National Study of Culturally and Linguistically Appropriate Services in Managed Care Organizations (CLAS in MCOs Study)

FINAL REPORT

Prepared for the
U.S. Department of Health and Human Services
Office of Minority Health
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Rockville, MD 20852

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PREFACE

This Report presents the results of the *National Study of Culturally and Linguistically Appropriate Services in Managed Care Organizations,* conducted by COSMOS Corporation for the Office of Minority Health (OMH), Office of Public Health and Science, U.S. Department of Health and Human Services (DHHS). The study was supported under a task order contract with DHHS (Task Order No. 10, Contract No. 282-98-0027).

The project could not have been conducted without the cooperation and support of the health plans, their senior executives, and other personnel. These respondents provided insightful information on the culturally and linguistically appropriate services provided by their organizations. The COSMOS research team is especially grateful for participants' time and commitment to health care research. Also, we acknowledge the invaluable guidance provided by members of the project's two advisory groups and greatly appreciate the collaborative spirit with which this study was conducted. A special note of appreciation is extended to Calvin Freeman, Project Expert Panel member, who served effectively and admirably as Chairperson for project meetings between the research team, OMH staff, and the project's two advisory groups, over the course of the study.

In addition, we would like to thank the American Association of Health Plans (AAHP) for their continued support throughout the study. The use of their *Directory of Health Plans* as the study sampling frame was especially generous. We extend special appreciation to Charles Stellar in particular, AAHP Executive Vice President and Project Expert Panel member, who was instrumental to the study's success during certain phases.

The various services and practices described in this Report have the potential to improve the health care delivery system and address persistent racial and ethnic health care disparities. Today's rapidly-changing health care environment creates an urgency and an opportunity to build a health care system that gives culturally and linguistically diverse populations access to high-quality health care. This is the spirit which grounded the study and guided this Report. We hope that this effort contributes to the ever-expanding flow of ideas and strategies for providing health care services that address the specific needs of culturally and linguistically diverse populations.

The COSMOS research team, led by Angela Ware, Ph.D., included Oscar Espinosa, M.A.; R. James Schmidt; Daniela Hanson; and Robert Johnson.

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Introduction

CHAPTER 1: INTRODUCTION

This report presents the results of the *National Study of Culturally and Linguistically Appropriate Services in Managed Care Organizations,* sponsored by the Office of Minority Health (OMH), U.S. Department of Health and Human Services (DHHS). Culturally and linguistically appropriate services (CLAS) are *health care services that are respectful of, and responsive to, the specific needs and preferences of racially, ethnically, culturally, and linguistically diverse populations* (OMH 2001). A managed care organization (MCO) is *any entity that utilizes certain concepts or techniques to manage the accessibility, cost, and quality of health care* (AAHP 2001). Managed health care plans engage in facilitating arrangements with selected providers to furnish a comprehensive set of health care services to members. MCOs differ in both organizational structure and service delivery practices and typically comprise three levels of operation: policy making, system design and implementation, and service provision (Dranove 2000; Wernet 1999).

The intent of this study was to examine the nature and extent of CLAS in MCOs across the country and