive, efficient, and effective services and accountability to the community
- empower members of the community to become active participants in the health and health care process.

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Standard 14

- facilitate open and transparent two-way communication and feedback mechanisms between individuals and organizations
- anticipate, identify, and respond to cross-cultural needs
- meet federal and/or state level regulations that address topics such as grievance procedures, the use of ombudspersons, and discrimination policies and procedures.

Standard 15

- convey information to intended audiences about efforts and accomplishments in meeting the National CLAS Standards
- learn from other organizations about new ideas and successful approaches to implementing the National CLAS Standards
- build and sustain communication on CLAS priorities and foster trust between the community and your organization
- meet community benefits and other reporting requirements, including accountability for meeting health care objectives in addressing the needs of diverse individuals or groups.

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HOW COULD I SHAPE MY EVALUATION TO ASSESS IMPLEMENTATION AND EFFECTIVENESS OF THESE STANDARDS?

In this section, we provide some ideas for how you might think about building out a logic model to evaluate your implementation of these CLAS Standards related to goals and policies, assessing population needs and tailoring services, developing partnerships, resolving conflicts, and communicating your success. Standard 10 is unique in relation to the other National CLAS Standards in that the Standard itself relates to implementing measurement activities. As such, the logic models you have developed for other National CLAS Standards will help you as you work to implement Standard 10 and should be referenced often throughout the process. Below are examples of things to consider as you tailor your logic model to implement and assess activities that aim to meet these Standards.

IMPLEMENTATION IN ACTION:
Lowell Community Health Center (Standard 13)

The Lowell Community Health Center (LCHC) in Lowell, Mass., offers services to an ethnically and economically diverse community. To better meet the needs of the community, LCHC is committed to partnering with grassroots organizations in every area of service delivery by

- building subcontracting opportunities for community partners into grants. Currently, ten community-based organizations have subcontracts with LCHC
- sponsoring several community advisory groups, including the African Advisory Council, the Southeast Asian Task Force, and Portuguese and Spanish-speaking Promotores.

LCHC also engaged residents in the Metta Health Center design process, asking key members of the local Southeast Asian community, "If you could design the ideal health center, what would it look like?" It also relies on ongoing communication with cultural brokers for cultural insights and feedback.

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Consider, for example, the *context*, *antecedents*, and *inputs* that highlight a need to change goals and policies, collect accurate data, and partner and communicate with outside entities:

- current organizational mission, goals, policies, and accountability frameworks
- cultural and linguistic characteristics of the population(s) you serve
- current measurement and assessment activities (e.g., consumer surveys, staff performance evaluations, accountability frameworks) and gaps where new measurement processes will need to be developed
- your organization's capacity to collect, store, and analyze data needed to assess CLAS Standard implementation
- landscape of potential partners
- your organization's capacity to develop partnerships and disseminate findings.

Implementation of National CLAS Standards often requires changes to or the development of new policies, procedures, and staffing. Your logic model should include the *activities that you have adopted and implemented*. Some examples related to Standards 9–15 are listed below.

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Changes to organizational policies

- Having a written policy that reinforces your organization's commitment to
  - – assessing progress of CLAS-related activities
  - – collecting reliable demographic data
  - – ensuring that data is not used to discriminate
  - – developing and maintaining partnerships
  - – disseminating results.

Changes to structure, staffing, and resources

- Staff who are responsible for identifying opportunities, resources, and processes for monitoring and evaluation, as well as partnership development
- Changes in budget to support the development of new policies and procedures, staff training, and related costs for measurement, partnership, and dissemination
- Allocating resources to evaluation, partnership, and dissemination activities
- Identifying internal and external champions; staff responsible for leading strategic planning activities that incorporate CLAS and encouraging full-scale implementation.

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Changes to processes and practices

- Creating plans for developing CLAS throughout your organization's goals, policies, and practices with accountability frameworks and associated measures and identifying the specific CLAS Standards you plan to implement
- CLAS integration into CQI processes (e.g., organizational assessments, CLAS-oriented surveys for consumers, focus groups with staff and consumers to identify barriers to CLAS implementation, CLAS-related questions in staff orientation materials and yearly reviews)
- Holding organizational retreats to identify goals, objectives, and timelines to provide culturally and linguistically appropriate services, using data gathered from evaluations to reimagine identity, mission, operating principles, service focus, budget, and quality improvement activities to focus on CLAS
- Changes in accountability mechanisms throughout the organization, including staff evaluations, individuals' satisfaction measures, and quality improvement to assess CLAS goal achievement (e.g., cultural competency, communication skills)
- Processes for collecting demographic information at different points of entry and sharing across your organization (e.g., enrollment data included on consumer records)
- Staff training on strategies and survey instruments for collecting race, ethnicity, sex, language, and disability status data relevant to your community in a sensitive, reliable manner (e.g., HHS Data Collection Standards; using self-identification and allowing for more than one category to be selected).

IMPLEMENTATION IN ACTION: Boston Public Health Commission's Data-Collection Efforts (Standard 11)

The Boston Public Health Commission undertook a citywide health disparities initiative that required the collection of data on consumer race/ethnicity and other potentially sensitive information. Commission leadership noted that their staff was initially reluctant to collect patient data, and patients were hesitant to provide the information when asked. This prompted the Commission to institute sensitivity training and provide staff with scripts to use that included a description of what the information would be used for: to provide equitable care. After implementation of the training, they found that patients were more likely to share information because they understood the purpose of data collection.

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Finally, list the anticipated outputs and outcomes of these activities. Here are some examples:

- Organizational mission, vision, goals, and accountability frameworks that are integrated with CLAS principles, including identification of specific National CLAS Standards for implementation
- Structure, processes, and measures for ongoing assessment of CLAS Standards
- Organization-wide database of race, ethnicity, sex, language, and disability status of consumers
- Analytic plan for ongoing assessment of the impact of CLAS on health equity and outcomes and to inform service delivery (e.g., service utilization by race/ethnicity).

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Table 6 illustrates an example of how to align the elements of a logic model using the points above, making it easier to develop or choose metrics and evaluation questions.

TABLE 6. ALIGNING THE LOGIC MODEL

				OUTCOMES AND IMPACTS	
	CONTEXT, ANTECEDENTS, AND INPUTS	PROPOSED CHANGES AND STRATEGIES FOR IMPLEMENTATION	OUTPUTS	SHORT TERM	LONGER TERM
Engagement, Continuous Improvement, and Accountability (Standards 9–15)	Organizational leadership emphasizes their mission to implement the National CLAS Standards	Having a written policy that reinforces the organization's commitment to assessing the progress of CLAS-related activities	Organization creates a structure for measuring CLAS implementation	National CLAS Standards are implemented, evaluated, and a new process for refining the approach to implementing CLAS is developed	

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HOW COULD I SHAPE MY EVALUATION TO ASSESS IMPLEMENTATION AND EFFECTIVENESS OF THESE STANDARDS?

In Chapter 2, we discussed set of overarching **evaluation questions** about the outcomes resulting from implementation of the National CLAS Standards following the logic model format description. As you read through the questions again, think to yourself about what these questions mean in the context of Standards 9–15, which relate to engagement, continuous improvement, and accountability. You should be able to observe changes within your organization and among the consumers you serve.

In both the short and long term, you should observe changes in how your organization develops its approach to implementation of the National CLAS Standards overall. In the short term, for example, think about how integrating CLAS goals into your operations would help consumers better access and navigate health care services. Or think about how conducting assessments and quality improvement activities would help to improve access to high-quality language services for ethnic and minority populations. In the long term, has integrating CLAS into your policies and procedures led to a cultural shift in your organization toward greater workforce buy-in of culturally and linguistically appropriate care and services? And how has implementing assessments improved satisfaction among individuals seeking your services over time? These pathways may help you to think about important process, implementation, and outcome measures you wish to capture in your evaluation.

In Table 7, we present some example metrics you can use to assess your progress toward implementing practices that align with Standards 9–15, as well as the outcomes of those processes for your organization and those you serve. This is not a comprehensive list, but it will

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help you get started and may complement metrics you already collect. Note that since Standard 10 relates to conducting assessments for CLAS-related activities, many of the metrics and ways of assessing the other National CLAS Standards are relevant to assessing practices that align with Standard 10.

TABLE 7. METRICS AND WAYS OF ASSESSING STANDARDS 9–15

EXAMPLE METRIC	DESCRIPTION
CAHPS Cultural Competence Item Set: linguistic competency (access to language services), experiences of discrimination because of race/ethnicity, insurance, or language measures	CAHPS Cultural Competence items are a set of supplemental items for the CAHPS Clinician/Group Survey that ask consumers about their experiences with the cultural competence of an organization that provided them services. CAHPS Cultural Competence items were designed for medical practices and clinics, but questions could be applied to diverse health care and public health settings. Scores are calculated for five item sets. The linguistic competency (access to language services) and experiences of discrimination because of race/ethnicity, insurance, or language items are the most relevant for Standard 9 and assess such things as • patients' preferred language • availability and promotion of language services • patients' experiences being treated unfairly at this provider's office because of their race or ethnicity.

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EXAMPLE METRIC	DESCRIPTION
C-CAT, leadership commitment, workforce development, performance evaluation, data collection, community engagement, and cross-cultural communication domains	The C-CAT provides assessments of consumers, staff, and organizational leadership to comprehensively measure the implementation and outcomes of providing language services. C-CAT has been validated in diverse health care settings nationwide. C-CAT scores are calculated on nine domains. The leadership commitment, workforce development, performance evaluation, data collection, community engagement, and cross-cultural communication domains are • policies that make effective communication a high priority • evaluation of achievement of effective communication goals • practices for assessing each patient's cultural beliefs, barriers to communication, and the like • use of feedback from patients to improve communication • how well organizations track language service usage and satisfaction • performance evaluation system's capacity to assess staff cross-cultural communication skills • whether patients understand documents, educational materials, and surveys • whether patients were asked about their race, ethnicity, and preferred language (patient perspective) • how often staff collect race/ethnicity information from patients (staff perspective) • work with local community and advocacy groups to collect information about new and emerging populations • who (individual or committee) is charged with outreach and maintaining ties to community partners • consumer awareness of who to call with feedback/complaints.

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EXAMPLE METRIC	DESCRIPTION
Cultural Competency Implementation Measure, commitment to serving a diverse population, dedicated staff and resources, strategic planning, reward systems, quality improvement, assessment of patient experiences with care, collection of patient cultural competency–related information, community outreach subdomains	The Cultural Competency Implementation Measure is an organizational survey designed to assist HCOs in identifying the degree to which they are providing culturally competent care and addressing the needs of diverse populations. The Cultural Competency Implementation Measure was designed for use in diverse health care settings. Scores are calculated for 12 subdomains. Several subdomains are relevant to this group of Standards (e.g., commitment to serving a diverse population, dedicated staff and resources, strategic planning, reward systems, quality improvement, assessment of patient experiences with care, collection of patient cultural competency–related information, and community outreach) and include items assessing • the organization's mission, vision, and goals for commitment to cultural competency • documentation of fiscal support for culturally competent policies and practices • involvement of staff and community members in the process of developing and refining goals, plans, and policies for culturally competent services • whether an organizational self-assessment has been completed to inform goals, plans, and policies • identification of performance measures to collect and use to support more culturally competent care • use of surveys to collect information on patient experiences with care • policies and procedures to ensure that race/ethnicity data is not used for discriminatory purposes • development, maintenance, and improvement of processes for integrating patient data into information systems • whether data on community needs have been gathered to inform the development and refinement of goals, plans, and policies • existence of collaborative relationships with community organizations.

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EXAMPLE METRIC	DESCRIPTION
Screening for preferred spoken language for health care measure	The screening for preferred spoken language for health care measure is used to assess the percentage of patient visits and admissions where the preferred spoken language for health care is screened and recorded. It relies on administrative claims, electronic health records, or other records of consumer visits. The measure was designed for use by hospitals and outpatient clinics, but could be applied across health care settings where patient records are kept. This measure is calculated by determining the number of hospital admissions, visits to the emergency department, and outpatient visits where preferred spoken language for health care is screened and recorded and dividing that number by the total number of hospital admissions, visits to the emergency department, and outpatient visits.
Patients receiving language services supported by qualified language services providers measure	This measure is used to assess the percentage of LEP patients receiving both initial assessment and discharge instructions supported by assessed and trained interpreters or from bilingual providers and bilingual workers/employees assessed for language proficiency. It relies on administrative claims, electronic health records, or other records of consumer visits. This measure was designed for use in medical practices and clinics, but questions could be applied to diverse health care and public health settings. This measure is calculated by determining the number of LEP patients with documentation that they received the initial assessment and discharge instructions and were supported by trained and assessed interpreters and dividing that number by the total number of patients that stated a preference to receive their spoken health care in a language other than English.

Chapter 4
Evaluation Resources

Earlier chapters of this toolkit provide helpful tips, insights, and examples related to the design and planning of an evaluation of the National CLAS Standards within a health setting. This chapter is designed to provide a guide to additional setting-specific information and resources that are useful for evaluating the National CLAS Standards. We provide a guide to the setting-specific appendixes which each discuss additional information on the importance of the National CLAS Standards to that setting, as well as information on the development of a setting-specific logic model. In the appendixes, we also provide tables of measures specific to each setting that may be used in an evaluation. We provide the measure name, description of the measure, general area of focus (e.g., health literacy, cultural competency), specific wording of relevant items, and the source and reference of the measure. We also include measures that are considered *cross-cutting*, meaning measures and resources that are broadly applicable to all settings.

Appendix A. Ambulatory care setting
- Logic model and relevance of the National CLAS Standards to ambulatory care
- Measures tables

Appendix B. Behavioral health setting
- Logic model and relevance of the National CLAS Standards to behavioral health
- Measures tables

Appendix C. Hospital setting
- Logic model and relevance of the National CLAS Standards to hospitals
- Measures tables

Appendix D. Public health setting
- Logic model and relevance of the National CLAS Standards to public health
- Measures tables

Appendix E. Cross-cutting measures

Appendix A
Ambulatory Care Setting

Ambulatory (i.e., walk-in) or outpatient care settings are where the vast majority of health care is received in the United States. It is estimated that there are over 928 million outpatient visits to physician offices each year and more than 125 million outpatient visits to hospitals (Centers for Disease Control and Prevention [CDC], 2016b). Ambulatory Care Settings (ACSs) include doctors' offices, outpatient clinics, community clinics, Federally Qualified Health Centers (FQHCs), rehabilitation centers, urgent care, emergency rooms, and ambulatory surgery clinics, among other settings. Depending on the type of ACS, they can range in size from a few clinician providers and support staff serving several hundred patients to several hundred providers and support staff serving tens of thousands of patients. ACSs can be freestanding or part of a larger medical facility, such as a medical center. Each ACS may operate independently with its own management (e.g., an FQHC), as part of a larger organization (e.g., a primary care division within a hospital or a large multispecialty group), or as one of a network of organizations (e.g., a large physician provider group made up of private practices throughout a community, but with shared management services and oversight).

Despite these differences, health care providers and organizational leaders within and across all types of ACSs share challenges and responsibilities with respect to recognizing and ensuring that cultural and linguistic issues are adequately addressed. While cultural and linguistic needs and concerns are often thought of as mainly relevant to community clinics or FQHCs that serve predominantly minority and/or low-income populations, the reality is that with growing numbers of insured individuals and demographic changes in the United States, these issues are becoming increasingly relevant in almost all types of ACSs.

In this report, we focus on ACSs that are sufficient in size and resources to have one or more management staff focused on quality improvement (QI) and/or cultural or language activities,

as in the case of the other types of HCOs discussed. Awareness of cultural and linguistic needs and guidelines is also salient to providers and staff in smaller ACSs (e.g., cultural competence training is still essential for clinicians and staff), but formally implementing all of the National CLAS Standards may not be feasible in these settings. Examples of ACSs where OMH's National CLAS Standards are directly applicable include FQHCs, urgent care centers or outpatient divisions in medical centers, large physician groups (e.g., independent physician associations, independent practice associations), and multispecialty clinics. The National CLAS Standards are also applicable to managed health plans and a variety of different types of emerging managed care organizations, such as accountable care organizations (ACOs).

While leadership and staff in some types of ACSs may have extensive experience and well-established infrastructure to provide culturally and linguistically appropriate services (e.g., FQHCs or some health plans), such resources may be more variable and less developed throughout the HCOs in other types of ACSs. Consequently, in many ACSs, the risk of cultural misunderstandings or language barriers remains high for growing subgroups of patients (Institute of Medicine, 2004). While failure to provide culturally and linguistically appropriate services is likely to result in lower satisfaction for the patient and provider, in many cases and settings, this can have more dire effects. For example, routine miscommunications and cultural misunderstandings in a private, multispecialty clinic between providers and patients with significant cardiac risk factors could potentially reduce the likelihood that patients will properly use or adhere to prescribed medications and thus could increase largely preventable heart attacks or strokes in the patients served.

An additional layer of complexity in the United States with respect to understanding and

addressing the needs of diverse populations served in ambulatory settings relates to the role of managed care plans operated by large health insurers and health reforms intended to promote more value and better outcomes for health care beneficiaries. Managed care plans receive funds from payers (employers, government, and individuals) to help ensure that enrolled members receive quality care at reasonable costs. The managed care plans, in turn, contract with providers and HCOs and pay them a portion of the funds to deliver the actual health care. Increasingly, the focus of payers and, consequently, health insurers, is on value-based payments. Value-based payment systems are intended to reward health care providers and delivery systems that can show higher-quality scores on the measures of care delivered to their patients and on the health outcomes experienced by those patients. (To receive full payments or bonuses, contracted providers and the delivery system also generally need to keep average costs of the care for patients they serve to a relatively low level.)

The growing emphasis on value-based care is increasing the salience of addressing diverse cultural and linguistic needs for ACSs. For example, the fact that payments to providers in ACSs increasingly depend on the outcomes of their patient population is compelling ACS leaders to better understand the populations they serve and address disparities between patient subgroups when found. Providing further motivation for ACS leaders to begin routinely examining whether patterns of care and outcomes significantly differ for patients from racial/ethnic minority groups or non-English speakers, state and possibly federal entities are requiring health insurers (who pay providers) to begin tracking and acting on identified racial/ethnic or linguistic disparities in care and to implement other recommended National CLAS Standards and practices.

LOGIC MODEL FOR IMPLEMENTING THE NATIONAL CLAS STANDARDS WITHIN THE AMBULATORY CARE SETTING

Figure A.1 provides a detailed logic model of the specific inputs, activities, outputs, and outcomes for the implementation of the National CLAS Standards within an ACS. Given the importance of the broader context, external resources, and partnerships in shaping an ACS's readiness for adopting the Standards, we include them in the context, antecedents, and inputs section and note that any changes should be made in partnership with the community and other stakeholders.

CONTEXT, ANTECEDENTS, AND INPUTS

Linkages with the Community and Other Stakeholders

Of all ACSs, FQHCs tend to have more ties to local community partners, such as food pantries, shelters, churches, and hospitals, than other provider groups that tend to care for more private or commercially insured or Medicare patients. As a result, linkages with stakeholders and the broader community vary significantly, depending on the population served and the broader needs of the patient population. However, in a growing number of regions, large clinics and provider groups are beginning to work together through multistakeholder collaboratives and initiatives to improve care and outcomes of certain conditions. For example, as part of a project sponsored by CDC, selected provider groups in southeast San Diego are beginning to work in concert with local faith-based organizations to help reduce cardiac risks among people living in that region ("Be There San Diego," undated). In early 2016, the Centers for Medicare & Medicaid Services (CMS) introduced the Accountable Health Communities Model (AHCM) to tackle the

LOGIC MODEL FOR IMPLEMENTING THE NATIONAL CLAS STANDARDS WITHIN THE AMBULATORY CARE SETTING

high prevalence of unmet health-related social needs that contribute to poor health and to address the current gap between clinical care and community services (CMS, 2016a). In the AHCM, universal, comprehensive screening in the areas of housing instability and housing quality, food insecurity, utility needs, interpersonal violence, and transportation needs will be conducted in the ACSs, and affected individuals will be linked to social services (CMS, 2016a; Alley et al., 2016). Questions about whether and how these models most effectively address health inequities and reduce health disparities will be answered over time, but all point to a need to consider how ambulatory care centers work with their partner and contracted organizations with respect to the National CLAS Standards, because this may influence their overall performance. Such partners should be involved at all steps of the process (e.g., assessment, design, implementation, evaluation).

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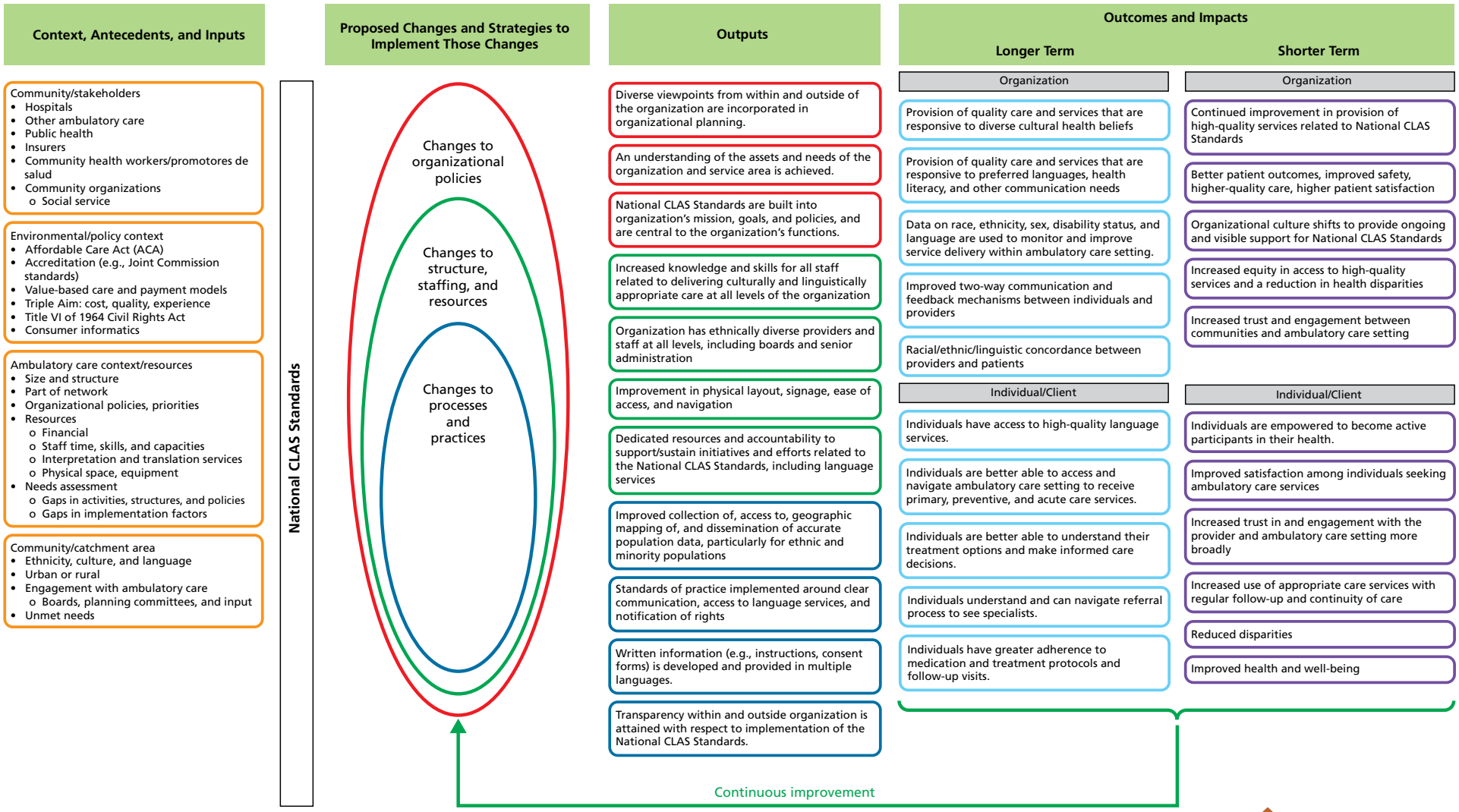
FIGURE A.1. LOGIC MODEL FOR IMPLEMENTATION OF THE NATIONAL CLAS STANDARDS WITHIN THE AMBULATORY CARE SETTING



LOGIC MODEL FOR IMPLEMENTING THE NATIONAL CLAS STANDARDS WITHIN THE AMBULATORY CARE SETTING

Environmental and Policy Context

Implementation of the National CLAS Standards within an organization is affected by a number of factors external to the organization itself. These factors include, for example, the federal, state, tribal, and local regulatory environment; accreditation mandates; policies; and standards of practice. In many cases, these factors influence how care is delivered and monitored and may impact whether and how organizations choose to adopt the Standards.

Health care, especially in ACSs, has been undergoing unprecedented changes during the past decade, and it is likely that some aspects of care in some ACSs will be unrecognizable five years from now. These changes are being driven partly by health care reforms, such as the ACA, as well as by the convergence of other factors, such as breakthroughs in mobile and wireless communications and biomedical advances. While these sorts of changes are manifesting in different ways, some of the most notable shifts relevant to the implementation of the Standards include

- **Increasing emphasis on value-based care.** Requirements have been increasing for reporting ambulatory care quality measures, including process and intermediate outcomes measures, e.g., Health Indicators Warehouse's Healthcare Effectiveness Data and Information Set (HEDIS) (Health Indicators Warehouse, undated) and the Agency for Healthcare Research and Quality's (AHRQ's) Ambulatory Consumer Assessment of Healthcare Providers and Systems (AHRQ, undated). This increase is partly driven by newer financing and care delivery models, which tie payments or other incentives to positive clinical outcomes among the ACS's patient population. Since outcomes tend to be worse in minority and/or lower–socioeconomic status (SES) populations where cultural

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and linguistic needs are thought to play a prominent role, ACS leaders may be motivated to adopt and apply the National CLAS Standards. However, widespread uptake and full implementation of the Standards will likely take time in many ambulatory settings and particularly in smaller sites because of competing demands, bandwidth issues, and a focus primarily on improving quality scores for the overall population.

- **Improving health care and consumer informatics.** Many, although not all, ACSs have undergone a transformation in recent years with respect to improvements in their electronic medical records (EMRs) and in their access to easy-to-use data analytics tools to support QI efforts. At the same time, consumers' access to interactive web tools with provider or regional-level quality report cards has been proliferating (CMS, 2016b). While the norm has been to only show quality scores for the overall patient populations that ambulatory providers serve, expectations for reporting quality scores for major racial/ethnic and linguistic groups (when there are enough patients to ensure confidentiality) will likely increase as race/ethnicity and language data become more readily available in non-FQHC ambulatory sites.
- **Leveraging meaningful use of health information technology (HIT) to reduce health disparities.** The Health Information Technology for Economic and Clinical Health (HITECH) Act was intended to promote the adoption and meaningful use of HIT (HHS, undated[a]). One of the Act's stated goals is to address health disparities. The Electronic Health Record Incentive Program, commonly referred to as "Meaningful Use," provides a relatively untapped opportunity to help ACSs collect more-granular data on patients' race, ethnicity, language, and other relevant characteristics. Given the increasing use of patient portals and other HIT that enables patients to access health information, decision support tools, test results, and correspondence with providers, some are calling for an expansion of Meaningful Use criteria to ensure that such technologies are being developed and implemented with the National CLAS Standards in mind (Consumer Partnership for eHealth, 2013).

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- **Health care reforms and demographic shifts.** As alluded to previously, not only is the overall U.S. population quickly becoming more ethnically, culturally, and linguistically diverse in most geographic regions, but Medicaid expansion and the establishment of commercial insurance health plan exchanges in many states are further changing the typical mix and flow of patients to different types of ACSs.

Finally, there are a number of other influences relevant to the provision of culturally and linguistically appropriate services more broadly. For example, under Title VI of the Civil Rights Act of 1964 (Chen, Youdelman, and Brooks, 2007), organizations receiving federal funds must take reasonable steps to provide meaningful access to their programs for individuals with LEP (U.S. Department of Justice, 2000). Furthermore, several states have recognized the importance of cultural and linguistic competency by legislating competency training in health care (HHS OMH, 2013). Accrediting bodies—such as The Joint Commission and the National Committee for Quality Assurance—have also established accreditation standards that target the improvement of communication, cultural competency, and patient-centered care and the provision of language assistance services (Briefer French et al., 2008; Wilson-Stronks and Galvez, 2007; HHS OMH, 2013).

The above examples of external influences and contexts may impact whether and how an ACS will adopt the National CLAS Standards and how easy or difficult such implementation may be.

Ambulatory Care Context, Resources, Community, and Catchment Area

Inputs and antecedents relevant to implementing the National CLAS Standards can vary considerably depending on the type of ACS (e.g., FQHC, small office, large practice) and on whether the ambulatory care location is part of a larger network. Practice size and group organization

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play an increasingly important role in many ACSs and can be a major factor in the uptake and implementation of the National CLAS Standards. For example, while smaller clinics or provider groups are much less likely to have the capacity or bandwidth to address diverse cultural and linguistic needs, larger clinics and provider groups may have staff members specifically tasked with leading or managing aspects of implementing and assessing the Standards within the clinic or network providers. However, one advantage of smaller clinics is that they may be nimbler and can come to know and respond to their patient population's needs better than some of the bigger, higher-volume clinics. Other inputs and antecedents—such as the ACS's strategic goals, policies, staff, resources, and physical space—may also play a role in the center's ability to adopt and implement the National CLAS Standards. For example, a lack of sufficient space and staff is often cited as a barrier to other types of QI efforts and may affect an organization's ability to implement the Standards.

Also relevant is the organization's capacity to absorb new knowledge and its receptivity for change, which may be driven, for example, by a gap analysis or a needs assessment. This assessment should include activities, structures, or policies that should be in place to support equitable care as well as implementation factors that could aid or hinder the adoption of the National CLAS Standards. The use of gap analyses varies in ACSs, but it generally falls under the rubric of CQI and may be completed as part of ongoing accreditation requirements.

NATIONAL CLAS STANDARDS

In this logic model, the National CLAS Standards are placed between the antecedents and inputs and the activities an organization adopts. Here, the National CLAS Standards are viewed as a

LOGIC MODEL FOR IMPLEMENTING THE NATIONAL CLAS STANDARDS WITHIN THE AMBULATORY CARE SETTING

perspective or lens through which such context and antecedents are interpreted and which help to shape the activities the organization chooses to implement to address gaps in culturally and linguistically appropriate care.

PROPOSED CHANGES AND STRATEGIES DEVELOPED TO IMPLEMENT THOSE CHANGES

Once an organization has decided to address identified gaps with respect to the National CLAS Standards, it must design relevant activities and approaches to close the gaps and develop implementation strategies to enhance the adoption and sustainability of those changes (Powell et al., 2015). Organizations may adopt the Standards altogether or in a staged approach, depending on the antecedents and inputs, the organization's readiness for implementing the National CLAS Standards, and the environmental and policy context. Given the wide range of potential approaches and activities an ACS may choose to develop or adopt, the logic model does not list specific activities; rather, it notes that changes are likely to occur in three nested areas of focus: (1) organizational policies; (2) structure, staffing, and resources; and (3) processes and practices.

Changes to organizational policies include making the National CLAS Standards central to the organization's functions and building them into the organization's mission, goals, and policies. Engaging diverse viewpoints both from inside and outside the ACS into planning is particularly important. Building this orientation to the Standards into the organization's approach is especially important when the ACS seeks to implement the Standards across multiple providers and office locations.

Changes to an ACS's organizational structure, staffing, and resources require that the ACS

LOGIC MODEL FOR IMPLEMENTING THE NATIONAL CLAS STANDARDS WITHIN THE AMBULATORY CARE SETTING

leaders have identified the necessary skill set for their staff to address the diverse cultural and linguistic needs of their patient population and require that they have the capacity to train staff when necessary. The organization should be focused both on diversifying its frontline staff and on having an ethnically diverse staff at all levels, including boards and senior administration. Changes to organizational structure include making improvements in the ease of access to its physical space and to the accessibility of information it provides to consumers through signage. In addition, the ACS should have dedicated resources to support and sustain the implementation of the Standards, including the availability of language services and a process for holding itself accountable for these improvements.

Changes to processes and practices encompass all of the unique functions of ambulatory care, including the provision of health care and services, diagnostic testing, treatment and follow-up, and referral to specialty providers. Changes would also involve a number of other relevant tasks, including health education, obtaining consent, discussing the use or sharing of medical data, and health insurance and billing.

The design and development of activities to address those gaps, and the development of an implementation strategy will benefit from close collaboration with, and input from, the community and other stakeholders that stand to benefit from such changes. Because of the heterogeneity of ACSs, the results of these gap analyses will be very different. Many ACSs, such as FQHCs, are uniquely positioned to draw out these lessons from stakeholders because of their long-standing partnerships, but not all ACSs are. Building a focus on the National CLAS Standards into organizational policy, practice, staffing, and resources is critical to ensuring that every ACS, no matter the context, takes appropriate steps to ensure that its services are accessible to all members of the community.

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OUTPUTS

The activities and changes implemented within the organization should result in immediate outputs that move the organization toward providing culturally and linguistically appropriate care and services. Such outputs may include

- incorporating diverse viewpoints from inside and outside the ACS into planning and implementation of policies, programs, and services, and building the National CLAS Standards into the ACS's mission, goals, and policies
- implementing standards of practice around clear communication, access to language services, and notification of rights
- increasing staff knowledge and skills related to delivering culturally and linguistically appropriate care at all levels of the organization
- incorporating ethnically diverse public health practitioners and staff at all levels of the organization
- improving the physical layout, signage, ease of access, and navigation
- improving the collection of, access to, geographic mapping of, and dissemination of accurate population data, particularly for ethnic and minority populations
- ensuring that resources and accountability to support and sustain initiatives and efforts related to meeting the National CLAS Standards are available.

The specific outputs expected will be determined by which Standards have been adopted, which organizational changes have been made, and by which activities have been implemented as a result.

LOGIC MODEL FOR IMPLEMENTING THE NATIONAL CLAS STANDARDS WITHIN THE AMBULATORY CARE SETTING

OUTCOMES

Collectively and over time, outputs from the ACS may contribute to changes in outcomes for individuals using ambulatory care services, as well as for the ACS organization overall. Examples of potential outcomes are listed below.

- For the organization
  - Short term (1–2 years)
    - > the provision of effective, equitable, understandable, respectful, and quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs
    - > data on race, ethnicity, sex, disability status, and language are used to monitor and improve service delivery within the ACS
    - > improved two-way communication and feedback mechanisms between individuals and providers
    - > enhanced or improved racial/ethnic and linguistic concordance among providers, ambulatory care staff, and patients
  - Longer term (3 or more years)
    - > continued improvement in the provision of high-quality services related to the National CLAS Standards
    - > better patient outcomes, improved safety, higher-quality care, and higher patient satisfaction
    - > organizational culture shifts to provide ongoing and visible support for the

LOGIC MODEL FOR IMPLEMENTING THE NATIONAL CLAS STANDARDS WITHIN THE AMBULATORY CARE SETTING

National CLAS Standards within the ACS

> increased equity in access to high-quality services and a reduction in health disparities

> increased trust and engagement between communities and ACSs.

- For the individuals seeking care
  - Short term (1–2 years)
    > individuals have access to high-quality language services
    > individuals are better able to access and navigate ambulatory care services to receive primary, preventive, and acute care services
    > individuals are better able to understand their treatment options and make informed care decisions
    > individuals understand and can navigate the referral process to see specialists
    > individuals have greater adherence to medication and treatment protocols and follow-up visits
  - Longer term (3 or more years)
    > individuals are empowered to become active participants in their health
    > improved satisfaction among individuals seeking ambulatory care services
    > increased trust in and engagement with the provider and ACS more broadly
    > increased use of appropriate care services with regular follow-up and continuity of care
    > disparities are reduced
    > improved health and well-being.

LOGIC MODEL FOR IMPLEMENTING THE NATIONAL CLAS STANDARDS WITHIN THE AMBULATORY CARE SETTING

QUALITY IMPROVEMENT

The logic model depicts adoption and implementation of the National CLAS Standards as a continual process, requiring a QI loop where outputs and outcomes inform the development of future ACS actions, policies, or programs to better align with the National CLAS Standards. Standard QI efforts, however, are broadly targeted to the general patient population and may maintain or increase health disparities (Green et al., 2010). Culturally competent QI tailors care to address the specific language and culture barriers, which both helps to reduce disparities and can improve care for everyone (Green et al., 2010). It is important that QI improvements be viewed specifically through a culturally competent lens when assessing the impact of the implementation of the National CLAS Standards and informing next steps.

AMBULATORY CARE MEASURES

In developing the process and outcomes/impact measures described in Chapter Seven of the main report (Davis et al., forthcoming), we identified measures relevant to the ambulatory care setting. In Table A.1, we list examples of ambulatory care measures identified along with a brief description, area of focus, source, relevant notes, and the reference for each measure. In addition, we include examples of disparity-sensitive measures that an ambulatory care organization might wish to consider to help it assess how well it is doing in addressing identified disparities in outcomes. Table A.2 provides additional detail for each measure and summarizes the relevant items that compose each measure.

AMBULATORY CARE MEASURES

TABLE A.1. LOGIC MODEL FOR IMPLEMENTATION OF THE NATIONAL CLAS STANDARDS WITHIN THE AMBULATORY CARE SETTING

MEASURE	DESCRIPTION	AREA OF FOCUS	SOURCE ID	NOTES	REFERENCE
CAHPS Cultural Competence Set	CAHPS surveys ask consumers and patients to report on and evaluate their experiences with health care. The CAHPS Cultural Competence Item Set, a supplement to the CAHPS Survey, is designed to capture the patient's perspective on the cultural competence of health care providers. The Cultural Competence Item Set covers the following topics: patient-provider communication; complementary and alternative medicine; experiences of discrimination because of race/ethnicity, insurance, or language; experiences leading to trust or distrust, including level of trust, caring, and truth-telling; and linguistic competency (access to language services). In Weech-Maldonado et al. (2012b), measures are grouped into eight composites: doctor communication (positive behaviors), doctor communication (negative behaviors), trust; access to interpreter services; doctor communication (health promotion); doctor communication (alternative medicine); shared decisionmaking; equitable treatment	Cultural competency	CAHPS Cultural Competence Item Set	See Table C.2 for list of measures.	AHRQ, 2012 Weech-Maldonado et al., 2012b
Clinician and Group Consumer Assessment of Healthcare Provider and Systems (CG-CAHPS)	CAHPS surveys ask consumers and patients to report on and evaluate their experiences with health care. The CG-CAHPS assesses patients' experiences with health care providers and staff in doctors' offices. The CG-CAHPS produces the following measures of patient experience: getting timely appointments, care, and information; how well providers communicate with patients; providers' use of information to coordinate patient care; helpful, courteous, and respectful office staff; and patients' rating of the provider.	Patient experience	CG-CAHPS	See Table C.2 for list of measures.	AHRQ, 2013b

AMBULATORY CARE MEASURES

MEASURE	DESCRIPTION	AREA OF FOCUS	SOURCE ID	NOTES	REFERENCE
Disparity-sensitive measures or CLAS-salient measures					
Controlling high blood pressure	The percentage of patients ages 18 to 85 who had a diagnosis of hypertension (HTN) and whose blood pressure (BP) was adequately controlled (< 140/90) during the measurement year.	Prevention and treatment, effective clinical care	National Quality Forum (NQF) #18 (measure steward: NCQA)	BP < 150/90 in patients ages 60 and older without diabetes considered controlled in HEDIS This is a disparity-sensitive measure.	NQF, undated (search: "18") NQF, 2012g
Diabetes: hemoglobin A1c poor control	The percentage of patients ages 18 to 75 with diabetes (type 1 and type 2) whose most recent HbA1c level during the measurement year was greater than 9.0% (poor control) or was missing a result, or if an HbA1c test was not done during the measurement year.	Effective communication and care coordination	NQF #59, #575 (measure steward: NCQA)	HbA1c < 8% also valid measure given improvements in control This is a disparity-sensitive measure.	NQF, undated (search: "59" or "575") NQF, 2012g

AMBULATORY CARE MEASURES

MEASURE	DESCRIPTION	AREA OF FOCUS	SOURCE ID	NOTES	REFERENCE
Uncontrolled diabetes admission rate	Admissions for a principal diagnosis of diabetes without mention of short-term (ketoacidosis, hyperosmolarity, or coma) or long-term (renal, eye, neurological, circulatory, or other unspecified) complications per 100,000 people ages 18 and older. Excludes obstetric admissions and transfers from other institutions.	Patient safety, primary prevention	NQF #638 (measure steward: AHRQ)	This is a disparity-sensitive measure.	NQF, undated (search: "638") NQF, 2012g
Diabetes short-term complications admission rate	Admissions for a principal diagnosis of diabetes with short-term complications (ketoacidosis, hyperosmolarity, or coma) per 100,000 people ages 18 and older. Excludes obstetric admissions and transfers from other institutions.	Patient safety, primary prevention	NQF #272 (measure steward: AHRQ)	This is a disparity-sensitive measure.	NQF, undated (search: "272") NQF, 2012g

AMBULATORY CARE MEASURES

TABLE A.2. AMBULATORY CARE MEASURES: ADDITIONAL DETAILS

MEASURE	ITEMS
CAHPS Cultural Competence Set	CAHPS surveys ask consumers and patients to report on and evaluate their experiences with health care. The CAHPS Cultural Competence Item Set, a supplement to the CAHPS Survey, is designed to capture the patient's perspective on the cultural competence of health care providers. The Cultural Competence Item Set covers the following topics: patient-provider communication; complementary and alternative medicine; experiences of discrimination because of race/ethnicity, insurance, or language; experiences leading to trust or distrust, including level of trust, caring, and truth-telling; linguistic competency (access to language services). In Weech-Maldonado et al. (2012b), measures are grouped into eight composites: doctor communication (positive behaviors); doctor communication (negative behaviors); trust; access to interpreter services; doctor communication (health promotion); doctor communication (alternative medicine); shared decisionmaking; equitable treatment.
Doctor communication (positive behaviors)	In the last 12 months, how often did this doctor explain things in a way that was easy to understand? In the last 12 months, how often did this doctor listen carefully to you? In the last 12 months, how often did this doctor spend enough time with you? In the last 12 months, how often did this doctor show respect for what you had to say? In the last 12 months, how often did this doctor give you easy-to-understand instructions about taking care of these health problems or concerns?
Doctor communication (negative behaviors)	In the last 12 months, how often did this doctor interrupt you when you were talking? In the last 12 months, how often did this doctor speak too fast when talking with you? In the last 12 months, did this doctor ever use a condescending, sarcastic, or rude tone or manner with you?
Trust	Do you feel you can tell this doctor anything, even things that you might not tell anyone else? Do you trust this doctor with your medical care? Do you feel this doctor always tells you the truth about your health, even if there is bad news? Do you feel this doctor cares as much as you do about your health? In the last 12 months, how often did you feel this doctor really cared about you as a person?

AMBULATORY CARE MEASURES

MEASURE	ITEMS
Access to interpreter services	In the last 12 months, did you use friends or family members as interpreters because there was no other interpreter available at this doctor's office? In the last 12 months, how often did your visit with this doctor start late because you had to wait for an interpreter? Do not include friends or family members. In the last 12 months, was there any time when you needed an interpreter and did not get one at this doctor's office? Do not include friends or family members.
Doctor communication (health promotion)	In the last 12 months, did you and this doctor talk about a healthy diet and healthy eating habits? In the last 12 months, did you and this doctor talk about the exercise or physical activity you get? In the last 12 months, did you and this doctor talk about things in your life that worry you or cause you stress? In the last 12 months, did this doctor ever ask you whether there was a period of time when you felt sad, empty, or depressed?
Doctor communication (alternative medicine)	In the last 12 months, has this doctor ever asked you whether you have used these other people to help with an illness or to stay healthy (e.g., acupuncturist or herbalist)? In the last 12 months, has this doctor ever asked you whether you used natural herbs?
Shared decisionmaking	In the last 12 months, did this doctor talk with you about the pros and cons of each choice for your treatment or health care? In the last 12 months, when there was more than one choice for your treatment or health care, did this doctor ask which choice you thought was best for you?
Equitable treatment	In the last 12 months, how often have you been treated unfairly at this doctor's office because of your race or ethnicity? In the last 12 months, how often have you been treated unfairly at this doctor's office because of the type of health insurance you have or because you do not have health insurance?

AMBULATORY CARE MEASURES

MEASURE	ITEMS
CG-CAHPS	CAHPS surveys ask consumers and patients to report on and evaluate their experiences with health care. The CG-CAHPS Survey assesses patients' experiences with health care providers and staff in doctors' offices. The CG-CAHPS Survey produces the following measures of patient experience: getting timely appointments, care, and information; how well providers communicate with patients; providers' use of information to coordinate patient care; helpful, courteous, and respectful office staff; and patients' rating of the provider.
Getting timely appointments, care, and information	Patient got an appointment for urgent care as soon as needed Patient got an appointment for nonurgent care as soon as needed Patient got an answer to medical question the same day he or she contacted provider's office
Providers' use of information to coordinate patient care	Provider knew important information about the patient's medical history Someone from the provider's office followed up with the patient to give results of blood test, X-ray, or other test Someone from the provider's office talked about all prescription medications being taken

Appendix B
Behavioral Health Setting

Behavioral health refers to mental and emotional well-being and/or actions that affect wellness. It includes mental and substance use disorders. Services for behavioral health are somewhat unique in that they can be provided in a range of health care settings, including inpatient psychiatric hospitals, psychiatric units of general acute care hospitals, inpatient residential treatment facilities, day treatment programs, individual provider or group behavioral health practices, community mental health centers, and rehabilitation programs. Increasingly, behavioral health services are also being provided in the general medical and primary care sector, such as outpatient or ambulatory care clinics, physician offices, or community health centers (HHS, 2001).[1]

In addition, behavioral health care can be provided by a diverse set of providers, including specialty providers (e.g., psychiatrists, psychologists, psychiatric nurses) and licensed clinical therapists, social workers, counselors, and nurses who have received specialized training in treating behavioral health concerns. Providers with training in general health care, such as internists, family practitioners, pediatricians, physician assistants, and nurse practitioners, may also provide mental health and substance abuse services as part of routine care. Although behavioral health services are increasingly provided in ACSs, the logic model described in this chapter focuses specifically on those settings that provide specialty care for behavioral health. In 2010, there were 10,374 specialty mental health treatment facilities and 13,339 specialty substance abuse treatment facilities in the United States.

[1] The human services sector (e.g., social welfare, including housing, transportation, and employment; criminal justice; educational, religious, and charitable services) also delivers mental health services in a range of settings, including in the home, community, and institutions. There is also the voluntary support network largely found in the community, which includes self-help groups and organizations devoted to education, communication, and support (Substance Abuse and Mental Health Services Administration [SAMHSA], 2012).

In the United States, mental and substance use disorders are among the top conditions that cause disability and carry a high burden of disease. According to SAMHSA, by 2020, mental and substance use disorders will surpass all physical diseases as a major cause of disability (SAMHSA, 2016b). In 2014, an estimated 9.8 million U.S. adults (ages 18 and older) had a serious mental illness, with 15.7 million adults and 2.8 million youth (ages 12 to 17) having had a major depressive episode during the past year (SAMHSA, 2012). In addition, an estimated 22.5 million Americans ages 12 years and older self-reported needing treatment for alcohol or illicit drug use, and 11.8 million adults self-reported needing mental health treatment or counseling in the past year (SAMHSA, 2016b). Despite this high prevalence, nearly 60 percent of adults with a mental illness and 90 percent of people with a substance use disorder do not receive the care they need (National Alliance on Mental Illness, undated; Sebelius, 2013).

In the United States, minority and low-income groups, as well as those living in rural areas, are more likely to have unmet behavioral health needs (National Institute of Mental Health [NIMH], undated; AHRQ, 2013a). Studies have shown, for example, that members of racial and ethnic minority groups are less likely to have access to mental health services (Wang et al., 2005) and less likely to seek or use community mental health services, compared with the general U.S. population (Samnaliev, McGovern, and Clark, 2009; Mulia, Tam, and Schmidt, 2014; Alegria et al., 2008). Minorities who do seek services for behavioral health conditions are more likely to receive lower-quality care (e.g., misdiagnoses [Alegria et al., 2008]) and are less likely to adhere to treatment plans (HHS, 2001). Although changes in how and where behavioral health care is delivered (e.g., primary care, telemedicine) and in who is delivering it may help address some of the current disparities in behavioral health care, significant work remains; this concern prompted

NIMH to include mental health disparities as a cross-cutting research theme in its 2015 Strategic Plan for Research.

Addressing disparities in behavioral health can be particularly challenging given the stigma surrounding it, as well as personal or cultural beliefs around the causes and treatment of mental health concerns. Communicating behavioral health symptoms, including thoughts and feelings, can also be challenging, particularly if there are cultural differences or language barriers between individuals and providers. Improving culturally and linguistically appropriate services within behavioral health settings may help reduce health inequities by improving the likelihood of help-seeking behaviors, improving perceptions about the value of behavioral health services and the likelihood of receiving high-quality care, improving communication and adherence to treatment protocols, and increasing patient satisfaction (Barksdale et al., 2012).

LOGIC MODEL FOR IMPLEMENTATION OF THE NATIONAL CLAS STANDARDS WITHIN THE BEHAVIORAL HEALTH SETTING

Figure B.1 provides a detailed logic model of the specific inputs, activities, outputs, and outcomes for the implementation of the National CLAS Standards within the behavioral health setting. Given the importance of the broader context, external resources, and partnerships in shaping a behavioral health provider's readiness for adopting the National CLAS Standards, we include these items in the context, antecedents, and inputs section. Any changes should be made in partnership with the community and other stakeholders.

CONTEXT, ANTECEDENTS, AND INPUTS

Linkages with the Community and Other Stakeholders

As shown in Figure B.1, linkages with the community and other stakeholders who can inform, support, and partner with the behavioral health organization at all stages in the process of adopting the National CLAS Standards (e.g., assessment, design, implementation, evaluation) are essential. In addition to engaging with other care settings that provide behavioral health (e.g., ACSs, hospitals), other community sectors and settings provide services and supports that can supplement behavioral health services. For example, social welfare systems (e.g., housing, transportation, employment) and the criminal and juvenile justice systems help individuals connect to care. They may be particularly important partners because they also serve individuals who may be more likely to have unmet behavioral health needs. Schools may be another important community stakeholder and partner, particularly for reaching children and families. Charitable and faith-based organizations, voluntary support networks (e.g., self-help groups), and advocacy

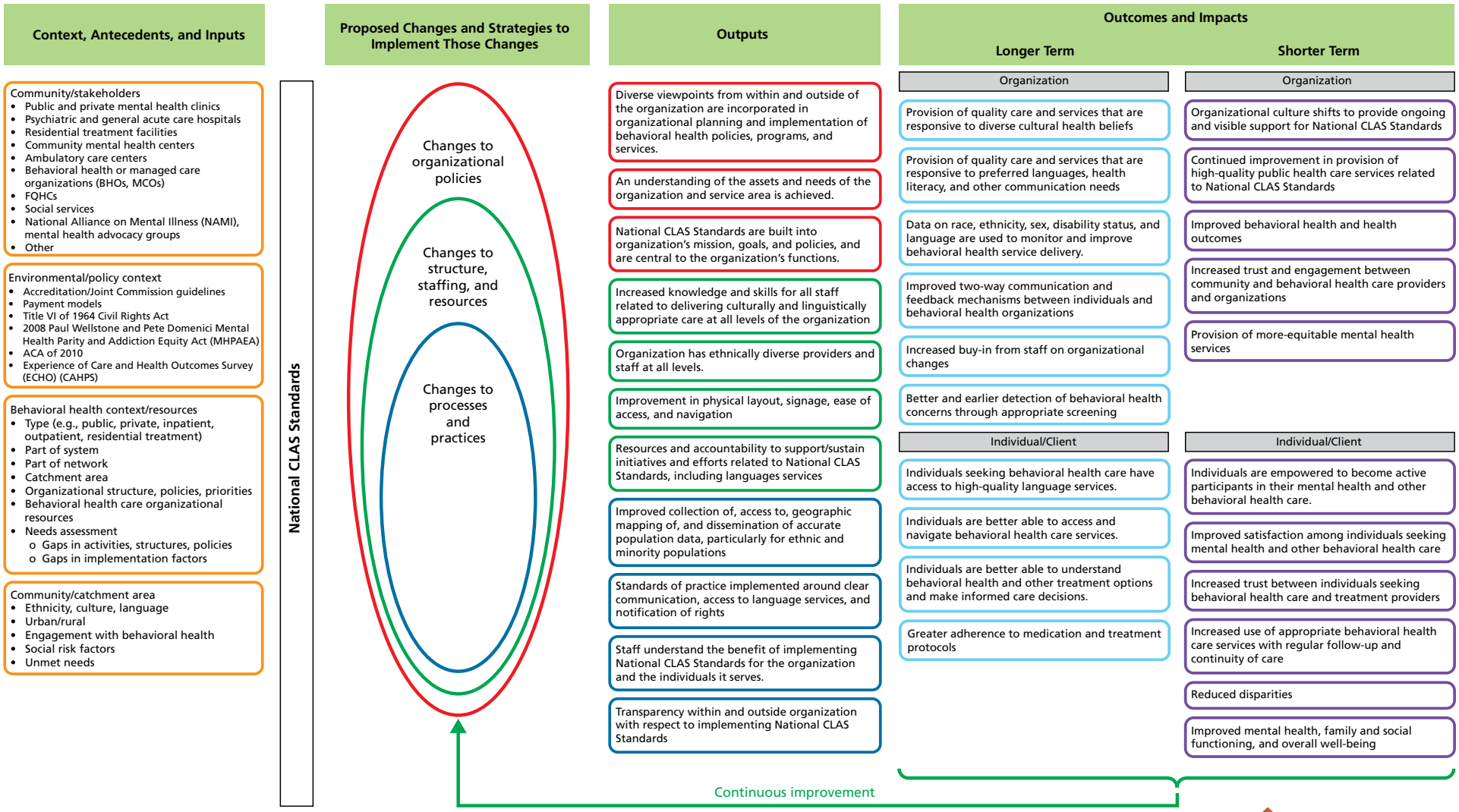
LOGIC MODEL FOR IMPLEMENTATION OF THE NATIONAL CLAS STANDARDS WITHIN THE BEHAVIORAL HEALTH SETTING

groups are also important stakeholders because they are often trusted organizations that are well-integrated into the community and may offer education, communication assistance, and support (SAMHSA, 2012). Given this diversity, behavioral health organizations should consider how they work with their partners, with community organizations, and with contracted organizations: doing so may influence their overall performance with respect to implementing the National CLAS Standards.

Payers are another example of key stakeholders for behavioral health settings. Publicly funded sources—Medicare, Medicaid, State Children's Health Insurance Program (SCHIP), and other federal and state mental health authorities—are the predominant payers of behavioral health services in the United States. Together, these payers contributed more than $75.4 billion in 2003, or about 62 percent of total behavioral health spending. At 26 percent, Medicaid represented the largest payer of behavioral health services (Medicaid and CHIP Payment and Access Commission [MACPAC], 2015). Of the public payers, states pay for behavioral health services through state appropriations for non-Medicaid services, block grant spending, and the state's match for Medicaid and SCHIP programs. For fiscal year 2003, the states' share of total behavioral health spending was $42.3 billion, or 35 percent of total spending among all payers, while private insurance represented 21.8 percent of behavioral health expenditures (Schwalbe, 2010).

LOGIC MODEL FOR IMPLEMENTATION OF THE NATIONAL CLAS STANDARDS WITHIN THE BEHAVIORAL HEALTH SETTING

FIGURE B.1. IMPLEMENTATION OF THE NATIONAL CLAS STANDARDS WITHIN THE BEHAVIORAL HEALTH SETTING



LOGIC MODEL FOR IMPLEMENTATION OF THE NATIONAL CLAS STANDARDS WITHIN THE BEHAVIORAL HEALTH SETTING

Environmental and Policy Context

Implementation of the National CLAS Standards within a behavioral health organization is affected by a number of factors external to the organization itself. These factors include, for example, the federal, state, and local regulatory environment; accreditation mandates; policies; and standards of practice. In many cases, these factors influence how care is delivered and monitored and may affect whether and how organizations may choose to adopt the Standards.

In 1996, Congress enacted the Mental Health Parity Act (MHPA), which required parity in aggregate lifetime and annual dollar limits for mental health benefits and medical/surgical benefits. The MHPAEA (or the federal parity law) generally prevents group health plans and health insurance issuers that provide mental health or substance use disorder benefits from imposing less-favorable benefit limitations on those benefits than on medical/surgical benefits. The changes made by MHPAEA consisted of new standards, including parity for coverage of substance use disorder benefits and amendments to the existing mental health parity provisions enacted in MHPA.[2]

[2] CMS's mental health and substance use disorder parity final rule for Medicaid and the Children's Health Insurance Program (CHIP) applies certain provisions of the MHPAEA to requirements for Medicaid managed care organizations, Medicaid alternative benefit plans, and CHIP. Specifically, the final rule requires that all beneficiaries who receive services through managed care organizations, alternative benefit plans, or CHIP be provided access to mental health and substance use disorder benefits that comply with parity standards, regardless of whether these services are provided through the managed care organization or another service delivery system. States are required to include contract provisions requiring compliance with parity standards in all applicable contracts for these Medicaid managed care arrangements that provide services to enrollees in managed care organizations, including prepaid inpatient health plans or prepaid ambulatory health plans.

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Of particular importance is the ACA, which represented a significant expansion of mental health and substance use disorder coverage. The ACA amended the MHPAEA—which originally applied to group health plans and group health insurance coverage—so that it also applied to individual health insurance coverage. Additionally, beginning in 2014, the ACA required nongrandfathered individual and small-group plans (including those in the state and federal marketplace) to provide coverage for mental health and substance use disorder services as one of ten essential health benefit categories and to cover them at parity with medical and surgical benefits. It is estimated that through the ACA, 32.1 million Americans will gain access to coverage that includes mental health and/or substance use disorder benefits that comply with federal parity requirements and that an additional 30.4 million Americans who currently have some mental health and substance use disorder benefits will benefit from the federal parity protections (Beronio et al., 2013). HHS has jurisdiction over public-sector group health plans (referred to as "non-Federal governmental plans"), while the U.S. Departments of Labor and the Treasury have jurisdiction over private group health plans.

There are also various existing cultural competency guidelines that have been developed for the behavioral health sector, two of which we highlight here. First, the American Psychological Association's *Guidelines on Multicultural Education, Training, Research, Practice, and Organizational Change for Psychologists* provides the rationale and the background information that supports the Association's six guidelines, as well as resources to enhance education, training, research, practice, and organizational change methodologies (American Psychological Association, 2002). Of particular relevance are Guideline 5, which addresses applying culturally appropriate skills in clinical and other applied psychological practices, and Guideline 6, which

LOGIC MODEL FOR IMPLEMENTATION OF THE NATIONAL CLAS STANDARDS WITHIN THE BEHAVIORAL HEALTH SETTING

encourages psychologists to use organizational change processes to support culturally informed organizational policies and practices. SAMHSA (2015) also provides guidance on applying cultural competence in each step of its *Strategic Prevention Framework*.[3] These guidelines are similar to the National CLAS Standards in their fundamental principles; however, the Standards outline specific action steps that health organizations or HCOs, including behavioral health care organizations, can undertake to implement culturally and linguistically appropriate services. The National CLAS Standards are intended to help organizations operationalize cultural and linguistic competency principles and implement them in their overall organizational culture (Barksdale et al., 2012).

These examples of external influences and contexts may impact whether and how behavioral health settings will adopt the National CLAS Standards and how easy or difficult such implementation may be.

Context, resources, community, and catchment area inputs and antecedents relevant to implementation of the National CLAS Standards for behavioral health organizations include the organization's strategic goals, policies, staff, resources, and physical environment. They can vary considerably depending on the type of behavioral health setting (e.g., public, for-profit, nonprofit) and on whether the behavioral health organization is part of a system or network (e.g., behavioral health managed care network). Inputs and antecedents may also be driven by the catchment area of the facility and whether that facility serves a geographic area or a specific population (e.g., low-income populations, racially/ethnically diverse populations) or is focused on mental health treatment services, substance abuse treatment services, or both. Other factors influencing the

[3] SAMHSA's framework draws on the National Center for Cultural Competence at Georgetown University's Center for Child and Human Development's 2005 guidance, which outlines the characteristics of culturally competent organizations and describes the six stages of Infusing Cultural and Linguistic Competence in Health Promotion Training (National Center for Cultural Competence, undated).

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organization's inputs and antecedents include internal and external factors. Internal factors—such as the proportion of patients with Medicare, Medicaid, or private insurance as well as the uninsured—can affect resource availability. External factors, such as competition, can provide an impetus for cultural competency activities as behavioral health organizations strive to increase or maintain their market share in an increasingly diverse population.

Also relevant is the organization's capacity to absorb new knowledge and its receptivity for change, which may be driven by a gap analysis or a needs assessment. This analysis should include both an assessment of activities, structures, or policies that should be in place to support equitable care, as well as implementation factors that could aid or hinder the adoption of the National CLAS Standards. A behavioral health needs assessment may also identify gaps in a community's mental health and substance use services system for non-English speakers, helping to inform the prioritization of strategies and activities to address needs in the community.

NATIONAL CLAS STANDARDS

In this logic model, the National CLAS Standards are placed between the antecedents and inputs and the activities an organization adopts. Here, the National CLAS Standards are viewed as a perspective or lens through which such context and antecedents are interpreted and help to shape the activities the organization chooses to implement to address gaps in culturally and linguistically appropriate care.

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PROPOSED CHANGES AND STRATEGIES DEVELOPED TO IMPLEMENT THOSE CHANGES

Behavioral health organizations may adopt the National CLAS Standards altogether or in a staged approach, depending on the antecedents and inputs, readiness for implementation, available resources, and the environmental and policy context. Given the wide range of potential approaches and activities behavioral health organizations may choose to develop or adopt, the logic model does not list specific activities; rather, it notes that changes are likely to occur in three nested areas of focus: (1) organizational policies; (2) structure, staffing, and resources; and (3) processes and practices. The identification of organizational gaps and priorities and the design, development, and implementation of activities to address those gaps are expected to be undertaken with input from the community and other stakeholders that stand to benefit from such changes.

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OUTPUTS

The activities and changes implemented within the organization should result in immediate outputs that move the organization closer to providing culturally and linguistically appropriate care and services. Such outputs may include the following:

- incorporating diverse viewpoints from inside and outside the behavioral health organization into the planning and implementation of policies, programs, and services
- building the National CLAS Standards into the organization's mission, goals, and policies and making them central to its functions
- implementing standards of practice around clear communication, access to language services, and notification of rights
- increasing staff knowledge and skills related to delivering culturally and linguistically appropriate care at all levels of the organization
- incorporating ethnically diverse practitioners and staff at all levels of the behavioral health organization
- improving the physical layout, signage, ease of access, and navigation
- improving the collection of, access to, geographic mapping of, and dissemination of accurate population data, particularly for ethnic and minority populations
- ensuring that resources and accountability to support and sustain initiatives and efforts related to the National CLAS Standards are available.

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The specific outputs expected will be determined by which of the National CLAS Standards have been adopted, by which organizational changes have been made, and by which activities have been implemented as a result.

OUTCOMES

Collectively and over time, outputs from behavioral health organizations may contribute to changes in outcomes for both individuals using these services and for the organization overall. Examples of potential outcomes within the behavioral health setting are listed below.

- For the organization
  - Short term (1–2 years)
    - > the provision of effective, equitable, understandable, respectful, and quality care and behavioral health services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs
    - > the use of data on race, ethnicity, sex, sexual orientation, disability status, and language to monitor and improve behavioral health service delivery
    - > racial/ethnic and linguistic concordance between behavioral health service providers and individuals seeking mental health and/or substance use treatment services
    - > improved two-way communication and feedback mechanisms between individuals and behavioral health organizations

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> increased buy-in from staff on organizational changes made to implement the National CLAS Standards.

– Longer term (3 or more years)

> organizational culture shifts to provide ongoing and visible support for the National CLAS Standards within behavioral health care organizations

> continued improvement in the provision of high-quality behavioral health care services related to the Standards

> improved behavioral health and health outcomes

> increased equity in access to high-quality behavioral health services and a reduction in health disparities

> increased trust and engagement between the community and behavioral health care providers and organizations.

- For the individuals seeking care

  – Short term (1–2 years)

  > individuals seeking specialty behavioral health care have access to high-quality language services

  > individuals are better able to access and navigate specialty behavioral health care services

  > individuals are better able to understand mental health and other treatment options and make informed behavioral health care decisions

  > greater adherence to medication and treatment protocols.

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– Longer term (3 or more years)

> individuals are empowered to become active participants in their behavioral health care

> improved satisfaction among individuals seeking mental health and other behavioral health care

> increased trust between individuals seeking behavioral health care and providers and between the community and behavioral health care organizations

> increased use of appropriate behavioral health care services with regular follow-up and continuity of care

> improved behavioral health, family and social functioning, and overall well-being.

QUALITY IMPROVEMENT

The logic model also depicts the adoption and implementation of the National CLAS Standards as a continual process, requiring a QI loop. For example, behavioral health organizations can assess their performance by applying for Behavioral Health Accreditation (The Joint Commission, 2007), psychologists can assess how well they are following the APA Guidelines, and consumers can provide feedback on their experiences with behavioral health treatment using the ECHO survey.[4] All of these tools may be helpful to assess the success and effectiveness of the implementation of the National CLAS Standards.

[4] Similar to the CAHPS Survey that asks consumers and patients to report on and evaluate their experiences with health care, the ECHO survey asks for consumers' assessments about their behavioral health treatment, including mental health and chemical dependency services. The ECHO survey asks health plan enrollees about their experiences with behavioral health care and services provided by either managed behavioral health care organizations (MBHOs) or managed care organizations. It is designed for use by consumers, clinicians, MBHOs, health care plans, purchasers, states, and federal agencies. The ECHO survey's contents were largely derived from two preexisting instruments for behavioral health care quality assessment: the Mental Health Statistics Improvement Program, and the Consumer Assessment of Behavioral Health Services surveys (AHRQ, 2016).

BEHAVIORAL HEALTH MEASURES

TABLE B.1. BEHAVIORAL HEALTH MEASURES

MEASURE	DESCRIPTION	AREA OF FOCUS	SOURCE ID	NOTES	REFERENCE
ECHO survey	The ECHO survey asks about the experiences of adults and children who have received mental health or substance abuse services through a health plan in the previous 12 months. It is appropriate for patients with a range of service needs, including those with severe mental illness, but does not include questions about inpatient stays or self-help groups. The survey can be used for two types of organizations that are responsible for delivering behavioral health services: MCOs and MBHOs.	Patient experience	ECHO	See Table E.2 for list of measures.	AHRQ, 2016
Disparity-sensitive measures or CLAS-salient measures					
Alcohol screening and follow-up for people with serious mental illness	The percentage of patients ages 18 and older with a serious mental illness who were screened for unhealthy alcohol use and received brief counseling or other follow-up care if identified as an unhealthy alcohol user	Primary prevention	NQF #2599 (measure steward: NCQA)	This is a disparity-sensitive measure.	NQF, undated (search: "2599")
Initiation and engagement of alcohol and other drug dependence treatment	Percentage of patients ages 13 and older with a new episode of alcohol and other drug (AOD) dependence who received the following. Two rates are reported: 1. percentage of patients who initiated treatment within 14 days of the diagnosis 2. percentage of patients who initiated treatment and who had two or more additional services with an AOD diagnosis within 30 days of the initiation visit.	Effective communication and Care coordination	NQF #4 (measure steward: NCQA)	This is a disparity-sensitive measure.	NQF, undated (search: "4") NQF, 2008

BEHAVIORAL HEALTH MEASURES

MEASURE	DESCRIPTION	AREA OF FOCUS	SOURCE ID	NOTES	REFERENCE
Antidepressant medication management (AMM)	The percentage of patients ages 18 and older with a diagnosis of major depression and were newly treated with antidepressant medication and who remained on an antidepressant medication treatment. Two rates are reported: 1. effective acute phase treatment: the percentage of newly diagnosed and treated patients who remained on an antidepressant medication for at least 84 days (12 weeks) 2. effective continuation phase treatment: the percentage of newly diagnosed and treated patients who remained on an antidepressant medication for at least 180 days (6 months).	Effective communication and care coordination	NQF #105 (measure steward: NCQA)	This is a disparity-sensitive measure.	NQF, undated (search: "105") NQF, 2008
30-day all-cause unplanned readmission following psychiatric hospitalization in an inpatient psychiatric facility (IPF)	This facility-level measure estimates an all-cause, unplanned, 30-day risk-standardized readmission rate (RSRR) for adult Medicare Fee-for-Service (FFS) patients with a principal discharge diagnosis of a psychiatric disorder or dementia/Alzheimer's disease.	Effective communication and care coordination	NQF #2860 (measure steward: CMS)		NQF, undated (search: "2860") SAMHSA, 2014b

BEHAVIORAL HEALTH MEASURES

TABLE B.2. BEHAVIORAL HEALTH MEASURES: ADDITIONAL DETAIL

MEASURE	ITEMS
ECHO survey	The ECHO survey asks about the experiences of adults and children who have received mental health or substance abuse services through a health plan in the previous 12 months. It is appropriate for patients with a range of service needs, including those with severe mental illness, but does not include questions about inpatient stays or self-help groups. The survey can be used for two types of organizations that are responsible for delivering behavioral health services: MCOs and MBHOs.
Getting treatment quickly (composite)	Q3: Get help by telephone Q5: Get urgent treatment as soon as needed Q7: Get appointment as soon as wanted
How well clinicians communicate (composite)	Q11: Clinicians listen carefully Q12: Clinicians explain things Q13: Clinicians show respect Q14: Clinicians spend enough time Q15: Feel safe with clinicians Q18: Involved as much as you wanted in treatment
Getting treatment and information from the plan or MBHO (composite)	Q43: (MCO only) Getting clinician happy with Q39: (MBHO)/Q45 (MCO) Delays in treatment while waiting for plan approval Q46: (MCO only) Problem getting necessary treatment Q48: (MCO only) Understanding information about treatment in written materials or on the Internet Q41: (MBHO)/Q50 (MCO) Helpfulness of customer service Q52: (MCO only) Filling out paperwork
Perceived improvement (composite)	Q31: Compare ability to deal with daily problems to one year ago Q32: Compare ability to deal with social situations to one year ago Q33: Compare ability to accomplish things to one year ago Q34: Compare ability to deal with symptoms or problems to one year ago

BEHAVIORAL HEALTH MEASURES

MEASURE	ITEMS
Information about treatment options (composite)	Q20: Told about self-help or consumer-run programs Q21: Told about different treatments that are available for condition
Rating of counseling and treatment	Q28: Overall rating of counseling and treatment
Rating of health plan (MCO only)	Q53: (MCO only) Overall rating of health plan
Office wait	Q10: Seen within 15 minutes of appointment time
Told about medication side effects	Q17: Told about side effects of medication
Including family and friends	Q19: Talk about including family and friends in treatment
Information to manage condition	Q22: Given as much information as wanted to manage condition
Patient rights information	Q23: Given information about rights as a patient
Patient feels he or she could refuse treatment	Q24: Patient feels that he or she could refuse a specific type of treatment

BEHAVIORAL HEALTH MEASURES

MEASURE	ITEMS
Privacy	Q25: Confident about privacy of treatment information
Cultural competency	Q27: Care responsive to cultural needs
Amount helped	Q29: Amount helped by treatment
Treatment after benefits are used up	Q37: (MBHO)/Q41 (MCO) Plan provides information about how to get treatment after benefits are used up

Appendix C
Hospital Setting

There are more than 5,500 registered hospitals in the United States, the majority of which are community hospitals. These consist of nonprofit, for-profit, or state and local government community hospitals (American Hospital Association [AHA], 2016). Other hospital types include federal government hospitals, psychiatric hospitals, and long-term care hospitals. In 2011, hospitals collectively conducted more than 125.7 million outpatient visits (CDC, National Center for Health Statistics [NCHS], 2016) and were responsible for about 35 million hospital discharges from inpatient care (CDC NCHS, 2016). While hospitals have traditionally focused on meeting the clinical needs of their patients through patient safety and high-quality care (The Joint Commission, 2010), such patient characteristics as language, culture, and other nonclinical needs can affect how individuals approach and participate in health care while in the hospital and during critical periods of transition, such as discharge.

Hospitals across the United States are increasingly serving diverse patient populations; some may have LEP or non-English proficiency. Findings from a national survey of hospitals revealed that 63 percent of hospitals reported encountering patients with LEP on a daily or weekly basis (Hasnain-Wynia et al., 2006). A 2009 survey of hospitals indicated that while 92 percent provided language services, about one-quarter used only one modality for providing such services. The most commonly used services are either over-the-phone interpreting services or the use of hospitals' own bilingual staff as interpreters. Often, these bilingual staff have not been assessed for their linguistic proficiency nor trained on interpreting skills. In addition to the limitations in interpreting services, only 55 percent of respondents indicated that their hospital provided translation services of written documents (CyraCom, 2010). Similarly, a 2012 national survey by the AHA and the Institute for Diversity in Health Management (IFD) indicated that hospitals' attention to diversity management and cultural competence practices are somewhat limited. While 77 percent of responding hospitals

collected patient demographic data, only 18 percent used these data to benchmark gaps in care. Fewer than half provided comprehensive cultural competence training (AHA and IFD, 2012). Providing culturally and linguistically competent care is crucial to ensuring a satisfactory patient experience, effective communication between patients and providers, and positive treatment outcomes (Gertner et al., 2010). If culturally and linguistically appropriate services are not provided in hospitals, patients may not be able to communicate effectively with their providers or adhere to care plans, hospitals will continue to put themselves and their patients at risk for negative consequences, and racial and ethnic disparities in health care may continue to increase (Wilson-Stronks and Galvez, 2007; The Joint Commission, 2010). Furthermore, given the increased emphasis on value-based care in our reimbursement system and paying for quality, hospitals that are not responsive to the cultural and linguistic needs of the patient population may see a negative impact on their financial performance.

One example of how providing culturally and linguistically appropriate care can improve quality while financially benefiting the hospital relates to readmissions. Hospitals are now being penalized for excess readmissions for several acute conditions, such as acute myocardial infarction (AMI), health failure, and pneumonia. Betancourt, Tan-McGrory, and Kenst (2015) have outlined several issues related to cultural and linguistic competence that may play a key role in driving higher readmission rates among diverse patient populations. For instance, having LEP is associated with lower rates of follow-up, use of preventive services, adherence to medications, and comprehension of discharge instructions and diagnosis, which may be tied to readmissions (Rodriguez et al., 2011; Karliner et al., 2012). Health literacy–related issues—including limited knowledge of conditions, poor medication management and self-care, and

lack of adherence to treatment plans—may also influence readmission rates among minorities (Berkman et al., 2011; Evangelista et al., 2010; Mitchell et al., 2012). Additionally, cultural factors may contribute to readmissions. In particular, cultural beliefs and customs can impact patients' health behaviors, care perceptions, and understanding of medical information or advice (Li et al., 2006; Davidson et al., 2007; Dickson et al., 2013). Implementing culturally and linguistically competent care and activities may effectively address the aforementioned issues, thus lowering hospital readmission rates and costs.

Brach and Fraser (2002) have presented the business case for cultural competency and have identified four interrelated financial incentives for cultural competency in hospitals.

- Cultural competency increases the hospital's appeal to diverse populations and thus increases its market share. This is particularly critical as the U.S. population becomes increasingly diverse.
- Cultural competency can improve the performance of hospitals in publicly reported quality and patient experience measures. This is important given that value-based purchasing reimbursement is increasingly tied to these metrics. A study by Weech-Maldonado et al. (2012c) shows a positive relationship between adherence to the National CLAS Standards and Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) scores among hospitals.
- Public purchasers, such as Medicaid and Medicare, increasingly are instituting cultural competency requirements in their contracts. Hospitals must comply with these requirements to maintain their contracts with public purchasers.
- There is the potential to reduce costs by reducing medical errors, complications, and readmissions. This is particularly important in the context of value-based reimbursement and ACOs.

LOGIC MODEL FOR IMPLEMENTATION OF THE NATIONAL CLAS STANDARDS WITHIN THE HOSPITAL SETTING

Figure C.1 provides a detailed logic model of the specific inputs, activities, outputs, and outcomes for the implementation of the National CLAS Standards within the hospital setting. Given the importance of the broader context and external resources and partnerships to shape a hospital's readiness for adopting the Standards, we include them in the context, antecedents, and inputs column and note that any changes should be made in partnership with the community and other stakeholders.

CONTEXT, ANTECEDENTS, AND INPUTS

Linkages with the Community and Other Stakeholders

Hospitals have a number of collaborative relationships and partnerships with community entities to understand and address the cultural and linguistic needs of the communities they serve (Wilson-Stronks and Galvez, 2007; Weech-Maldonado and Merrill, 2000). These partnerships include educational, social service, religious, and public health organizations, as well as other hospitals and providers that may provide specialty care for their patients. For example, hospitals may work with alternative medicine providers to augment allopathic treatments and avoid complications from incompatible therapies (Brach and Fraser, 2000). Such linkages may also include liaisons with trusted members of the community, such as community health workers or *promotores de salud* (Rural Health Information Hub, 2011; The Lewin Group, 2002; Brach and Fraser, 2000). Furthermore, hospitals may have a direct presence in the community through hospital-owned primary care practices. These linkages are particularly important as hospitals seek to improve transitions in care for patients discharged from the hospital, with the goal of reducing readmissions and unnecessary Emergency Department use. In addition, these linkages are critical given the emergence

LOGIC MODEL FOR IMPLEMENTATION OF THE NATIONAL CLAS STANDARDS WITHIN THE HOSPITAL SETTING

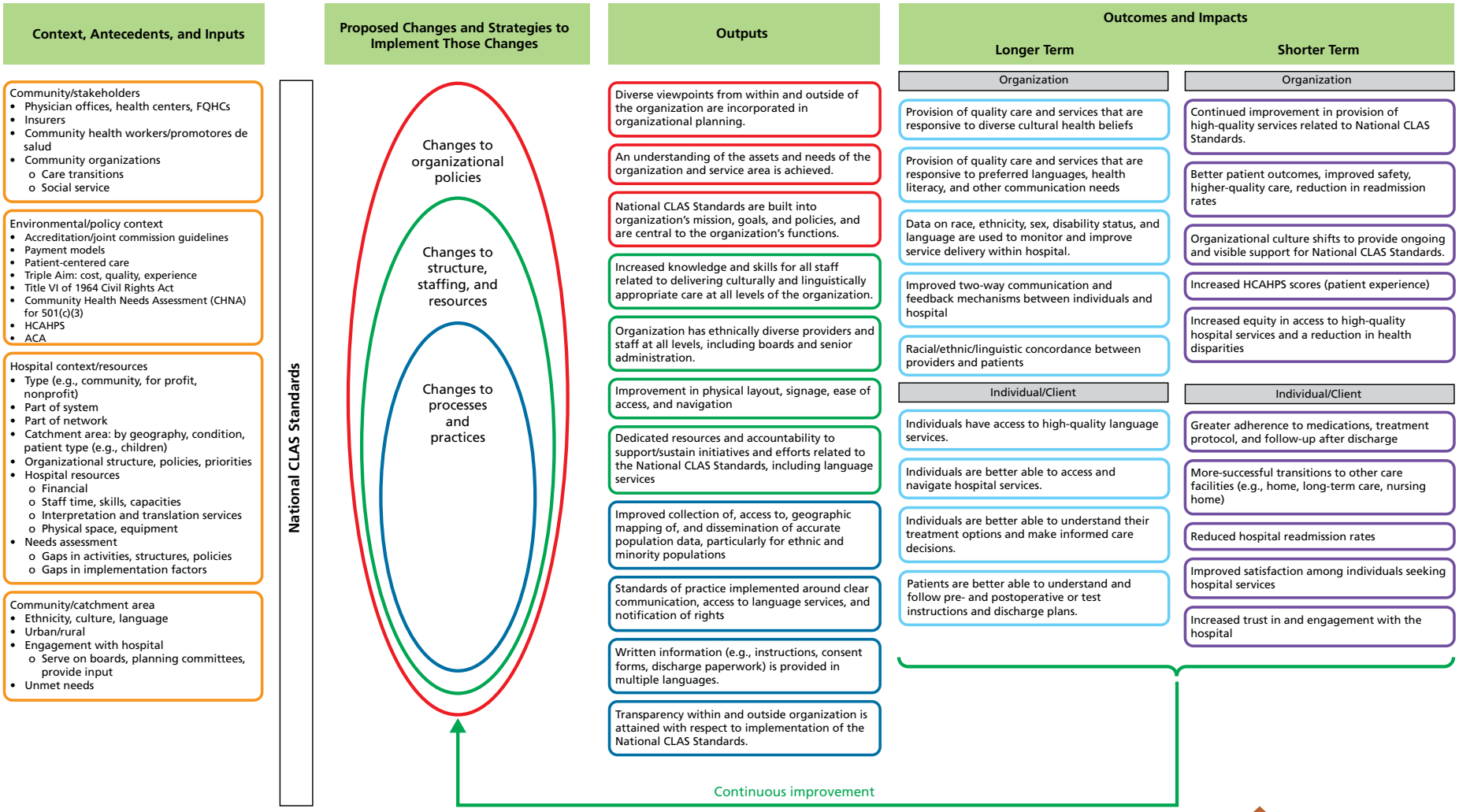
of ACOs, where hospitals are assuming risk for the duration of care. This has increased the focus of hospitals on population health and the social determinants of health and has resulted in an increased awareness of the importance of community linkages.

Hospitals may also be connected to other provider stakeholders (e.g., physicians and other health care providers) through ACOs. ACO arrangements focus on forming provider networks to coordinate care delivery. Since ACOs may be rewarded based on their ability to improve quality and reduce costs, implementing the National CLAS Standards may provide an opportunity to reach these goals (Adepoju, Preston, and Gonzales, 2015). Hospitals should consider how they work with partners and contracted organizations with respect to meeting the diverse cultural and linguistic needs of their patient populations because this may influence their own overall performance with respect to the National CLAS Standards.

Other stakeholders include payers and employers. Rising health care costs, coupled with the oftentimes subpar quality of care in the United States, is resulting in an increased emphasis on value-based care, or paying for value rather than volume. As such, both payers and employers can be partners in hospital efforts to increase cultural competency activities, which may result in higher-quality care at lower costs for diverse patient populations. Such partners should be involved at all stages of Standards adoption (e.g., assessment, design, implementation, evaluation).

LOGIC MODEL FOR IMPLEMENTATION OF THE NATIONAL CLAS STANDARDS WITHIN THE HOSPITAL SETTING

FIGURE C.1. LOGIC MODEL FOR IMPLEMENTATION OF THE NATIONAL CLAS STANDARDS WITHIN THE HOSPITAL SETTING



LOGIC MODEL FOR IMPLEMENTATION OF THE NATIONAL CLAS STANDARDS WITHIN THE HOSPITAL SETTING

Environmental and Policy Context

Implementation of the National CLAS Standards within an organization is affected by a number of factors external to the organization itself. These include, for example, the federal (e.g., ACA), state, tribal, and local regulatory environment; accreditation mandates; policies; and standards of practice. In many cases, these factors influence how care is delivered and monitored and may impact whether and how organizations may choose to adopt the Standards.

One external factor that can affect implementation is the ACA, which contains several provisions related to providing culturally and linguistically appropriate care. In addition, under Title VI of the Civil Rights Act of 1964 (Chen, Youdelman, and Brooks, 2007), organizations receiving federal funds must take reasonable steps to provide meaningful access to their programs for individuals with LEP (Federal Register, 2000). Furthermore, several states have recognized the importance of cultural and linguistic competency by legislating cultural and linguistic competency training in health care (HHS OMH, 2016). Accrediting bodies, such as The Joint Commission and the NCQA, have also established accreditation standards that target the improvement of communication, cultural competency, patient-centered care, and the provision of language assistance services (Briefer French et al., 2008; HHS OMH, 2013; Wilson-Stronks and Galvez, 2007).

In addition to changes in the regulatory environment, hospitals are also working within changes in payment models toward more value-based purchasing and toward an increasing emphasis on population health, which align with the National CLAS Standards. Related to this are the various financial penalties and rewards associated with performance on publicly reported measures, such as readmissions and patient experience.

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These types of external influences and contexts may impact whether and how a hospital will adopt the National CLAS Standards and how easy or difficult such implementation may be for the hospital.

Hospital Context, Resources, Community, and Catchment Area

Inputs and antecedents relevant to the implementation of the National CLAS Standards can vary considerably depending on the type of hospital (e.g., public, for-profit, nonprofit) and on whether the hospital is part of a system (e.g., a group of hospitals) or network. Inputs and antecedents—such as the hospital's strategic goals, policies, staff, resources, and physical environment—may also be driven by the catchment area of the hospital and whether that hospital serves a geographic area or a specific population (e.g., children) or is disease-specific (e.g., cancer center).

Other factors influencing hospital inputs and antecedents include both internal and external elements. Internal factors—such as payer mix, the proportion of inpatients with Medicare, Medicaid, or private insurance, or the proportion uninsured—can affect resource availability. External factors, such as competition, can provide an impetus for cultural competency activities as hospitals strive to increase or maintain their market share in an increasingly diverse population. Weech-Maldonado and colleagues (2012c) found that hospitals in more-competitive markets had a higher degree of adherence to culturally and linguistically appropriate care.

Also relevant is the organization's capacity to absorb new knowledge and its receptivity for change, which may be driven, for example, by a gap analysis or needs assessment. This analysis should include an assessment of activities, structures, or policies that should be in place to support equitable care as well as implementation factors that could aid or hinder the adoption

LOGIC MODEL FOR IMPLEMENTATION OF THE NATIONAL CLAS STANDARDS WITHIN THE HOSPITAL SETTING

of the National CLAS Standards. Of note, all nonprofit hospitals are required to complete a CHNA and implementation strategy (CDC, 1987). These assessments and strategies are intended to help hospitals obtain the information they need to provide benefits that better meet the needs of their communities and to provide an opportunity for coordination with other community services (CDC, 1987). Although not all hospitals are required to complete a CHNA, those that do may use such information to inform the adoption and implementation of the National CLAS Standards.

NATIONAL CLAS STANDARDS

As with the other logic models, the National CLAS Standards are placed between the antecedents and inputs and the activities an organization adopts. Again, the National CLAS Standards are viewed as a perspective or lens through which such context and antecedents are interpreted and help to shape the activities the organization chooses to implement to address gaps in culturally and linguistically appropriate care within its setting.

PROPOSED CHANGES AND STRATEGIES DEVELOPED TO IMPLEMENT THOSE CHANGES

Once an organization has decided to address identified gaps with respect to the National CLAS Standards, it must plan and design relevant activities and approaches to close these gaps. As was noted in earlier chapters in this report, organizations may adopt the National CLAS Standards either altogether or in a staged approach, depending on the antecedents and inputs, readiness

LOGIC MODEL FOR IMPLEMENTATION OF THE NATIONAL CLAS STANDARDS WITHIN THE HOSPITAL SETTING

for Standards implementation, and the environmental and policy context. Given the wide range of potential approaches and activities a hospital may choose to develop or adopt, the logic model does not include specific activities; rather, it notes that changes are likely to occur in three nested areas of focus: (1) organizational policies; (2) structure, staffing, and resources; and (3) processes and practices. The identification of gaps and priorities and the design and development of activities to address those gaps are expected to be done in close collaboration with the community and other stakeholders that stand to benefit from such changes.

OUTPUTS

The activities and changes implemented within the organization should result in immediate outputs that move the organization closer to providing culturally and linguistically appropriate care and services. Such outputs may include the following:

- incorporating diverse viewpoints from inside and outside the hospital into the planning and implementation of policies, programs, and services
- building the National CLAS Standards into the hospital's mission, goals, and policies and making them central to its functions
- implementing standards of practice around clear communication, access to language services, and notification of rights
- increasing staff knowledge and skills related to delivering culturally and linguistically appropriate care at all levels of the organization
- incorporating ethnically diverse health care practitioners and staff at all levels of the hospital

LOGIC MODEL FOR IMPLEMENTATION OF THE NATIONAL CLAS STANDARDS WITHIN THE HOSPITAL SETTING

- improving the physical layout, signage, ease of access, and navigation
- improving the collection of, access to, geographic mapping of, and dissemination of accurate population data, particularly for ethnic and minority populations
- targeting QI activities to disparities in access and outcomes of care
- ensuring that resources and accountability to support and sustain initiatives and efforts related to the National CLAS Standards are available.

The specific outputs expected will be determined by which of the National CLAS Standards have been adopted, by which organizational changes have been made, and by which activities have been implemented as a result.

OUTCOMES

Collectively and over time, outputs from hospitals may contribute to changes in outcomes for both individuals using inpatient services and for the hospital overall. Examples of potential outcomes within the hospital setting are listed below.

- For the organization
  - Short term (1–2 years)
    - > the provision of effective, equitable, understandable, respectful, and quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs
    - > the use of data on race, ethnicity, sex, sexual orientation, disability status, and language to monitor and improve service delivery within the hospital

LOGIC MODEL FOR IMPLEMENTATION OF THE NATIONAL CLAS STANDARDS WITHIN THE HOSPITAL SETTING

> improved two-way communication and feedback mechanisms between individuals and hospitals

> racial/ethnic and linguistic concordance between providers, hospital staff, and patients

> increased linkages with community stakeholders, with a focus on social determinants of health.

– Longer term (3 or more years)

> continued improvement in the provision of high-quality services related to the National CLAS Standards

> better patient outcomes, improved safety, higher-quality care, and a reduction in readmission rates

> reduced hospitalizations for ambulatory-sensitive conditions

> organizational culture shifts to provide ongoing and visible support for the National CLAS Standards within the hospital

> increased HCAHPS scores (patient experience)

> increased equity in access to high-quality hospital services and a reduction in health disparities.

- For the individuals seeking care:

  – Short term (1–2 years)

  > individuals have access to high-quality language services

  > individuals are better able to access and navigate hospital services

  > individuals are better able to understand their treatment options and make

LOGIC MODEL FOR IMPLEMENTATION OF THE NATIONAL CLAS STANDARDS WITHIN THE HOSPITAL SETTING

informed care decisions

> patients are better able to understand and follow pre- and post-operative or test instructions and discharge plans

> patients are connected with community resources to facilitate transitions in care.

– Longer term (3 or more years)

> greater adherence to medications, treatment protocols, and follow-up after discharge

> more-successful transitions to other care facilities (e.g., home care, long-term care, nursing home care)

> reduced hospital readmission rates and reduced admissions for ambulatory-sensitive conditions

> improved satisfaction among individuals seeking hospital services

> increased trust in and engagement with the hospital.

LOGIC MODEL FOR IMPLEMENTATION OF THE NATIONAL CLAS STANDARDS WITHIN THE HOSPITAL SETTING

QUALITY IMPROVEMENT

The logic model also depicts the adoption and implementation of the National CLAS Standards as a continual process, requiring a QI loop where outputs and outcomes inform the development of future hospital actions, policies, or programs to better align with the National CLAS Standards. Culturally competent QI tailors care to address the specific language and culture barriers, which both helps to reduce disparities and can improve care for everyone (Green et al., 2010). When assessing the impact of the implementation of the National CLAS Standards and informing next steps, it is important that QI improvements be viewed specifically through a culturally competent lens.

HOSPITAL MEASURES

In developing the process and outcomes/impact measures described in Chapter Seven of the full report (Davis et al., forthcoming), we identified measures relevant to the hospital setting. In Table C.1, we list examples of hospital measures identified along with a brief description, area of focus, source, relevant notes, and the reference for each measure. In addition, we include examples of disparity-sensitive measures that a hospital might wish to consider to help it assess how well it is doing in addressing identified disparities in outcomes. Table C.2 provides additional detail for each measure and summarizes the relevant items that compose each measure.

TABLE C.1. HOSPITAL MEASURES

MEASURE	DESCRIPTION	AREA OF FOCUS	SOURCE ID	NOTES	REFERENCE
Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) Survey	The HCAHPS Survey, also known as the CAHPS Hospital Survey or Hospital CAHPS, is a standardized survey instrument and data-collection methodology to measure patients' perspectives of hospital care. The HCAHPS Survey contains 21 patient perspectives on care and patient-rating items that encompass nine key topics: communication with doctors, communication with nurses, responsiveness of hospital staff, pain management, communication about medicines, discharge information, cleanliness of the hospital environment, quietness of the hospital environment, and transition of care.	Cultural competency	HCAHPS	See Table D.2 for list of measures.	AHRQ, 2014.

HOSPITAL MEASURES

MEASURE	DESCRIPTION	AREA OF FOCUS	SOURCE ID	NOTES	REFERENCE
Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) Survey Health Literacy Set	These measures are based on the CAHPS Item Set for Addressing Health Literacy, a set of supplemental items for the HCAHPS. The item set includes the following domains: information about medications; communication between nurses and patients; communication between doctors and patients; communication about tests; communication about forms; and information about how to care for yourself at home.	Health literacy	HCAHPS health literacy	See Table D.2 for list of measures.	AHRQ, 2012
Cultural Competency Assessment Tool for Hospitals (CCATH)	The CCATH is a survey designed to assess hospitals' adherence to the National CLAS Standards. The CCATH was subject to extensive qualitative testing, including pilot testing, focus groups, and cognitive interviews. Exploratory and confirmatory factor analysis of the data supported 12 composite scales: clinical cultural competency practices, human resources practices, diversity training, availability of interpreter services, interpreter services policies, quality of interpreter services, translation of written materials, leadership and strategic planning, performance management systems and QI, data collection on inpatient population, data collection on service area, and community representation.	Cultural competency	CCATH	See Table D.2 for list of measures.	CCATH Overview, undated
The Joint Commission Hospital Accreditation Standards and Elements of Performance	Joint Commission standards are the basis of an objective evaluation process that can help HCOs measure, assess, and improve performance. The standards focus on important patient, individual, or resident care and organization functions that are essential to providing safe, high-quality care. The Joint Commission's state-of-the-art standards set expectations for organizational performance that are reasonable, achievable, and surveyable. The Joint Commission has several accreditation standards that directly or indirectly support the provision of culturally and linguistically appropriate services.	CLAS	JCAHO[a] accreditation standards	See Table D.2 for list of measures.	The Joint Commission, 2014

HOSPITAL MEASURES

MEASURE	DESCRIPTION	AREA OF FOCUS	SOURCE ID	NOTES	REFERENCE
The Joint Commission: *2016 Accountability Measure List for Accreditation Chart-Abstracted Process Measures*	The Joint Commission categorizes its process performance measures into accountability and nonaccountability measures. This approach places more emphasis on an organization's performance on *accountability measures*—quality measures that meet four criteria designed to identify measures that produce the greatest positive impact on patient outcomes when hospitals demonstrate improvement: research, proximity, accuracy, and adverse effects. Measures that meet all four criteria should be used for purposes of accountability (e.g., for accreditation, public reporting, or pay-for-performance). Those measures that have not been designated as accountability measures may be useful for QI, exploration, and learning within individual HCOs and are good measures in terms of gauging appropriate patient care. The accountability measures cover areas including inpatient psychiatric services, venous thromboembolism (VTE) care, stroke care, perinatal car, immunization, tobacco treatment, and substance use.	Account-ability	JCAHO[a] account-ability measures	See Table D.2 for list of measures.	The Joint Commission, 2016
Disparity-sensitive measures or CLAS-salient measures					
Hospital 30-day, all-cause RSRR following pneumonia hospitaliza-tion	The measure estimates a hospital-level 30-day, all-cause RSRR for patients discharged from the hospital with either a principal discharge diagnosis of pneumonia, including aspiration pneumonia or a principal discharge diagnosis of sepsis (not severe sepsis) with a secondary diagnosis of pneumonia (including aspiration pneumonia) coded as present on admission (POA). Readmission is defined as unplanned readmission for any cause within 30 days of the discharge date for the index admission. A specified set of planned readmissions do not count as readmissions. CMS annually reports the measure for patients who are 65 years or older and are enrolled in FFS Medicare hospitalized in nonfederal hospitals.	Patient safety, care coordination	NQF #506, #505, #695, #1891, #2515, #1551 (measure steward: CMS)	Also available for AMI, PCI, COPD, HF, CABG, THA/TKA This is a disparity-sensitive measure.	NQF, undated (search: "506," "505," "695," "1891," "2515," or "1551") Weissman et al., 2012

HOSPITAL MEASURES

MEASURE	DESCRIPTION	AREA OF FOCUS	SOURCE ID	NOTES	REFERENCE
Median time to electro-cardiogram (ECG)	Median time from emergency department arrival to ECG (performed in the emergency department prior to transfer) for AMI or chest pain patients (with probable cardiac chest pain)	Prevention and treatment	NQF #289 (measure steward: CMS)		NQF, undated (search: "289")
Hospital 30-day, all-cause, RSMR following CABG surgery	The measure estimates a hospital-level RSMR for patients ages 18 and older discharged from the hospital following a qualifying isolated CABG procedure. Mortality is defined as death from any cause within 30 days of the procedure date of an index CABG admission. The measure was developed using Medicare FFS patients ages 65 and older and was tested in all-payer patients ages 18 and older. An index admission is the hospitalization for a qualifying isolated CABG procedure considered for the mortality outcome.	Patient safety, care coordination	NQF #2558, #230, #1893, #229, #468 (measure steward: CMS)	Also available for AMI, COPD, HF, pneumonia This is a disparity-sensitive measure.	NQF, undated (search: "2558," "230," "1893," "229," or "468") Weissman et al., 2012
Risk-adjusted deep sternal wound infection	Percentage of patients ages 18 and older undergoing isolated CABG who develop mediastinitis or deep sternal wound infection within 30 days postoperatively	Prevention and treatment, safety	NQF #130 (measure steward: Society of Thoracic Surgeons)	This is a disparity-sensitive measure.	NQF, undated (search: "130") Weissman et al., 2012

NOTE: PCI = percutaneous coronary intervention. CABG = coronary artery bypass grafting. COPD = chronic obstructive pulmonary disease. HF = heart failure. THA/TKA = total hip arthroplasty/total knee arthroplasty.

[a] The Joint Commission on Accreditation of Healthcare Organizations is now known as the Joint Commission.

HOSPITAL MEASURES

TABLE C.2. HOSPITAL MEASURES: ADDITIONAL DETAIL

MEASURE	ITEMS
HCAHPS Survey	The HCAHPS Survey, also known as the CAHPS Hospital Survey or Hospital CAHPS, is a standardized survey instrument and data-collection methodology to measure patients' perspectives of hospital care. The HCAHPS Survey contains 21 patient perspectives on care and patient rating items that encompass nine key topics: communication with doctors, communication with nurses, responsiveness of hospital staff, pain management, communication about medicines, discharge information, cleanliness of the hospital environment, quietness of the hospital environment, and transition of care.
Nurse communication	During this hospital stay, how often did nurses treat you with courtesy and respect? During this hospital stay, how often did nurses listen carefully to you? During this hospital stay, how often did nurses explain things in a way you could understand?
Doctor communication	During this hospital stay, how often did doctors treat you with courtesy and respect? During this hospital stay, how often did doctors listen carefully to you? During this hospital stay, how often did doctors explain things in a way you could understand?
Communication about medicines	Before giving you any new medicine, how often did hospital staff tell you what the medicine was for? Before giving you any new medicine, how often did hospital staff describe possible side effects in a way you could understand?
Discharge information	After you left the hospital, did you go directly to your own home, to someone else's home, or to another health facility? During this hospital stay, did doctors, nurses, or other hospital staff talk with you about whether you would have the help you needed when you left the hospital? During this hospital stay, did you get information in writing about what symptoms or health problems to look out for after you left the hospital?
Care transition	During this hospital stay, staff took my preferences and those of my family or caregiver into account in deciding what my health care needs would be when I left. When I left the hospital, I had a good understanding of the things I was responsible for in managing my health. When I left the hospital, I clearly understood the purpose for taking each of my medications.

HOSPITAL MEASURES

MEASURE	ITEMS
HCAHPS Survey Health Literacy Set	These measures are based on the CAHPS Item Set for Addressing Health Literacy, a set of supplemental items for the HCAHPS. The item set includes the following domains: information about medications; communication between nurses and patients; communication between doctors and patients; communication about tests; communication about forms; information about how to care for yourself at home.
Information about medications	H-HL1: Staff asked patient to describe how patient would take medications at home H-HL2: Staff told patient who to call if patient had questions about medications
Communication between nurses and patients	H-HL3: Nurses were hard to understand because of the way they spoke patient's language H-HL4: Nurses used medical words patient did not understand H-HL5: Nurses spoke too fast H-HL6: Nurses interrupted patient H-HL7: Nurses answered all questions to patient's satisfaction H-HL8: Nurses used condescending, sarcastic, or rude tone or manner with patient H-HL9: Nurses cared about patient as a person
Communication between doctors and patients	H-HL10: Doctors were hard to understand because of the way they spoke patient's language H-HL11: Doctors used medical words patient did not understand H-HL12: Doctors spoke too fast H-HL13: Doctors used pictures, drawings, models, or videos to explain things H-HL14: Doctors interrupted patient H-HL15: Doctors answered all questions to patient's satisfaction H-HL16: Doctors made sure patient understood all information H-HL17: Doctors used condescending, sarcastic, or rude tone or manner with patient H-HL18: Doctors cared about patient as a person

HOSPITAL MEASURES

MEASURE	ITEMS
Communication about tests (Note: H-HL20 through H-HL23 form a composite measure: how well hospital staff explain tests and test results)	H-HL19: Patient had a blood test, X-ray, or other test H-HL20: Hospital staff explained what a blood test, X-ray, or other test was for H-HL21: Explanation of blood test, X-ray, or other test was easy to understand H-HL22: Hospital staff explained blood test, X-ray, or other test results to patient H-HL23: Blood test, X-ray, or other test results were easy to understand
Communication about forms (Note: H-HL25, H-HL27, H-HL28 and H-HL29 form a composite measure: ease of filling out forms)	H-HL24: Patient had to sign forms H-HL25: Staff explained the purpose of a form before patient signed it H-HL26: Patient had to fill out forms H-HL27: Staff offered patient help in filling out a form H-HL28: Forms were easy for patient to fill out H-HL29: Patient was given enough time to fill out forms H-HL30: Patient needed forms in a language other than English H-HL31: Forms were available in patient's language
Information about how to care for yourself at home	H-HL32: Patient went to own home, someone else's home, or another health facility H-HL33: Staff give patient a telephone number to call if patient had problems after leaving hospital H-HL34: Staff told patient how to take care of self at home H-HL35: Information from hospital staff about taking care of self at home was easy to understand H-HL36: Patient received instructions in writing about how to take care of self at home H-HL37: Written instructions about how to take care of self at home were easy to understand H-HL38: Patient needed instructions about how to take care of self at home in a language other than English H-HL39: Instructions about how to take care of self at home were available in patient's language

HOSPITAL MEASURES

MEASURE	ITEMS
CCATH	The CCATH is a survey designed to assess hospitals' adherence to the CLAS Standards. The CCATH was subject to extensive qualitative testing, including pilot testing, focus groups, and cognitive interviews. Exploratory and confirmatory factor analysis of the data supported 12 composite scales: clinical cultural competency practices, human resources practices, diversity training, availability of interpreter services, interpreter services policies, quality of interpreter services, translation of written materials, leadership and strategic planning, performance management systems and QI, data collection on inpatient population, data collection on service area, and community representation.
Clinical cultural competency practices	Does the hospital consider cultural and language needs during discharge planning? Does the hospital accommodate the ethnic/cultural dietary preferences of inpatients? Does the hospital tailor patient educational materials for different cultural and language groups? Does the hospital tailor patient clinical assessments for different cultural and language groups?
Human resources practices	Which of the following benefits are available to staff? • Formal mentoring program • Management training • Tuition assistance or tuition reimbursement for ongoing education • Personal counseling or employee assistance programs • Flexible benefits, such as domestic partner benefits, family illness, death, and personal leave policies that accommodate alternative definitions of family • Affinity (networking) groups for racial/ethnic minority staff • Work/life balance programs, such as flex time, job-sharing or telecommuting, child or elder care
Diversity training	Does this hospital have a formal and ongoing training program on cultural and language diversity? Does the staff involved in the formal complaint and grievance process receive formal training in conflict resolution? Does the staff involved in the formal complaint and grievance process receive formal training about cultural or language differences?

HOSPITAL MEASURES

MEASURE	ITEMS
Availability of interpreter services	Are interpreter services available for inpatients in Spanish? Are interpreter services available for inpatients in Chinese? Are interpreter services available for inpatients in Vietnamese? Are interpreter services available for inpatients in Korean? Are interpreter services available for inpatients in Tagalog?
Interpreter services policies	Does this hospital have a written policy and procedures about the use of bilingual staff as interpreters? Does this hospital have a written policy and procedures about the use of face-to-face professional interpreters? Does this hospital have a written policy and procedures about the use of face-to-face volunteer interpreters? Does this hospital have a written policy and procedures about the use of family or friends as interpreters?
Quality of interpreter services	Does this hospital include information on the availability of interpreter services in marketing and community outreach initiatives, such as television advertising, marketing brochures, and health fairs? Does the hospital require an assessment of interpreter fluency in translating medical terms and procedures? Does the hospital require an assessment of interpreter accuracy and completeness?
Translation of written materials	What types of written materials does this hospital routinely provide to inpatients in languages other than English? • Informed consent statements? • Medication instructions? • Discharge planning instructions? • Patient advance directives? • Health education material? • Does this hospital post signs providing directions in languages other than English?

HOSPITAL MEASURES

MEASURE	ITEMS
Leadership and strategic planning	Does this hospital's statement of strategic goals include specific language about recruitment of a culturally diverse workforce? Does this hospital's statement of strategic goals include specific language about retention of a culturally diverse workforce? Does this hospital's statement of strategic goals include specific language about the provision of culturally appropriate patient services? During the strategic planning process, does this hospital routinely assess achievement of its cultural diversity goals? Is there a person, office, or committee who has dedicated responsibility for promoting this hospital's cultural diversity goals? Does this hospital report information to the community at least once per year about its performance in meeting the cultural and language needs of the service area?
Performance management systems and QI	Does the employee satisfaction survey include measures of diversity climate? Is the following assessment conducted at least once each year: • Accessibility of interpreter services? • Racial/ethnic differences in inpatient service use?
Data collection on inpatient population	Does this hospital collect any ethnicity or racial data on individuals receiving inpatient services? Does this hospital collect data on the preferred language for individuals receiving inpatient services?
Data collection on service area	Does this hospital track changes in the race or ethnicity of its workforce? Does this hospital collect or receive any of the following data on the population residing in the service area? • Race/ethnicity • Languages spoken • Income levels • Education levels • Health risk profiles (for diseases or conditions that disproportionately affect a particular racial/ethnic/gender group, such as African-American men, Latino women, or individuals of Jewish ethnicity) • Using health screening services (mammograms, prostate screening exams, Pap smears)

HOSPITAL MEASURES

MEASURE	ITEMS
Community representation	Are community representatives routinely involved in the planning and design of inpatient services for culturally diverse populations? Are community representatives routinely involved in the evaluation of existing services for culturally diverse populations?
The Joint Commission Hospital Accreditation Standards and Elements of Performance	Joint Commission standards are the basis of an objective evaluation process that can help HCOs measure, assess, and improve performance. The standards focus on important patient, individual, or resident care and organizational functions that are essential to providing safe, high-quality care. The Joint Commission's state-of-the-art standards set expectations for organizational performance that are reasonable, achievable, and surveyable. The Joint Commission has several accreditation standards that directly or indirectly support the provision of culturally and linguistically appropriate services. Here we highlight standards that support CLAS Standard 10.
The hospital compiles and analyzes data (PI.02.01.01)	Element of Performance (EP) 4: The hospital analyzes and compares internal data over time to identify levels of performance, patterns, trends, and variations.
The hospital improves performance on an ongoing basis (PI.03.01.01)	EP 11: For hospitals that elect the Joint Commission Primary Care Medical Home option: The primary care medical home uses the data it collects on the patient's perception of the safety and quality of care, treatment, or services to improve its performance. These data include the following: • Patient experience and satisfaction related to access to care, treatment, or services and communication • Patient perception of the comprehensiveness of care, treatment, or services • Patient perception of the coordination of care, treatment, or services • Patient perception of the continuity of care, treatment, or services

HOSPITAL MEASURES

MEASURE	ITEMS
The Joint Commission: 2016 Accountability Measure List for Accreditation Chart-Abstracted Process Measures	The Joint Commission categorizes its process performance measures into accountability and nonaccountability measures. This approach places more emphasis on an organization's performance on accountability measures—quality measures that meet four criteria designed to identify measures that produce the greatest positive impact on patient outcomes when hospitals demonstrate improvement: research, proximity, accuracy, and adverse effects. Measures that meet all four criteria should be used for purposes of accountability (e.g., for accreditation, public reporting, or pay-for-performance). Those measures that have not been designated as accountability measures may be useful for QI, exploration, and learning within individual HCOs, and are good advice in terms of appropriate patient care. The accountability measures cover areas including inpatient psychiatric services, VTE care, stroke care, perinatal car, immunization, tobacco treatment, and substance use. Here we highlight measures in VTE care and substance use.
VTE care	VTE-5 warfarin therapy discharge instructions
Immunization	IMM-2 16253 Influenza immunization
Substance use	SUB-1 16350 Alcohol use screening SUB-2 16351 Alcohol use brief intervention provided or offered 2014 SUB-3 16353 Alcohol and other drug use disorder treatment provided or offered at discharge 2014 SUB-4 16355 Alcohol and drug use: assessing status after discharge

Appendix D
Public Health Setting

The field of public health encompasses local health departments, local boards of health, tribal health departments, and other local government organizations that are responsible for providing essential public health services within a specific jurisdiction (CDC, 2017b). Together, these agencies are often referred to as local health departments (LHDs). LHDs play a critical role in monitoring community health, informing and educating the public about health, mobilizing community partnerships, and developing policies and plans that support individual and community health efforts (CDC, 2016a). In particular, there are three core functions of public health around which LHDs often organize their work (CDC, 2017b):

1. linking people to needed personal health services and ensuring the provision of health care when otherwise unavailable
2. ensuring a competent public and personal health care workforce
3. evaluating the effectiveness, accessibility, and quality of personal and population-based health services.

The National CLAS Standards are in alignment with and have the potential to further strengthen each of these core functions (see Table D.1). Given their focus on population health, LHDs serve individuals from a variety of cultural and linguistic backgrounds. As a result, the National CLAS Standards are particularly relevant to LHDs.

FIGURE D.1. LINKING THE NATIONAL CLAS STANDARDS TO CORE PUBLIC HEALTH DEPARTMENT FUNCTIONS

CORE PUBLIC HEALTH DEPARTMENT FUNCTION	ROLE OF THE NATIONAL CLAS STANDARDS
Linking people to needed personal health services and ensuring the provision of health care when otherwise unavailable	Ensure that the provision of health care—provided by LHDs or organizations partnering with LHDs—is culturally and linguistically appropriate
Ensuring a competent public and personal health care workforce	Ensure workforce competencies, including cross-cultural communication skills and the ability to communicate (alone or through a translator) in ways that individuals can understand
Evaluating the effectiveness, accessibility, and quality of personal and population-based health services	Ensure data collection, including data on cultural subgroups—such as race/ethnicity, language preferences, education, and income of patients—to ensure evaluations capture cultural and linguistic differences

Despite the natural alignment between the National CLAS Standards, the core functions of public health, and the populations LHDs commonly serve, the acceptance of the Standards by LHD leadership differs across jurisdictions. These differences may be based on a range of characteristics unique to each LHD and the perceived needs of the population served (see Table D.2). For example, LHDs often already include professionals who reflect the populations they serve. This means that they may have critical cultural and language competencies and they may be more sensitive to the diversity of the populations they serve. Training on cultural and linguistic appropriateness of care is increasingly offered as part of formal public health schooling, embedded in existing pub-

lic health staff training, and required by some states (e.g., Maryland). As a result, LHDs may have different perceptions of the added value of the National CLAS Standards relative to their current standards of practice.

FIGURE D.1. LINKING THE NATIONAL CLAS STANDARDS TO CORE PUBLIC HEALTH DEPARTMENT FUNCTIONS

CHARACTERISTIC	DETAILS
Geographic reach	LHDs can serve communities at the local, state, tribal, and/or regional level. Some states have no local public health agencies and rely on LHDs with larger catchment areas.
Size of population served	The size of the population served varies considerably, with 43 percent of LHDs serving populations of 25,000 or less and 5 percent serving populations of 500,000 or more.
Relationship between state, tribal, and LHD	Services offered can be centralized, decentralized, or hybrid; centralized services are provided by a state health department and are coordinated by local offices, while decentralized services are planned and provided by local agencies.
Type of jurisdiction	The type of jurisdiction varies considerably and can include county, city/county, township, multi-county/district/regional, city, and tribal communities.
Governance	A board of health may serve in a policymaking capacity or an advisory capacity only.
Funding sources	The combination of funding sources varies by LHD and may include local contributions, state contributions, federal pass-through funding, Medicaid and Medicare reimbursements, and fees.
Size of staff, budget, type of health care services provided	Varies considerably

LOGIC MODEL FOR IMPLEMENTATION OF THE NATIONAL CLAS STANDARDS WITHIN THE PUBLIC HEALTH SETTING

Figure D.1 provides a detailed logic model of the specific inputs, activities, outputs, and outcomes for the implementation of the National CLAS Standards within the public health setting. Given the importance of the broader context and external resources and partnerships to shape a public health setting's readiness for adopting the National CLAS Standards, we include them in the context, antecedents, and inputs section. Any changes should be made in partnership with the community and other stakeholders.

CONTEXT, ANTECEDENTS, AND INPUTS

Linkages with the Community and Other Stakeholders

Successful implementation of the National CLAS Standards requires clear and meaningful linkages between LHDs, the community, and relevant stakeholder groups in every step of the process to understand and address the cultural and linguistic needs of the communities served (Wilson-Stronks and Galvez, 2007; Weech-Maldonado and Merrill, 2000). LHDs are increasingly focused on developing partnerships with community and faith-based organizations (CFBOs) to mitigate the negative consequences of economic changes on their budgets and to leverage greater assets in community health promotion. Partnerships between LHDs and CFBOs likely increase the capacity of LHDs to provide public health services (Wholey, Gregg, and Moscovice, 2009) and can expand the reach of LHD activities into communities that are marginalized because of cultural divisions and a lack of resources. CFBOs are a critical component to public health systems (Mays, Halverson, and Scutchfield, 2003). They often have the capabilities needed to provide public health interventions and are trusted resources in their communities (Acosta et al., 2011). CFBOs share an interest in population health and well-being and can bring community knowledge to

LOGIC MODEL FOR IMPLEMENTATION OF THE NATIONAL CLAS STANDARDS WITHIN THE PUBLIC HEALTH SETTING

the table, improve trust in governmental public health, and make the work of public health more transparent and understandable. The development of partnerships and coalitions has been evident in most public health program areas, such as maternal and child health, HIV/AIDS, and chronic disease prevention.

In this section we focus on the role of LHDs in implementing the National CLAS Standards and in coordinating with a range of stakeholders. Some LHDs provide direct services (e.g., immunizations, screenings, treatment for tuberculosis and sexually transmitted diseases) at public health centers and through community clinics. LHDs may also provide inpatient care through public hospitals. In other places, they do not provide services directly, instead developing formal and informal partnerships to provide care for the most vulnerable. The most formal of these partnerships are contracts to provide services. In these cases, the National CLAS Standards are relevant both to the LHD and to its community partners. In health care, these partners include ambulatory care clinics that may screen for infectious diseases and provide vaccinations. As a result, LHDs must consider how they work with partners and contracted organizations to implement the Standards because this will influence their performance with respect to meeting the cultural and linguistic needs of the individuals they serve. Primary care and inpatient providers are also obligated to report certain conditions to LHDs. For example, in California, providers must report a large number of communicable diseases, HIV, outbreaks of any condition or disease, the occurrence of any unusual disease, and some noncommunicable conditions or diseases (California Department of Public Health, 2016). Other entities provide substance abuse treatment, maternal and child health services, environmental health services, and communicable/infections disease

LOGIC MODEL FOR IMPLEMENTATION OF THE NATIONAL CLAS STANDARDS WITHIN THE PUBLIC HEALTH SETTING

and chronic disease programs (National Association of County and City Health Officials [NACCHO], 2014). LHDs engage many different partners inside and outside the health care system, including schools, media, local businesses, faith-based organizations, and other community-based organizations (NACCHO, 2009).

LHDs' links to outside partners provide opportunities for formal and informal dissemination of the National CLAS Standards. There are several mechanisms through which this might occur. LHDs are part of a rich network of organizations in the community that are aligned toward the same population health goals, including health care clinics and mental health and substance abuse treatment centers, as well as organizations that provide specialty services to persons with specific conditions, such as HIV. Dissemination of the National CLAS Standards within public health organizations could increase the likelihood that these Standards are adopted by other organizations. LHDs sometimes have more-formal relationships with these organizations through memoranda of understanding and funding mechanisms. LHDs could thus exert financial pressure on partners to adopt the National CLAS Standards. In addition, LHDs could support the adoption of the National CLAS Standards within the community by disseminating toolkits and collecting and analyzing data that evaluate the impact of the Standards in their communities.

PUBLIC HEALTH MEASURES

In developing the process and outcomes/impact measures described in Chapter Seven of the main report (Davis et al., forthcoming), we identified measures relevant to public health settings. In Table D.1 we list examples of relevant measures identified along with a brief description, area of focus, source, relevant notes, and the reference for each measure. In addition, we include examples of disparity sensitive measures that a public health organization might wish to consider to help it assess how well it is doing in addressing identified disparities in outcomes. Table D.2 provides additional detail for each measure and summarizes the relevant items that compose each measure.

TABLE D.1. PUBLIC HEALTH MEASURES

MEASURE(S)	DESCRIPTION	AREA OF FOCUS	SOURCE ID	NOTES	REFERENCE
Developing a Self-Assessment Tool for CLAS in Local Public Health Agencies (LPHAs)	This self-assessment tool for LPHAs is aimed to offer sound measures of CLAS. The term *LPHA* is defined as a publicly funded entity (i.e., local health department, local board of health, and other local government organization) responsible for providing essential public health services within a specific jurisdiction. The instrument consists of a director or designee interview protocol; a staffing questionnaire; and a client services questionnaire. Because the content among the three survey instruments greatly overlap, not all items from each instrument are presented in this document. Listed in the appendix of COSMOS Corporation (2003) are items from the Client Services Questionnaire (consisting of four sections: quality monitoring and improvement, management information systems, translation and interpretation services, and other related client services and benefits), and select items from the director or designee interview protocol.	CLAS Services	Developing a Self-Assessment Tool for Culturally and Linguistically Appropriate Services in Local Public Health Agencies	Though a pilot test has been conducted on the self-assessment tools, measures have yet to be tested/validated. See Table F.2 for list of measures	COSMOS Corporation, 2003

PUBLIC HEALTH MEASURES

MEASURE(S)	DESCRIPTION	AREA OF FOCUS	SOURCE ID	NOTES	REFERENCE
CG-CAHPS	CAHPS surveys ask consumers and patients to report on and evaluate their experiences with health care. The CG-CAHPS assesses patients' experiences with health care providers and staff in doctors' offices. The CG-CAHPS produces the following measures of patient experience: getting timely appointments, care, and information; how well providers communicate with patients; providers' use of information to coordinate patient care; helpful, courteous, and respectful office staff; patients' rating of the provider.	Patient experience	CG-CAHPS	See Table F.2 for list of measures.	AHRQ, 2013b
Disparity-sensitive measures or CLAS-salient measures					
Flu vaccinations for adults ages 18 and older	The percentage of adults ages 18 and older who self-report receiving an influenza vaccine within the measurement period. This measure collected via the CAHPS 5.0H adults survey for Medicare, Medicaid, commercial populations. It is reported as two separate rates stratified by age: 18–64 and 65 years of age and older.	Health and well-being	NQF #39 (measure steward: NCQA)	This is a disparity-sensitive measure.	NQF, undated (search: "39") NQF, 2012g
Asthma emergency department visits	Percentage of patients with asthma who have one or more visits to the emergency room for asthma during the measurement period.	Chronic care management	NQF #1381 (measure steward: Alabama Medicaid Agency)	This is a disparity-sensitive measure.	NQF, undated (search: "1381") NQF, 2012g

PUBLIC HEALTH MEASURES

MEASURE(S)	DESCRIPTION	AREA OF FOCUS	SOURCE ID	NOTES	REFERENCE
Depression screening by 18 years of age	The percentage of adolescents 18 years of age who had a screening for depression using a standardized tool.	Health and well-being	NQF #1515 (measure steward: NCQA)	This is a disparity-sensitive measure.	NQF, undated (search: "1515") NQF, 2012g
Preventive care and screening: tobacco use: screening and cessation intervention	Percentage of patients ages 18 and older who were screened for tobacco use one or more times within 24 months AND who received cessation counseling intervention if identified as a tobacco user.	Community/ population health	NQF #28 (measure steward: American Medical Association–convened Physician Consortium for Performance Improvement)		NQF, undated (search: "28")

PUBLIC HEALTH MEASURES

TABLE D.2. PUBLIC HEALTH MEASURES: ADDITIONAL DETAIL

MEASURES	ITEMS
Developing a self-assessment tool for CLAS in LPHAs	This self-assessment tool for LPHAs is aimed to offer sound measures of CLAS. The term *LPHA* is defined as a publicly funded entity (i.e., local health department, local board of health, and other local government organization) responsible for providing essential public health services within a specific jurisdiction. The instrument consists of a director or designee interview protocol; a staffing questionnaire; and a Client Services Questionnaire. Because the content among the three survey instruments greatly overlap, not all items from each instrument are presented in this document. Listed in the appendix of COSMOS Corporation (2003) are items from the Client Services Questionnaire (consisting of four sections: quality monitoring and improvement, management information systems, translation and interpretation services, and other related client services and benefits), and select items from the director or designee interview protocol. Refer to the cited report for complete instruments, including survey questions and multiple-choice items (COSMOS Corporation, 2003).
Director or designee telephone interview protocol (selected items)	2. Does your local board of health or other governing body have a subcommittee or other group responsible for issues involving services provided to racial, ethnic, and linguistic minority groups? 3. Does your agency use community advisory boards or other similar entities to address community and client issues specifically related to the cultural and linguistic groups (represented by your clients)? 5. Does your agency conduct periodic needs assessments of community and/or clients' needs? 5a. Do these assessments include a component that specifically measures the need for culturally and linguistically appropriate services? 6a. Does your agency's plan include a component that improves the quality of services provided specifically to culturally and linguistically diverse clients? 7. Which of the following activities does your agency use to monitor the quality of culturally and linguistically appropriate services? 8. Is there a position in your agency specifically designated to promote and coordinate culturally and linguistically appropriate services? 9. Does your agency have a written policy governing language translation of written information for your clients? 11. Does your agency have a written policy governing interpretation services and assistance for your clients?

PUBLIC HEALTH MEASURES

MEASURES	ITEMS
Client services questionnaire: quality monitoring and improvement	12. Does your agency's client information database record race and ethnicity? 13. Please report or estimate what percentage of your clients falls into the following racial groups. 14. Please report or estimate what percentage of your clients falls into the following ethnic groups. 15. Does your agency's client information database record the primary language spoken by each client? 16. Approximately what percentage of your clients speaks a primary language other than English? 17. In your agency's data systems, can client demographic information (such as race/ethnicity and language) be linked with other data (such as client satisfaction, grievances/complaints, and dis-enrollment)?
Client services questionnaire: translation and interpretation services	18. Which of the following types of written materials are available to your clients in one or more languages other than English? 19. Which of the following activities are used to develop written materials in languages other than English? 20. Which of the following practices generally apply to the translations of written materials provided by your agency to its clients? 21. Which of the following entities provide review and/or approval of translated materials and products available to your clients? 22. Does your agency set and monitor targets or threshold levels for which vital documents and other written materials are translated to meet the language needs of your clients? 23. What methods are used by your agency to determine the need for translation of written materials into languages spoken by your clients? 24. Which of the following sources are used to determine the languages spoken by the populations served by your agency? 25. Which of the following methods are used to inform clients of the availability of translated documents and materials? 26. Is there a specific budget line in your agency for the allocation of funds to support translation of written documents and materials into languages spoken by your clients? 27. Which of the following interpretation services are available to your clients? 28. Which of the following characteristics apply to the language interpreters used by your agency? 29. Which of the following entities review and/or approve staffing and operation of interpretation services available to your clients? 30. Does your agency set and monitor targets or threshold levels for which interpretation services are systematically made available to meet the language needs of your clients?

PUBLIC HEALTH MEASURES

MEASURES	ITEMS
	31. What methods are used by your agency to determine the need for interpretation services? 32. Please provide the best estimate of how many employed, contracted, and certified medical interpreters are available to provide language assistance to your clients and staff? 33. At which of the following key entry or contact points does your agency provide interpretation services in languages other than English spoken by your clients? 34. Which of the following methods are used to inform clients of the availability of bilingual speakers and interpretation services in your agency? 35. Is there a specific budget line for the allocation of funds to support bilingual speakers and interpretation services in your agency? 36. For which of the following groups are translated materials and interpretation services generally made available by your agency?
Client services questionnaire: other related client services	37. Which of the following are provided or assured by your agency in an effort to be more culturally responsive to your clients? (Mark all that apply.) 38. Which of the following complementary or alternative healing practices are offered to your clients? (Mark all that apply.) 39. Which of the following kinds of information are available to your clients to promote the ability of your employed staff, contractors, and/or partnership members to serve culturally and linguistically diverse groups? (Mark all that apply.) 40. Which of the following characteristics pertain to written materials available to your clients? (Mark all that apply.) 41. Which of the following benefits have been achieved by your agency as a result of providing or assuring services that are responsive to the cultural and linguistic diversity of your clients? (Mark all that apply.) 42. Which of the following factors present challenges for your agency in providing or assuring services that are responsive to the needs of culturally and linguistically diverse clients? (Mark all that apply.)
CG-CAHPS Survey	CAHPS Surveys ask consumers and patients to report on and evaluate their experiences with health care. The CG-CAHPS assesses patients' experiences with health care providers and staff in doctors' offices. The CG-CAHPS produces the following measures of patient experience: getting timely appointments, care, and information; how well providers communicate with patients; providers' use of information to coordinate patient care; helpful, courteous, and respectful office staff; patients' rating of the provider.

PUBLIC HEALTH MEASURES

MEASURES	ITEMS
Getting timely appointments, care, and information	• Patient got appointment for urgent care as soon as needed. • Patient got appointment for non-urgent care as soon as needed. • Patient got answer to medical question the same day he/she contacted provider's office.
How well providers communicate with patients	• Provider explained things in a way that was easy to understand. • Provider listened carefully to patient. • Provider showed respect for what patient had to say. • Provider spent enough time with patient.

Appendix E
Cross-Cutting Measures

When we developed the process and outcomes/impact measures described in Chapter Seven of the full report (Davis et al., forthcoming), we also identified measures that are relevant to more than one setting and refer to them as cross-cutting. In Table E.1, we list the six cross-cutting measures identified, along with a brief description, area of focus, source, the settings the measure is applicable to, and the reference for each measure. Table E.2 provides additional detail for each measure and lists the items that compose each measure.

TABLE E.1. CROSS-CUTTING MEASURES

MEASURE(S)	DESCRIPTION	AREA OF FOCUS	SOURCE ID	NOTES	REFERENCE
Clinician/ group's cultural competence based on the CAHPS Cultural Competence Item Set	These measures are based on the CAHPS Cultural Competence Item Set, a set of supplemental items for the CG-CAHPS that includes the following domains: patient-provider communication; complementary and alternative medicine; experiences of discrimination because of race/ethnicity, insurance, or language; experiences leading to trust or distrust, including level of trust, caring, and confidence in the truthfulness of their provider; and linguistic competency (access to language services). Samples for the survey are drawn from adults who have at least one provider visit within the past year. Measures can be calculated at the individual clinician level or at the group (e.g., practice, clinic) level.	Cultural competency	NQF #1904—Clinician/ group's cultural competence based on the CAHPS Cultural Competence Item Set (AHRQ)	Applicable to ambulatory care, hospital, and behavioral health settings. See Appendix C for list of measures.	NQF, 2012c NQF, 2012f
Clinician/ groups' health literacy practices based on the CAHPS Item Set for Addressing Health Literacy	These measures are based on the CAHPS Item Set for Addressing Health Literacy, a set of supplemental items for the CG-CAHPS. The item set includes the following domains: communication with provider (doctor), disease self-management, communication about medicines, communication about test results, and communication about forms. Samples for the survey are drawn from adults who have had at least one provider visit within the past year. Measures can be calculated at the individual clinician level or at the group (e.g., practice, clinic) level.	Health literacy	NQF #1902—Clinician/groups' health literacy practices based on the CAHPS Item Set for Addressing Health Literacy (AHRQ)	Applicable to ambulatory care, hospital, and behavioral health settings.	NQF, 2012d NQF, 2012f

MEASURE(S)	DESCRIPTION	AREA OF FOCUS	SOURCE ID	NOTES	REFERENCE
Patients receiving language services supported by qualified language services providers	This measure is used to assess the percentage of patients with LEP receiving both initial assessment and discharge instructions from assessed and trained interpreters or from bilingual providers and bilingual workers/employees assessed for language proficiency. The measure provides information on the extent to which language services are provided by trained and assessed interpreters or assessed bilingual providers and bilingual workers/employees during critical times in a patient's health care experience.	Language services	NQF #1821—L2: Patients receiving language services supported by qualified language services providers (measure steward: George Washington University Department of Health Policy)	Applicable to all settings	NQF, 2012b NQF, 2012f
Screening for preferred spoken language for health care	This measure is used to assess the percentage of patient visits and admissions where preferred spoken language for health care is screened and recorded. This measure provides information on the extent to which patients are asked about the language they prefer to receive care in and the extent to which this information is recorded.	Language screening	NQF #1824—L1A: Screening for preferred spoken language for health care (measure steward: George Washington University Department of Health Policy)	Applicable to ambulatory care, hospital, and behavioral health settings	NQF, 2012a NQF, 2012f

MEASURE(S)	DESCRIPTION	AREA OF FOCUS	SOURCE ID	NOTES	REFERENCE
Cultural Competency Implementation Measure	The Cultural Competency Implementation Measure is an organizational survey designed to assist HCOs in identifying the degree to which they are providing culturally competent care and addressing the needs of diverse populations, as well as their adherence to 12 of the 45 NQF-endorsed cultural competency practices prioritized for the survey. Domains include leadership, integration into the management system and operations, patient-provider communication, care delivery and supporting mechanisms, workforce diversity and training, community engagement, data collection, public accountability, and quality improvement.	Cultural competency implementation	NQF #1919—Cultural Competency Implementation Measure (measure steward: RAND Corporation)	Applicable to ambulatory care, hospital, and behavioral health settings These measures have yet to be tested/validated.	NQF, 2012e NQF, 2012f
C-CAT	C-CAT, which has been extensively validated in diverse HCOs nationally, provides a 360-degree organizational assessment using coordinated patient, staff, and leadership surveys, as well as an organizational workbook that collects important information on the organization's policies and practices. When analyzed together, C-CAT's tools provide tangible, reliable metrics that demonstrate whether an organization's policies, practices, and culture promote effective, patient-centered communication. Trained consultants provide guidance and assistance throughout the assessment, conduct statistical analysis of data (including comparisons against a national benchmarking database) and create a feedback report featuring personalized, site-specific recommendations. In addition to helping maximize the impact of performance improvement efforts, the use of C-CAT provides valuable information regarding needs assessments and meeting local and national standards. Organizations using C-CAT find that it compliments CAHPS assessments, documents compliance with Title VI (CLAS) standards, and is invaluable in meeting The Joint Commission's patient-centered communication standards.	Communication climate	C-CAT survey (measure steward: University of Colorado Center for Bioethics and Humanities)	Applicable to all settings	Center for Bioethics and Humanities, undated NQF, 2012f

TABLE E.2. CROSS-CUTTING MEASURES: ADDITIONAL DETAILS

MEASURES	ITEMS
Clinician/group's cultural competence based on the CAHPS Cultural Competence Item Set	These measures are based on the CAHPS Cultural Competence Item Set, a set of supplemental items for the CG-CAHPS that includes the following domains: patient-provider communication; complementary and alternative medicine; experiences of discrimination because of race/ethnicity, insurance, or language; experiences leading to trust or distrust, including level of trust, caring, and confidence in the truthfulness of their provider; and linguistic competency (access to language services). Samples for the survey are drawn from adults who have had at least one provider visit within the past year. Measures can be calculated at the individual clinician level or at the group (e.g., practice, clinic) level.
Patient-provider communication (Note: CU3, CU5, and CU8 form a composite measure: Providers are polite and considerate)	CU1: In the last 12 months, how often were the explanations this provider gave you hard to understand because of an accent or the way the provider spoke English? CU2: In the last 12 months, how often did this provider use medical words you did not understand? CU3: In the last 12 months, how often did this provider talk too fast when talking with you? CU4: In the last 12 months, how often did this provider ignore what you told him or her? CU5: In the last 12 months, how often did this provider interrupt you when you were talking? CU6: In the last 12 months, how often did this provider show interest in your questions and concerns? CU7: In the last 12 months, how often did this provider answer all of your questions to your satisfaction? CU8: In the last 12 months, how often did this provider use a condescending, sarcastic, or rude tone or manner with you?
Complementary and alternative medicine	CU9: People sometimes see someone else besides their providers or specialists to help with an illness or to stay healthy. In the last 12 months, have you ever used an acupuncturist? CU10: In the last 12 months, have you ever used an herbalist? CU11: In the last 12 months, has this provider ever asked you if you have used an acupuncturist or an herbalist to help with an illness or to stay healthy? CU12: Some people use natural herbs for health reasons or to stay healthy. Natural herbs include such things as ginseng, green tea, and other herbs. People can take them as a pill, a tea, an oil, or a powder. In the last 12 months, have you ever used natural herbs for your own health? CU13: In the last 12 months, has this provider ever asked you if you used natural herbs?

MEASURES	ITEMS
Experiences of discrimination because of race/ethnicity, insurance, or language	CU14: In the last 12 months, how often have you been treated unfairly at this provider's office because of your race or ethnicity? CU15: In the last 12 months, how often have you been treated unfairly at this provider's office because of the type of health insurance you have or because you do not have health insurance?
Experiences leading to trust or distrust, including level of trust, caring, and truth-telling (Note: CU16–CU20 form a composite measure: Providers are caring and inspire trust.)	CU16: In the last 12 months, did you feel you could tell this provider anything, even things that you might not tell anyone else? CU17: In the last 12 months, did you feel you could trust this provider with your medical care? CU18: In the last 12 months, did you feel that this provider always told you the truth about your health, even if there was bad news? CU19: In the last 12 months, did you feel this provider cared as much as you do about your health? CU20: In the last 12 months, did you feel this provider really cared about you as a person? CU21: Using any number from 0 to 10, where 0 means that you do not trust this provider at all and 10 means that you trust this provider completely, what number would you use to rate how much you trust this provider?

MEASURES	ITEMS
Linguistic competency (access to language services)	CU22: What is your preferred language? CU23: How well do you speak English? CU24: In the last 12 months, how often were you treated unfairly at this provider's office because you did not speak English very well? CU25: An interpreter is someone who helps you talk with others who do not speak your language. Interpreters can include staff from the provider's office or telephone interpreters. In the last 12 months, was there any time when you needed an interpreter at this provider's office? CU26: In the last 12 months, did anyone in this provider's office let you know that an interpreter was available free of charge? CU27: In the last 12 months, how often did you use an interpreter provided by this office to help you talk with this provider? CU28: In the last 12 months, when you used an interpreter provided by this office, who was the interpreter you used most often? CU29: In the last 12 months, how often did this interpreter treat you with courtesy and respect? CU30: Using any number from 0 to 10, where 0 is the worst interpreter possible and 10 is the best interpreter possible, what number would you use to rate this interpreter? CU31: In the last 12 months, did any of your appointments with this provider start late? CU32: Did any of your appointments start late because you had to wait for an interpreter? CU33: In the last 12 months, how often did you use a friend or family member as an interpreter when you talked with this provider? CU34: In the last 12 months, did you use friends or family members as interpreters because that was what you preferred?
Clinician/groups' health literacy practices based on the CAHPS Item Set for Addressing Health Literacy	These measures are based on the CAHPS Item Set for Addressing Health Literacy, a set of supplemental items for the CG-CAHPS. The item set includes the following domains: communication with provider (doctor), disease self-management, communication about medicines, communication about test results, and communication about forms. Samples for the survey are drawn from adults who have had at least one provider visit within the past year. Measures can be calculated at the individual clinician level or at the group (e.g., practice, clinic) level.

MEASURES	ITEMS
Communication with provider	HL1: In the last 12 months, how often were the explanations this provider gave you hard to understand because of an accent or the way the provider spoke English? HL2: In the last 12 months, how often did this provider use medical words you did not understand? HL3: In the last 12 months, how often did this provider talk too fast when talking with you? HL4: In the last 12 months, how often did this provider use pictures, drawings, models, or videos to explain things to you? HL5: In the last 12 months, how often did this provider ignore what you told him or her? HL6: In the last 12 months, how often did this provider interrupt you when you were talking? HL7: In the last 12 months, how often did this provider show interest in your questions and concerns? HL8: In the last 12 months, how often did this provider answer all of your questions to your satisfaction? HL9: In the last 12 months, how often did this provider give you all the information you wanted about your health? HL10: In the last 12 months, how often did this provider encourage you to talk about all your health questions or concerns? HL17: In the last 12 months, how often did this provider use a condescending, sarcastic, or rude tone or manner with you?
Disease self-management	HL11: In the last 12 months, did you see this provider for a specific illness or for any health condition? HL12: In the last 12 months, did this provider give you instructions about what to do to take care of this illness or health condition? HL13: In the last 12 months, how often were these instructions easy to understand? HL14: In the last 12 months, how often did this provider ask you to describe how you were going to follow these instructions? HL15: Sometimes providers give instructions that are hard to follow. In the last 12 months, how often did this provider ask you whether you would have any problems doing what you needed to do to take care of this illness or health condition? HL16: In the last 12 months, how often did this provider explain what to do if this illness or health condition got worse or came back?

MEASURES	ITEMS
Communication about medicines (Note: HL20, HL22, HL24, and HL26 form a composite measure: Providers communicate about medicines.)	HL19: In the last 12 months, did this provider prescribe any new medicines or change how much medicine you should take? HL20: In the last 12 months, did this provider give instructions about how to take your medicines? HL21: In the last 12 months, how often were these instructions about how to take you medicines easy to understand? HL22: In the last 12 months, did this provider explain the possible side effects of your medicines? HL23: In the last 12 months, how often were these explanations easy to understand? HL24: In the last 12 months, other than a prescription, did this provider give you written information or write down information about how to take your medicines? HL25: In the last 12 months, how often was the written information you were given easy to understand? HL26: In the last 12 months, how often did this provider suggest ways to help you remember to take your medicines?
Communication about test results	Core 21: In the last 12 months, did this provider order a blood test, X-ray, or other test for you? Core 22: In the last 12 months, when this provider ordered a blood test, X-ray, or other test for you, how often did someone from this provider's office follow up to give you those results? HL26: In the last 12 months, how often were the results of your blood test, X-ray, or other test easy to understand?
Communication about forms	HL27: In the last 12 months, did you sign any forms at this provider's office? HL28: In the last 12 months, how often did someone explain the purpose of a form before you signed it? HL29: In the last 12 months, did you fill out any forms at this provider's office? HL30: In the last 12 months, how often were you offered help to fill out a form at this provider's office? HL31: In the last 12 months, how often were the forms from this provider's office easy to fill out?
Cultural Competency Implementation Measure	The Cultural Competency Implementation Measure is an organizational survey designed to assist HCOs in identifying the degree to which they are providing culturally competent care and addressing the needs of diverse populations, as well as their adherence to 12 of the 45 NQF-endorsed cultural competency practices prioritized for the survey. The target audience for this survey includes HCOs across a range of health care settings, including hospitals, health plans, community clinics, and dialysis organizations. Information from the survey can be used for QI, provide information that can help HCOs establish benchmarks and assess how they compare in relation to peer organizations, and for public reporting. Domains include leadership, integration into the management system and operations, patient-provider communication, care delivery and supporting mechanisms, workforce diversity and training, community engagement, data collection, public accountability, and quality improvement.

MEASURES	ITEMS
Subdomain: commitment to serving a diverse population	Has your organization: 1. reviewed its vision statement, goals, and mission to ensure that they reflect a commitment to culturally competent care? 2. provided staff members with the opportunity to provide input and comment on the action plan for providing culturally competent care? 3. made the vision statement, goals, mission, and the action plan for providing culturally competent care publicly available throughout the organization and the community? 4. developed and/or revised the organization's vision statement, goals, and mission to ensure that it reflects a commitment to providing high-quality, culturally competent care for diverse populations? 5. developed an action plan that includes explicit expectations and measureable objectives relating to culturally competent care? 6. implemented or updated the action plan for providing high-quality, culturally competent care to the diverse populations your organization serves?
Subdomain: leadership diversity	Has your organization: 1. reviewed the strategies for staff recruitment and the selection processes to assess whether staff at all levels of the organization reflect the demographic characteristics of the service area? 2. ensured that staff recruitment and selection processes focus on meeting the needs of the organization's goals for culturally competent care? 3. sought input from community leaders on strategies to recruit, retain, and promote staff at all levels of the organization (including upper management)? 4. used a committee of current diverse staff to develop strategies for recruitment, retention, and promotion of staff that reflect the community at all levels of the organization (including upper management)? 5. conducted an internal assessment on how to address the need for staff diversity at all levels of the organization, including upper management? 6. conducted an external assessment on how to address the need for staff diversity at all levels of the organization, including upper management? (This can include obtaining data on the demographic characteristics of the service area and comparing it to the diversity of staff.) 7. developed or implemented strategies for recruiting, retaining, and promoting a diverse staff at all levels of the organization, including upper management? 8. advertised and recruited from the community served?

MEASURES	ITEMS
Subdomain: dedicated staff and resources	Have your organization's leaders: 1. consulted with the care setting managers, clinical leaders, language service providers, and others to identify needed fiscal resources to appropriately meet the cultural needs of patients? 2. consulted with the care setting managers, clinical leaders, language service providers, and others to identify needed human resources to appropriately meet the cultural needs of patients? 3. documented where the fiscal support for culturally competent policies and practices is within the organization? 4. established and enforced organizational policies that support the allocation of fiscal resources for cultural competency? 5. ensured that there are budget line items and specific allocations for cultural competency activities and programs that reflect the organization's goals for providing culturally competent care? 6. provided staff with time and resources for training programs and practices that promote culturally competent care? 7. provided training and coaching on culturally competent care to new staff? 8. provided continued training and coaching on culturally competent care to current staff?
Subdomain: strategic planning	Has your organization: 1. reviewed the organizational strategic plan to ensure that it has clear goals that include providing culturally competent services? 2. involved consumers and the community served in the development of a strategic plan that has clear goals that include providing culturally competent services? 3. involved staff in the development of a strategic plan that has clear goals that include providing culturally competent services? 4. gathered data on community needs to inform the development and refinement of goals, plans, and policies for providing culturally competent care as part of the organizational strategic plan? 5. conducted an organizational self-assessment to inform the development and refinement of goals, plans, and policies for providing culturally competent care as part of the organizational strategic plan? 6. used results from the community needs assessment and self-assessment processes to inform the development and refinement of goals, plans, and policies for providing culturally competent care as part of the organizational strategic plan?

MEASURES	ITEMS
Subdomain: reward systems	Has your organization: 1. reviewed job performance evaluation criteria to assess staff to ensure that they include specific improvement goals related to cultural competence? 2. reviewed evaluation criteria used to assess initiatives and programs within the organization that promote cultural competence? 3. compared job performance evaluation criteria that include aspects of cultural competence with other recognition activities and awards to make sure they are on equal par? 4. compared evaluation criteria to assess initiatives and programs that promote cultural competence with other recognition activities and awards to make sure they are on equal par? 5. established standardized evaluation criteria that include aspects of cultural competence to assess individuals within the organization who promote cultural competency? 6. established standardized evaluation criteria that include aspects of cultural competence to assess initiatives and programs within the organization that promote cultural competency? 7. rewarded or recognized individuals within the organization who improve cultural competency and reduce health care disparities or who go beyond the preferred practices included in the *Framework and Preferred Practices for Measuring and Reporting on Cultural Competency*? 8. rewarded or recognized initiatives or programs within the organization that improve cultural competency and reduce health care disparities or that go beyond the preferred practices included in the *Framework and Preferred Practices for Measuring and Reporting on Cultural Competency*?

MEASURES	ITEMS
Subdomain: language access	Has your organization: 1. reviewed its language assistance resource policies to ensure that it is providing language assistance to persons with LEP at no cost to them? 2. reviewed language assistance services available in different areas of the organization? 3. reviewed wait times for language assistance services available in different areas of the organization? 4. evaluated the qualifications of all staff providing interpreting services or care directly provided in another language to patients? 5. assessed the competency of all staff providing interpreting services or care directly provided in another language to patients? 6. monitored all staff providing interpreting services or care directly provided in another language to patients to determine competency to provide services in health care settings? 7. created uniform procedures for timely and effective telephone communication between staff and LEP patients? 8. informed individuals with LEP—in their primary language—that they have the right to free language assistance services and that such services are readily available? 9. distributed, at points of contact, written notices with information informing patients that they have the right to free language assistance services and that such services are readily available? 10. used language identification or "I speak. . . " cards to inform patients that they have the right to free language assistance services and that such services are readily available? 11. posted translated signage at points of entry in regularly encountered languages that language assistance services are available free of charge? 12. distributed to the public brochures, booklets, outreach materials, and other materials in regularly encountered non-English languages that include statements about the language assistance services available and the right to free language assistance services? 13. provided qualified language resources, including competent interpreters (staff, contractors from outside agencies, remote telephonic or video interpreting services, or credentialed volunteers) and/or bilingual/multilingual clinical staff for clinical encounters? 14. provided bilingual/multilingual general staff as navigators for other encounters (e.g., to assist in making appointments, assist with transfers within a facility)?

MEASURES	ITEMS
Subdomain: clinical encounter	Within the past 12 months, how often has your organization: 1. reviewed patient care plans provided to patients to ensure that they address the physical, cultural, and social needs of the patient, including cultural background, religion, and spiritual belief system? Within the past 12 months, has your organization: 2. developed a comprehensive care plan with patients and their caregivers to ensure that the plan addresses the physical, cultural, and social needs of the patient, including cultural background, religion, and spiritual belief system? Within the past 12 months, how often has your organization: 3. collected information on patients' and families' primary written and spoken languages and any cultural beliefs that might affect the care plan, including but not limited to those involving spirituality/religion, nation of origin, and ethnicity? Within the past 12 months, has your organization: 4. implemented comprehensive care plans that address the physical, cultural, and social needs of the patient, including cultural background, religion, and spiritual belief system?
Subdomain: training commitment and content	Has your organization: 1. reviewed training materials and programs used to provide cultural competence training? 2. assessed its progress in recruiting, hiring, and retaining qualified, diverse staff at all levels of the organization? 3. evaluated cultural competence training programs to ensure that managers and staff at all levels receive training that is effective, relevant, and up to date? 4. had human resource managers assess the qualifications of staff responsible for cultural competency training? 5. had human resource managers assess and report on employee promotions, terminations, and resignations to evaluate how well the organization is doing in the promotion and retention of a diverse workforce? 6. developed or updated training materials or programs to increase staff awareness of the cultural needs, beliefs, and attitudes of the predominant populations served by the organization? 7. included or updated training materials or programs to provide staff with in-depth information about the causes of and research on cultural competency, inequities, and health care disparities? 8. provided staff with time and resources for training programs and practices that promote culturally competent care? 9. provided training and coaching to new staff to increase cultural competency awareness, knowledge, and skills? 10. provided training and coaching to current staff to increase cultural competency awareness, knowledge, and skills?

MEASURES	ITEMS
Subdomain: community outreach	Has your organization: 1. identified resources in the community to develop training programs, research projects, and outreach activities to help understand and address the cultural needs of the communities served? 2. created a community advisory board that is representative of the diverse community served by the organization? 3. established or maintained collaborative relationships with community organizations to help understand and address the cultural needs of the communities served? 4. worked with community organizations on specific health education programs to raise awareness about local health care services? 5. utilized community experience and resources to develop training programs, research projects, or outreach activities to address the needs of culturally diverse populations, or to address health care disparities and equity in the community?
Subdomain: collection of patient cultural competency-related information	Has your organization: 1. reviewed patient data on race/ethnicity to ensure that you are collecting this information using Office of Management and Budget (OMB) categories as modified by HRET231? 2. reviewed data from health records to ensure that data on an individual patient's race/ethnicity and primary written and spoken language are collected? 3. reviewed data from your organization's management information system to ensure data from patients' health records on an individual patient's race and ethnicity and primary written and spoken language are integrated into the management information systems? 4. reviewed policies and procedures to ensure that patients' race/ethnicity data is not used for discriminatory purposes? 5. developed, maintained, or improved the process for collecting data on an individual patient's race and ethnicity and primary written and spoken language in the patient's health record? 6. developed, maintained, or improved the process for integrating data on an individual patient's race/ethnicity and primary written and spoken language into management information systems?

MEASURES	ITEMS
Subdomain: quality improvement	Has your organization: 1. identified NQF-endorsed performance measures to collect and use for QI activities focused on providing more culturally competent care and discovering and eliminating health care disparities in access, outcomes, or patient experiences with care? 2. based on national benchmarks, set organizational targets and benchmarks for performance measures? 3. utilized performance improvement methodology and science, such as rapid-cycle change and Plan-Do-Study-Act cycles to implement QI activities focused on providing more culturally competent care and eliminating health care disparities in access, outcomes, or patient experiences with care? 4. used information on patients' race, ethnicity, and primary written and spoken language to design and/or inform QI strategies and projects focused on providing more culturally competent care and eliminating health care disparities in access, outcomes, or patient experiences with care? 5. implemented QI strategies or projects focused on providing more culturally competent care and eliminating health care disparities in access, outcomes, or patient experiences with care?
Subdomain: assessment of patient experiences with care	Within the past 12 months, has your organization: 1. collected information on model health care programs that use patient- and family-centered communication? 2. conducted site visits to successful health care programs that use patient- and family-centered communication? 3. consulted published guides on improving patient-provider communication? 4. utilized focus groups or patient surveys in the patient's preferred language, to collect data on patient experience of care as it relates to patient-provider communication? 5. collected data or sought input from staff on patient and family communication needs and performance? 6. utilized a patient survey to collect patient experience of care data that is being publicly reported either by your organization or by another organization? 7. designed communication initiatives based on the needs of patients, families, and staff? 8. used champions to build support for new communication initiatives by presenting qualitative and quantitative data on patient and family communication needs and staff performance? 9. implemented communication initiatives designed to improve patient and family-centered communication? 10. utilized findings from patient focus groups or patient surveys to assess whether patients and their families find that patient-provider communication is effective?

MEASURES	ITEMS
C-CAT	C-CAT, which has been extensively validated in diverse HCOs nationally, provides a 360-degree organizational assessment using coordinated patient, staff, and leadership surveys, as well as an organizational workbook that collects important information on the organization's policies and practices. When analyzed together, C-CAT's tools provide tangible, reliable metrics that demonstrate whether an organization's policies, practices, and culture promote effective, patient-centered communication. Trained consultants provide guidance and assistance throughout the assessment, conduct statistical analysis of data (including comparisons against a national benchmarking database) and create a feedback report featuring personalized, site-specific recommendations. In addition to helping maximize the impact of performance improvement efforts, the use of C-CAT provides valuable information regarding needs assessments and meeting local and national standards. Organizations using C-CAT find that it compliments CAHPS assessments, documents compliance with Title VI (CLAS) Standards and is invaluable in meeting The Joint Commission's patient-centered communication standards.
Workforce development measure derived from the workforce development domain of the C-CAT	Site score on the measure domain of "workforce development" of the C-CAT, 0–100
Leadership commitment measure derived from the leadership commitment domain of the C-CAT	Site score on the measure derived from the domain of "leadership commitment" of the C-CAT, 0–100

MEASURES	ITEMS
Cross-cultural communication measure derived from the cross-cultural communication domain of the C-CAT	Site score for "cross-cultural communication" domain of the C-CAT, 0–100
Health literacy measure derived from the health literacy domain of the C-CAT	Site score on the domain of "health literacy" of the C-CAT, 0–100
Performance evaluation measure derived from the performance evaluation domain of the C-CAT	Site score on domain of "performance evaluation" of the C-CAT, 0–100
Individual engagement measure derived from the individual engagement domain of the C-CAT	Site score on "individuals' engagement" domain of patient-centered communication, per the C-CAT, 0–100

MEASURES	ITEMS
Language services measure derived from the language services domain of the C-CAT	Site score on the domain of "language services" of the C-CAT, 0–100

References

Acosta, Joie D., Anita Chandra, Malcolm Williams, and Lois M. Davis, *Source Materials for the Healthy Communities Toolkit: A Resource Guide for Community and Faith-Based Organizations*, Santa Monica, Calif.: RAND Corporation, TR-951-DHHS, 2011. As of August 18, 2016: http://www.rand.org/pubs/technical_reports/TR951.html

Adepoju, Omolola E., Michael A. Preston, and Gilbert Gonzales, "Health Care Disparities in the Post–Affordable Care Act Era," *American Journal of Public Health*, Vol. 105, No. 5, November 2015, pp. S665–S667.

Agency for Healthcare Research and Quality, "CAHPS Surveys and Tools to Advance Patient-Centered Care," undated. As of August 22, 2016: http://www.ahrq.gov/cahps/index.html

———, *About the CAHPS Cultural Competency Set*, Rockville, Md., No. 2312, May 1, 2012. As of November 10, 2017: https://www.ahrq.gov/sites/default/files/wysiwyg/cahps/surveys-guidance/survey4.0-docs/2312_about_cultural_comp.pdf

———, "2012 National Healthcare Disparities Report," Rockville, Md., June 2013a. As of August 18, 2016: https://archive.ahrq.gov/research/findings/nhqrdr/nhdr12/2012nhdr.pdf

———, "CAHPS Clinician & Group Survey," webpage, June 2013b. As of November 10, 2017: https://www.ahrq.gov/cahps/surveys-guidance/cg/index.html

———, "CAHPs Hospital Survey," webpage, October 2014. As of November 10, 2017: https://www.ahrq.gov/cahps/surveys-guidance/hospital/index.html

———, "Experience of Care & Health Outcomes (ECHO)," Rockville, Md., May 2016. As of November 10, 2017: http://www.ahrq.gov/cahps/surveys-guidance/echo/index.html

AHA—*See* American Hospital Association.

REFERENCES

AHRQ—*See* Agency for Healthcare Research and Quality.

Alegria, Margarita, Pinka Chatterji, Kenneth Wells, Zuhn Cao, Chih-nan Chen, David Takeuchi, James Jackson, and Xiao-Li Meng, "Disparity in Depression Treatment Among Racial and Ethnic Minority Populations in the United States," *Psychiatric Services*, Vol. 59, No. 11, November 2008, pp. 1264–1272.

Alley, Dawn E., Chisara N. Asomugha, Patrick H. Conway, and Darshak M. Sanghavi, "Accountable Health Communities—Addressing Social Needs Through Medicare and Medicaid," *New England Journal of Medicine*, Vol. 374, No. 1, 2016, pp. 8–11.

American Hospital Association, "Fast Facts on U.S. Hospitals," January 2016. As of November 10, 2017: http://www.aha.org/research/rc/stat-studies/fast-facts.shtml

American Hospital Association and the Institute for Diversity in Health Management, *Diversity and Disparities: A Benchmark Study of U.S. Hospitals*, Chicago, Ill.: The Health Research and Educational Trust, 2012.

American Psychological Association, *Guidelines on Multicultural Education, Training, Research, Practice, and Organizational Change for Psychologists*, 2002. As of November 10, 2017: http://www.apa.org/pi/oema/resources/policy/multicultural-guidelines.aspx

Anderson, Laurie M., Susan C. Scrimshaw, Mindy T. Fullilove, Jonathan E. Fielding, and Jacques Normand, "Culturally Competent Healthcare Systems: A Systematic Review," *American Journal of Preventive Medicine*, Vol. 24, No. 3, April 2003, pp. 68–79.

Barksdale, Crystal L., Phyllis Gyamfi Ottley, Robert Stephens, Tesfayi Gebreselassie, Imogen Fua, Melissa Azur, and Christine Walrath-Greene, "System-Level Change in Cultural and Linguistic Competence (CLC): How Changes in CLC are Related to Service Experience Outcomes in Systems of Care," *American Journal of Community Psychology*, Vol. 49, No. 3–4, 2012, pp. 483–493.

REFERENCES

Berkman, Nancy D., Stacey L. Sheridan, Katrina E. Donahue, David J. Halpern, and Karen Crotty, "Low Health Literacy and Health Outcomes: An Updated Systematic Review," *Annals of Internal Medicine*, Vol. 155, No. 2, 2011, pp. 97–107. As of November 10, 2017: http://annals.org/aim/article-abstract/747040/low-health-literacy-health-outcomes-updated-systematic-review?doi=10.7326%2f0003-4819-155-2-201107190-00005

Beronio, Kirsten, Rosa Po, Laura Skopec, and Sherry Glied, *Affordable Care Act Expands Mental Health and Substance Use Disorder Benefits and Federal Parity Protections for 62 Million Americans*, Washington, D.C.: U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation, February 20, 2013. As of August 18, 2016: https://aspe.hhs.gov/report/affordable-care-act-expands-mental-health-and-substance-use-disorder-benefits-and-federal-parity-protections-62-million-americans

Betancourt, Joseph R., Alexander R. Green, and J. Emilio Carrillo, *Cultural Competence in Health Care: Emerging Frameworks and Practical Approaches*, New York: The Commonwealth Fund, 2002.

Betancourt, Joseph R., Alexander R. Green, J. Emilio Carrillo, and Owusu Ananeh-Firempong, II, "Defining Cultural Competence: A Practical Framework for Addressing Racial/Ethnic Disparities in Health and Health Care," *Public Health Reports*, Vol. 118, No. 4, July–August 2003, pp. 293–302. As of November 9, 2017: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1497553/pdf/12815076.pdf

Betancourt, Joseph R., Aswita Tan-McGrory, and Karey S. Kenst, *Guide to Preventing Readmissions Among Racially and Ethnically Diverse Medicare Beneficiaries*, Baltimore, Md.: Centers for Medicare & Medicaid Services Office of Minority Health, September 2015. As of November 10, 2017: https://www.cms.gov/About-CMS/Agency-Information/OMH/Downloads/OMH_Readmissions_Guide.pdf

"Be There San Diego," homepage, undated. As of August 22, 2016: http://betheresandiego.org/

Brach, Cindy, and Irene Fraser, "Can Cultural Competency Reduce Racial and Ethnic Health Disparities? A Review and Conceptual Model," *Medical Care Research Review*, Vol. 57, No. 1, 2000, pp. 181–217. As of November 10, 2017: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5091811/pdf/nihms825245.pdf

REFERENCES

———, "Reducing Disparities Through Culturally Competent Health Care: An Analysis of the Business Case," *Quality Management in Health Care*, Vol. 10, No. 4, Summer 2002, pp. 15–28.

Brach, Cindy, Kathryn Paez, and Irene Fraser, *Cultural Competence California Style*, Rockville, Md.: Agency for Healthcare Research and Quality, February 2006.

Briefer French, Jessica, Diane Schiff, Esther Han, and Robin Weinick, *Multicultural Health Care: A Quality Improvement Guide*, Washington, D.C.: The National Committee for Quality Assurance, 2008. As of November 10, 2017: https://innovations.ahrq.gov/qualitytools/multicultural-health-care-quality-improvement-guide

Brownson, Ross C., Peg Allen, Kathleen Duggan, Katherine A. Stamatakis, and Paul C. Erwin, "Fostering More-Effective Public Health by Identifying Administrative Evidence-Based Practices: A Review of the Literature," *American Journal of Preventive Medicine*, Vol. 43, No. 3, 2012, pp. 309–319.

Bureau of Primary Health Care, *Uniform Data System: Reporting Instructions for Health Centers*, Rockville, Md.: Health Resources and Services Administration, September 3, 2015. As of August 22, 2016: https://bphc.hrsa.gov/datareporting/reporting/2015udsmanual.pdf

Campinha-Bacote, Josepha, "The Process of Cultural Competence in the Delivery of Healthcare Services: A Model of Care," *Journal of Transcultural Nursing*, Vol. 13, No. 3, July 2002, pp. 181–184.

CDC—*See* Centers for Disease Control and Prevention.

CDC NCHS—*See* Centers for Disease Control and Prevention, National Center for Health Statistics.

California Department of Public Health, Title 17, California Code of Regulations §2500, §2593, §2641.5–2643.20, and §2800–2812, Reportable Diseases and Conditions, July 2016.

Center for Bioethics and Humanities, "C-CAT Surveys," webpage, University of Colorado Anschutz Medical Campus, undated. As of November 10, 2017: http://www.ucdenver.edu/academics/colleges/medicalschool/centers/BioethicsHumanities/C-CAT/Pages/C-CAT-Surveys.aspx

REFERENCES

Centers for Disease Control and Prevention, "Introduction to Program Evaluation for Public Health Programs: A Self-Study Guide," webpage, May 11, 2012. As of November 6, 2017: https://www.cdc.gov/eval/guide/introduction/

———, *Community Needs Assessment: Participant Workbook*, Atlanta, Ga., 2013. As of November 6, 2017: https://www.cdc.gov/globalhealth/healthprotection/fetp/training_modules/15/community-needs_pw_final_9252013.pdf

———, "Core Functions of Public Health and How They Relate to the 10 Essential Services," webpage, June 10, 2016a. As of August 19, 2016: http://www.cdc.gov/nceh/ehs/ephli/core_ess.htm

———, "Ambulatory Care Use and Physician Office Visits," data set, June 13, 2016b. As of August 22, 2016: http://www.cdc.gov/nchs/fastats/physician-visits.htm

———, "Developing and Using a Logic Model," Atlanta, Ga., January 19, 2017a. As of November 6, 2017: https://www.cdc.gov/dhdsp/programs/spha/evaluation_guides/logic_model.htm

———, "State, Tribal, Local & Territorial Public Health Professionals Gateway: The Public Health System and the 10 Essential Public Health Services," webpage, September 20, 2017b. As of November 10, 2017: https://www.cdc.gov/stltpublichealth/publichealthservices/essentialhealthservices.html

Centers for Disease Control and Prevention, National Center for Health Statistics, "National Hospital Ambulatory Medical Care Survey: 2011 Outpatient Department Summary Tables," undated. As of November 10, 2017: https://www.cdc.gov/nchs/data/ahcd/nhamcs_outpatient/2011_opd_web_tables.pdf

———, *Association of State and Territorial Health Officials, Policies for Eliminating Healthcare-Associated Infections: Lessons from State Stakeholder Engagement*, 1987.

———, "Hospital Utilization (in Non-Federal Short-Stay Hospitals)," April 2016. As of November 10, 2017: http://www.cdc.gov/nchs/fastats/hospital.htm

REFERENCES

Centers for Medicare & Medicaid Services, "Accountable Health Communities (AHC) Model Fact Sheet," January 5, 2016a. As of August 22, 2016: https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2016-Fact-sheets-items/2016-01-05.html

———, "CMS Releases Interactive Mapping Medicare Disparities Tool," press release, March 17, 2016b. As of August 22, 2016: https://www.cms.gov/Newsroom/MediaReleaseDatabase/Press-releases/2016-Press-releases-items/2016-03-17.html

Chen, Alice H., Mara K. Youdelman, and Jamie Brooks, "The Legal Framework for Language Access in Healthcare Settings: Title VI and Beyond," *Journal of General Internal Medicine*, Vol. 22, No. 2, November 2007, pp. 362–367. As of August 22, 2016: http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2150609/

Chinman, Matthew, Pamela Imm, and Abraham Wandersman, *Getting to Outcomes 2004: Promoting Accountability Through Methods and Tools for Planning, Implementation, and Evaluation*, Santa Monica, Calif.: RAND Corporation, TR-101-CDC, January 2004. As of October 31, 2017: https://www.rand.org/pubs/technical_reports/TR101.html

CMS—*See* Centers for Medicare & Medicaid Services.

Community Tool Box, "2. Assessing Community Needs and Resources," undated(a). As of November 6, 2017: http://ctb.ku.edu/en/assessing-community-needs-and-resources

———, "Chapter 3: Section 1. Developing a Plan for Accessing Local Needs and Resources," undated(b). As of November 6, 2017: http://ctb.ku.edu/en/table-of-contents/assessment/assessing-community-needs-and-resources/develop-a-plan/main

Consumer Partnership for eHealth, *Leveraging Meaningful Use to Reduce Health Disparities: An Action Plan*, Washington, D.C.: National Partnership for Women and Families, August 2013. As of November 10, 2017: http://www.nationalpartnership.org/research-library/health-care/HIT/leveraging-meaningful-use-to.pdf

REFERENCES

COSMOS Corporation, *Developing a Self-Assessment Tool for Culturally and Linguistically Appropriate Services in Local Public Health Agencies: Final Report*, Bethesda, Md., December 2003. As of November 10, 2017: http://minorityhealth.hhs.gov/assets/pdf/checked/lphas_finalreport.pdf

CyraCom, LLC, *How Language Services are Provided in Hospitals Across the U.S.: Survey Results*, 2010. As of November 10, 2017: http://img.en25.com/Web/CyraComInternationalInc/%7B6f50fa62-512c-4ffd-9f6d-f2d0a626be26%7D_Whitepaper_-_How_Language_Services_are_Provided_in_Hospitals_Across_the_US.pdf

Dansky, Kathryn H., Robert Weech-Maldonado, Gita De Souza, and Janice L. Dreachslin, "Organizational Strategy and Diversity Management: Diversity-Sensitive Orientation as a Moderating Influence," *Health Care Management Review*, Vol. 28, No. 3, July–September 2003, pp. 243–253. As of November 10, 2017: https://insights.ovid.com/pubmed?pmid=12940346

Davidson, Patricia M., Peter Macdonald, Debra K. Moser, Esther Ang, Glenn Paull, Sam Choucair, John Daly, Leila Gholizadeh, and Kathleen Dracup, "Cultural Diversity in Heart Failure Management: Findings from the DISCOVER Study (Part 2)," *Contemporary Nurse*, Vol. 25, No. 1–2, 2007, pp. 50–62.

Davis, Lois M., Laurie T. Martin, Allen Fremont, Robert Weech-Maldonado, Malcolm V. Williams, and Alice Kim, *Development of a Long-Term Evaluation Framework for the National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health and Health Care*, Washington, D.C.: U.S. Department of Health and Human Services, Office of Minority Health, PR-3598-DHHS/OMH, forthcoming.

DeRosa, Nancy, and Kim Kochurka, "Implement Culturally Competent Healthcare in Your Workplace," *Nursing Management*, Vol. 37, No. 10, October 2006, pp. 18, 20, 22.

Diamond, Lisa C., Amy Wilson-Stronks, and Elizabeth A. Jacobs, "Do Hospitals Measure Up to the National Culturally and Linguistically Appropriate Services Standards?" *Medical Care*, Vol. 48, No. 12, December 2010, pp. 1080–1087. As of November 10, 2017: https://www.ncbi.nlm.nih.gov/pubmed/21063229

Dickson, Victoria Vaughan, Margaret M. McCarthy, Alexandra Howe, Judith Schipper, and Stuart M. Katz, "Sociocultural Influences on Heart Failure Self-Care Among an Ethnic Minority Black Population," *Journal of Cardiovascular Nursing*, Vol. 28, No. 2, 2013, pp. 111–118.

REFERENCES

Diversity Connection, *Cultural Competency Assessment Tool for Hospitals (CCATH): Assessing Adherence to the CLAS Standards*, undated. As of April 18, 2018: http://www.diversityconnection.org/diversityconnection/membership/Resource%20Center%20Docs/CCATHOverview.pdf

Dreachslin, J. L., and F. Hobby, "Racial and Ethnic Disparities: Why Diversity Leadership Matters," *Journal of Healthcare Management*, Vol. 53, No. 1, January–February 2008, pp. 8–13.

Evangelista, Lorraine S., Kismet D. Rasmusson, Ann S. Laramee, Joan Barr, Susan E. Ammon, Sandra Dunbar, Susan Ziesche, J. Herbert Patterson, and Clyde W. Yancy, "Health Literacy and the Patient with Heart Failure—Implications for Patient Care and Research: A Consensus Statement of the Heart Failure Society of America," *Journal of Cardiac Failure*, Vol. 16, No. 1, 2010, pp. 9–16.

Federal Register, Executive Order 13166: Improving Access to Services for Persons with Limited English Proficiency, Vol. 65, No. 159, August 16, 2000. As of November 10, 2017: https://www.gpo.gov/fdsys/pkg/FR-2000-08-16/pdf/00-20938.pdf

Gertner, Eric J., Judith N. Sabino, Erica T. Mahady, Lynn M. Deitrich, Jarret R. Patton, Mary Kay Grim, James F. Geiger, and Debbie Salas-Lopez, "Developing a Culturally Competent Health Network: A Planning Framework and Guide," *Journal of Healthcare Management*, Vol. 55, No. 3, May–June 2010, pp. 190–204.

Green, Alexander R., Aswita Tan-McGrory, Marina C. Cervantes, and Joseph R. Betancourt, "Leveraging Quality Improvement to Achieve Equity in Health Care," *The Joint Commission Journal on Quality and Patient Safety*, Vol. 36, No. 10, 2010, pp. 435–442.

Greenhalgh, Trisha, Glenn Robert, Fraser Macfarlane, Paul Bate, and Olivia Kyriakidou, "Diffusion of Innovations in Service Organizations: Systematic Review and Recommendations," *Milbank Quarterly*, Vol. 82, No. 4, December 2004, pp. 581–629.

Hasnain-Wynia, Romana, Julie Yonek, Debra Pierce, Ray Kang, and Cynthia Hedges Greising, *Hospital Language Services for Patients with Limited English Proficiency: Results from a National Survey*, Chicago, Ill.: The Health Research and Educational Trust, 2006. As of November 10, 2017: http://www.hret.org/quality/projects/resources/languageservicesfr.pdf

REFERENCES

Health Indicators Warehouse, *Healthcare Effectiveness Data and Information Set (HEDIS)*, undated. As of August 22, 2016: http://www.healthindicators.gov/Resources/DataSources/HEDIS_56/Profile

HealthIT.gov, "How to Implement EHRs: Step 6: Continue Quality Improvement," webpage, March 20, 2014. As of February 14, 2018: https://www.healthit.gov/providers-professionals/ehr-implementation-steps/step-6-continue-quality-improvement

HHS—*See* U.S. Department of Health and Human Services.

HHS OMH—*See* U.S. Department of Health and Human Services, Office of Minority Health.

Hobgood, Cherri, Susan Sawning, Josie Bowen, and Katherine Savage, "Teaching Culturally Appropriate Care: A Review of Educational Models and Methods," *Academic Emergency Medicine*, Vol. 13, No. 12, December 2006, pp. 1288–1295.

Hyde, Justeen K., and Stephen M. Shortell, "The Structure and Organization of Local and State Public Health Agencies in the U.S.: A Systematic Review," *American Journal of Preventive Medicine*, Vol. 42, No. 5, 2012, pp. S29–S41.

Institute of Medicine, *Health Literacy: A Prescription to End Confusion*, Report Brief, April 2004. As of November 10, 2017: http://www.nationalacademies.org/hmd/~/media/Files/Report%20Files/2004/Health-Literacy-A-Prescription-to-End-Confusion/healthliteracyfinal.pdf

The Joint Commission, "Accountability Measures," undated(a). As of November 10, 2017: https://www.jointcommission.org/accountability_measures.aspx

———, "Behavioral Health Care," undated(b). As of August 18, 2016: https://www.jointcommission.org/accreditation/behavioral_health_care.aspx

———, *Behavioral Health Care Accreditation*, Oakbrook Terrace, Ill., 2007. As of November 10, 2017: https://www.jointcommission.org/assets/1/18/BHC_Toolkit.pdf

REFERENCES

———, *Advancing Effective Communication, Cultural Competence, and Patient- and Family-Centered Care: A Roadmap for Hospitals*, Oakbrook Terrace, Ill., 2010. As of November 10, 2017: https://www.jointcommission.org/assets/1/6/ARoadmapforHospitalsfinalversion727.pdf

———, *A Crosswalk of the National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health and Health Care to The Joint Commission Hospital Accreditation Standards*, Oakbrook Terrace, Ill., July 2014. As of November 10, 2017: https://www.jointcommission.org/assets/1/6/Crosswalk-_CLAS_-20140718.pdf

———, 2016 *Accountability Measure List for Accreditation: Chart Abstracted Process Measures*, January 2016. As of November 10, 2017: https://www.jointcommission.org/assets/1/18/accountability_measures_list_2016.pdf

Joynt, Karen E., E. John Orav, and Ashish K. Jha, "Thirty-Day Readmission Rates for Medicare Beneficiaries by Race and Site of Care," *JAMA*, Vol. 305, No. 7, February 16, 2011, pp. 675–681.

Karliner, Leah S., Andrew Auerbach, Anna Nápoles, Dean Schillinger, Dana Nickleach, and Eliseo J. Pérez-Stable, "Language Barriers and Understanding of Hospital Discharge Instructions," *Medical Care*, Vol. 50, No. 4, 2012.

Kim-Godwin, Yeoun Soo, Pamela N. Clarke, and Leslie Barton, "A Model for the Delivery of Culturally Competent Community Care," *Journal of Advanced Nursing*, Vol. 35, No. 6, September 2001, pp. 918–925.

The Lewin Group, Inc., *Indicators of Cultural Competence in Health Care Delivery Organizations: An Organizational Cultural Competence Assessment Profile*, April 2002. As of November 10, 2017: https://www.hrsa.gov/culturalcompetence/healthdlvr.pdf

Li, Wen-Wen, Anita L. Stewart, Nancy Stotts, and Erika Sivarajan Froelicher, "Cultural Factors Associated with Antihypertensive Medication Adherence in Chinese Immigrants," *Journal of Cardiovascular Nursing*, Vol. 21, No. 5, 2006, pp. 354–362.

MACPAC—*See* Medicaid and CHIP Payment and Access Commission.

REFERENCES

Mays, Glen P., Paul K. Halverson, and F. Douglas Scutchfield, "Behind the Curve? What We Know and Need to Learn from Public Health Systems Research," *Journal of Public Health Management and Practice*, Vol. 9, No. 3, 2003, pp. 179–182.

Medicaid and CHIP Payment and Access Commission, "Chapter 4: Behavioral Health in the Medicaid Program—People, Use and Expenditures," *Report to Congress on Medicaid and CHIP*, 2015. As of November 10, 2017:
https://www.macpac.gov/wp-content/uploads/2015/06/Behavioral-Health-in-the-Medicaid-Program%E2%80%94People-Use-and-Expenditures.pdf

Mitchell, Suzanne E., Ekaterina Sadikova, Brian W. Jack, and Michael K. Paasche-Orlow, "Health Literacy and 30-Day Postdischarge Hospital Utilization," *Journal of Health Communication*, Vol. 17, No. 3, 2012, pp. 325–338.

Mulia, Nina, Tammy W. Tam, and Laura A. Schmidt, "Disparities in the Use and Quality of Alcohol Treatment Services and Some Proposed Solutions to Narrow the Gap," *Psychiatric Services*, Vol. 65, No. 5, May 1, 2014, pp. 626–633.

NACCHO—*See* National Association of County and City Health Officials.

National Alliance on Mental Illness, "Mental Health By the Numbers," webpage, undated. As of March 14, 2016:
https://www.nami.org/Learn-More/Mental-Health-By-the-Numbers

National Association of County and City Health Officials, *2005 National Profile of Local Health Departments*, Washington, D.C., 2006. As of August 19, 2016:
http://www.naccho.org/topics/infrastructure/profile/upload/NACCHO_report_final_000.pdf

———, *2008 National Profile of Local Health Departments*, Washington, D.C., July 2009. As of August 19, 2016:
http://archived.naccho.org/topics/infrastructure/profile/resources/2008report/upload/NACCHO_2008_ProfileReport_post-to-website-2.pdf

REFERENCES

———, *2013 National Profile of Local Health Departments*, Washington, D.C., January 2014. As of August 19, 2016: http://archived.naccho.org/topics/infrastructure/profile/upload/2013-national-profile-of-local-health-departments-report.pdf

———, "Mobilizing for Action Through Planning and Partnerships (MAPP)," 2016. As of August 19, 2016: http://archived.naccho.org/topics/infrastructure/mapp/

National Center for Cultural Competence, *A Guide to Infusing Cultural & Linguistic Competence in Health Promotion Training: Group Activity—Understanding the Cultural Competence Continuum*, Washington, D.C.: Georgetown University Center for Child and Human Development, undated. As of November 10, 2017: https://nccc.georgetown.edu/video-infusing-clc/continuum.pdf

National CLAS Standards Implementation Activities, Rockville, Md.: U.S. Department of Health and Human Services, 2016. As of August 19, 2016: https://www.thinkculturalhealth.hhs.gov/pdfs/CLASCompendium.pdf

National Institute of Mental Health, "Minority Health and Mental Health Disparities Program," webpage, undated. As of November 10, 2017: http://www.nimh.nih.gov/about/organization/gmh/minority-health-and-mental-health-disparities-program.shtml

The National Learning Consortium, *Continuous Quality Improvement (CQI) Strategies to Optimize Your Practice*, April 30, 2013. As of November 6, 2017: https://www.healthit.gov/sites/default/files/tools/nlc_continuousqualityimprovementprimer.pdf

National Quality Forum, "NQF Quality Positioning System: NQF Measure Specifications," webpage, undated. As of November 10, 2017: http://www.qualityforum.org/QPS/QPSTool.aspx

REFERENCES

———, *National Voluntary Consensus Standards for Ambulatory Care—Measuring Healthcare Disparities*, Washington, D.C., March 2008. As of November 10, 2017: https://www.qualityforum.org/Publications/2008/03/National_Voluntary_Consensus_Standards_for_Ambulatory_Care%E2%80%94Measuring_Healthcare_Disparities.aspx

———, *A Comprehensive Framework and Preferred Practices for Measuring and Reporting Cultural Competency, A Consensus Report*, Washington, D.C., 2009. As of November 10, 2017: http://www.qualityforum.org/Publications/2009/04/A_Comprehensive_Framework_and_Preferred_Practices_for_Measuring_and_Reporting_Cultural_Competency.aspx

———, "L1A: Screening for Preferred Spoken Language for Health Care," Measure Submission and Evaluation Worksheet, NQF #1824, January 17, 2012a. As of November 10, 2017: http://www.qualityforum.org/WorkArea/linkit.aspx?LinkIdentifier=id&ItemID=70143

———, "L2: Patients Receiving Language Services Supported by Qualified Language Servcies [sic] Providers," Measure Submission and Evaluation Worksheet, NQF #1821, January 17, 2012b. As of November 10, 2017: http://www.qualityforum.org/WorkArea/linkit.aspx?LinkIdentifier=id&ItemID=70142

———, "Clinician/Group's Cultural Competence Based on the CAHPS Cultural Competence Item Set," Measure Submission and Evaluation Worksheet, NQF #1904, January 18, 2012c. As of November 10, 2017: http://www.qualityforum.org/WorkArea/linkit.aspx?LinkIdentifier=id&ItemID=70154

———, "Clinician/Group's Health Literacy Based on the CAHPS Item Set for Addressing Health Literacy," Measure Submission and Evaluation Worksheet, NQF #1902, January 18, 2012d. As of November 10, 2017: http://www.qualityforum.org/WorkArea/linkit.aspx?LinkIdentifier=id&ItemID=70154

———, "Cultural Competency Implementation Measure," Measure Submission and Evaluation Worksheet, NQF #1919, February 20, 2012e. As of November 10, 2017: http://www.qualityforum.org/WorkArea/linkit.aspx?LinkIdentifier=id&ItemID=70166

———, "Endorsement Summary: Healthcare Disparities and Cultural Competency Measures," August 2012f. As of November 10, 2017: https://www.qualityforum.org/WorkArea/linkit.aspx?LinkIdentifier=id&ItemID=71695

REFERENCES

———, *Healthcare Disparities and Cultural Competency Consensus Standards: Disparities-Sensitive Measure Assessment*, Washington D.C., November 15, 2012g. As of November 10, 2017: https://www.qualityforum.org/Publications/2012/11/Healthcare_Disparities_and_Cultural_Competency_Consensus_Standards__Disparities-Sensitive_Measure_Assessment.aspx

New York State Office of Mental Health, "Continuous Quality Improvement (CQI) Initiative for Health Promotion and Care Coordination," undated. As of November 6, 2017: https://www.omh.ny.gov/omhweb/psyckes_medicaid/initiatives/freestanding/project_tools/cqi/handbook/cqi-handbook.pdf

New York State Office of Mental Health, Office of Quality Management, "Quality Improvement Plan," 2005. As of April 17, 2018: https://www.doh.wa.gov/Portals/1/Documents/1000/PMC-NY-QI-Plan.pdf

NIMH—*See* National Institute of Mental Health.

NQF—*See* National Quality Forum.

Olavarria, Marcela, Julie Beaulac, Alexandre Bélanger, Marta Young, Tim Aubry, "Organizational Cultural Competence in Community Health and Social Service Organizations: How to Conduct a Self-Assessment," *Journal of Cultural Diversity*, Vol. 16, No. 4, Winter 2009, pp. 140–150.

Powell, Byron J., Thomas J. Waltz, Matthew J. Chinman, Laura J. Damschroder, Jeffrey L. Smith, Monica M. Matthieu, Enola K. Proctor, and JoAnn E. Kirchner, "A Refined Compilation of Implementation Strategies: Results from the Expert Recommendations for Implementing Change (ERIC) Project," *Implementation Science*, Vol. 10, No. 21, 2015. As of November 10, 2017: https://implementationscience.biomedcentral.com/articles/10.1186/s13012-015-0209-1

Public Health Accreditation Board, homepage, undated. As of November 10, 2017: http://www.phaboard.org/

RAND Corporation, "Getting to Outcomes: Improving Community-Based Prevention," webpage, undated. As of November 6, 2017: https://www.rand.org/health/projects/getting-to-outcomes.html

REFERENCES

Rodriguez, Fátima, Karen E. Joynt, Lenny López, Fidencio Saldaña, and Ashish K. Jha, "Readmission Rates for Hispanic Medicare Beneficiaries with Heart Failure and Acute Myocardial Infarction," *American Heart Journal*, Vol. 162, No. 2, 2011, pp. 254–261.

Rural Health Information Hub, "Promotora de Salud/Lay Health Worker Model," 2011. As of November 10, 2017:
https://www.ruralhealthinfo.org/community-health/community-health-workers/2/layhealth

Saha, Somnath, Mary Catherine Beach, and Lisa A. Cooper, "Patient Centeredness, Cultural Competence and Healthcare Quality," *Journal of the National Medical Association*, Vol. 100, No. 11, November 2008, pp. 1275–1285.

SAMHSA—*See* Substance Abuse and Mental Health Services Administration.

Schwalbe, Leslie, *Behavioral Health Providers: Expenditures, Methods and Sources of Payment, Electronic Health Record Incentive Payments for Certain Behavioral Health Providers Policy Descriptions*, Washington, D.C.: U.S. Department of Health and Human Services, Assistant Secretary for Planning and Evaluation, Office of Disability, Aging and Long-Term Care Policy, June 30, 2010. As of August 18, 2016:
https://aspe.hhs.gov/system/files/pdf/76206/behhp.pdf

Substance Abuse and Mental Health Services Administration, "Grantee Stories, Tools, and Resources," webpage, undated. As of November 6, 2017:
https://www.samhsa.gov/capt/tools-learning-resources/evaluation-tools-resources

———, *Behavioral Health United States, 2012*, Rockville, Md.: Center for Behavioral Health Statistics and Quality, 2012. As of August 18, 2016:
https://www.samhsa.gov/data/sites/default/files/2012-BHUS.pdf

———, "Appendix C: Tools for Assessing Cultural Competence," *Improving Cultural Competence*, Rockville, Md., Treatment Improvement Protocol Series No. 59, 2014a. As of November 10, 2017:
https://www.ncbi.nlm.nih.gov/books/NBK248429/

REFERENCES

———, "National Behavioral Health Quality Framework," webpage, October 30, 2014b. As of November 10, 2017: https://www.samhsa.gov/data/national-behavioral-health-quality-framework#examples

———, "Applying the Strategic Prevention Framework (SPF): Cultural Competence and the SPF," webpage, September 25, 2015. As of August 18, 2016: http://www.samhsa.gov/capt/applying-strategic-prevention-framework/cultural-competence/cultural-competence-spf

———, "Applying the Strategic Prevention Framework (SPF): Step 5: Evaluate: Process and Outcomes Evaluation," webpage, April 5, 2016a. As of November 10, 2017: https://www.samhsa.gov/capt/applying-strategic-prevention-framework/step5-evaluation/process-outcomes-evaluation

———, "The National CLAS Standards in Action," webinar, August 4, 2016b. As of November 6, 2017: https://www.samhsa.gov/capt/tools-learning-resources/national-clas-standards-action

———, "Prevention of Substance Abuse and Mental Illness," webpage, August 9, 2016c. As of August 18, 2016: https://www.samhsa.gov/prevention

———, "Resources Related to Cultural Competence," webpage, November 22, 2016d. As of November 10, 2017: https://www.samhsa.gov/capt/tools-learning-resources/resources-related-cultural-competence

Samnaliev, Mihail, Mark P. McGovern, and Robin E. Clark, "Racial/Ethnic Disparities in Mental Health Treatment in Six Medicaid Programs," *Journal of Health Care for the Poor and Underserved*, Vol. 20, No. 1, 2009, pp. 165–176.

Sebelius, Kathleen, "Increasing Access to Mental Health Services," Washington, D.C.: Barack Obama White House, April 10, 2013. As of November 10, 2017: https://www.whitehouse.gov/blog/2013/04/10/increasing-access-mental-health-services

REFERENCES

University of Maryland, "Maryland State Legislation for Cultural Competency Training," undated. As of August 19, 2016: https://sph.umd.edu/department/epib/cchc/md-legislation-cultural-competency-training

U.S. Department of Health and Human Services, "HITECH Act Enforcement Interim Final Rule," undated(a). As of August 22, 2016: http://www.hhs.gov/hipaa/for-professionals/special-topics/HITECH-act-enforcement-interim-final-rule/index.html

———, "Think Cultural Health: The Blueprint," webpage, undated(b). As of November 6, 2017: https://www.thinkculturalhealth.hhs.gov/clas/blueprint

———, "Think Cultural Health: Resource Library," webpage, undated(c). As of November 6, 2017: https://www.thinkculturalhealth.hhs.gov/resources/library

———, *Mental Health: Culture, Race, and Ethnicity—A Supplement to Mental Health: A Report of the Surgeon General*, Rockville, Md.: Substance Abuse and Mental Health Services Administration, August 2001.

U.S. Department of Health and Human Services, Health Resources and Services Administration, "Quality Improvement & Risk Management Training," webpage, March 31, 2011a. As of April 17, 2018: https://www.hrsa.gov/public-health/guidelines/quality-improvement.html

———, *Developing and Implementing a QI Plan*, April 2011b. As of November 6, 2017: https://www.hrsa.gov/sites/default/files/quality/toolbox/508pdfs/developingqiplan.pdf

U.S. Department of Health and Human Services, Indian Health Services, "About IHS," webpage, undated. As of November 9, 2017: https://www.ihs.gov/aboutihs/

U.S. Department of Health and Human Services, Office of Minority Health, "National Partnership for Action to End Health Disparities," homepage, undated. As of November 9, 2017: https://minorityhealth.hhs.gov/npa/

REFERENCES

———, *National Standards for Culturally and Linguistically Appropriate Services in Health Care: Final Report*, Washington, D.C., March 2001. As of August 19, 2016: https://minorityhealth.hhs.gov/assets/pdf/checked/finalreport.pdf

———, *Developing a Self-Assessment Tool for Culturally and Linguistically Appropriate Services in Local Public Health Agencies*, December 2003. As of November 6, 2017: https://minorityhealth.hhs.gov/assets/pdf/checked/LPHAs_FinalReport.pdf

———, *Evaluation Planning Guidelines for Grant Applicants*, Rockville, Md., June 2010. As of November 10, 2017: https://minorityhealth.hhs.gov/Assets/pdf/Checked/1/Evaluation%20Planning%20Guidelines%20for%20Grant%20Applicants.pdf

———, *National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care: A Blueprint for Advancing and Sustaining CLAS Policy and Practice*, Washington, D.C., April 2013. As of November 6, 2017: https://www.thinkculturalhealth.hhs.gov/assets/pdfs/EnhancedCLASStandardsBlueprint.pdf

———, *National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care: Compendium of State-Sponsored National CLAS Standards Implementation Activities*, Washington, D.C., 2016. As of April 18, 2018: https://www.thinkculturalhealth.hhs.gov/assets/pdfs/CLASCompendium.pdf

U.S. Department of Health and Human Services, Office of the Surgeon General and National Action Alliance for Suicide Prevention, *2012 National Strategy for Suicide Prevention: Goals and Objectives for Action*, Washington, D.C., September 2012. As of November 9, 2017: http://www.surgeongeneral.gov/library/reports/national-strategy-suicide-prevention/full_report-rev.pdf

U.S. Department of Justice, Executive Order 13166, Improving Access to Services for Persons with Limited English Proficiency, Washington, D.C.: White House, Office of the Press Secretary, August 11, 2000. As of August 22, 2016: https://www.justice.gov/crt/federal-coordination-and-compliance-section-180

REFERENCES

Wang, Philip S., Patricia Berglund, Mark Olfson, Harold A. Pincus, Kenneth B. Wells, and Ronald C. Kessler, "Failure and Delay in Initial Treatment Contact After First Onset of Mental Disorders in the National Comorbidity Survey Replication," *Archives of General Psychiatry*, Vol. 62, No. 6, 2005, pp. 603–613. As of November 10, 2017: http://dx.doi.org/10.1001/archpsyc.62.6.603

Weech-Maldonado, Robert, and Sonya B. Merrill, "Building Partnership with the Community: Lessons from the Camden Health Improvement Learning Collaborative," *Journal of Healthcare Management*, Vol. 45, No. 3, 2000, pp. 189–205.

Weech-Maldonado, Robert, Janice L. Dreachslin, Julie Brown, Rohit Pradhan, Kelly L. Rubin, Cameron Schiller, and Ron D. Hays, "Cultural Competency Assessment Tool for Hospitals: Evaluating Hospitals' Adherence to the Culturally and Linguistically Appropriate Services Standards," *Health Care Management Review*, Vol. 37, No. 1, January–March 2012a, pp. 54–66. As of November 10, 2017: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4983191/

Weech-Maldonado, Robert, Adam Carle, Beverly Weidmer, Margarita Hurtado, Quyen Ngo-Metzger, and Ron D. Hays, "The Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Cultural Competence (CC) Item Set," *Medical Care*, Vol. 50, No. 902, September 2012b, pp. S22–S31. As of November 10, 2017: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3748811/

Weech-Maldonado, Robert, Marc N. Elliott, Rohit Pradhan, Cameron Schiller, Janice Dreachslin, and Ron D. Hays, "Moving Towards Culturally Competent Health Systems: Organizational and Market Factors," *Social Science Medicine*, Vol. 75, No. 5, September 2012c, pp. 815–822.

Weiner, Bryan J., Jeffrey A. Alexander, Stephen M. Shortell, Laurence C. Baker, Mark Becker, and Jeffrey J. Geppert, "Quality Improvement Implementation and Hospital Performance on Quality Indicators," *Health Services Research*, Vol. 41, No. 2, April 2006, pp. 307–334.

REFERENCES

Weissman, Joel S., Joseph R. Betancourt, Alexander R. Green, Gregg S. Meyer, Aswita Tan-McGrory, Jacob D. Nudel, Jessica A. Zeidman, and J. Emilio Carrillo, *Commissioned Paper: Healthcare Disparities Measurement*, Washington, D.C.: National Quality Forum, February 2012. As of November 10, 2017: http://www.qualityforum.org/Publications/2012/02/Commissioned_Paper__Healthcare_Disparities_Measurement.aspx

Wholey, Douglas R., Walter Gregg, and Ira Moscovice, "Public Health Systems: A Social Networks Perspective," *Health Services Research*, Vol. 44, No. 5, Part 2, 2009, pp. 1842–1862.

Wilson-Stronks, Amy, and Erica Galvez, *Exploring Cultural and Linguistic Services in the Nation's Hospitals: A Report of Findings*, Oakbrook Terrace, Ill.: Joint Commission on Accreditation of Healthcare Organizations, 2007.

Wiseman, Shelley H., Matthew Chinman, Patricia A. Ebener, Sarah B. Hunter, Pamela Imm, and Abraham Wandersman, *Getting To Outcomes: 10 Steps for Achieving Results-Based Accountability*, Santa Monica, Calif.: RAND Corporation, TR-101/2-CDC, 2007. As of October 31, 2017: https://www.rand.org/pubs/technical_reports/TR101z2.html

World Health Organization, *Constitution of the World Health Organization*, Geneva, Switzerland, 1946. As of November 9, 2017: http://apps.who.int/gb/bd/PDF/bd47/EN/constitution-en.pdf?ua=1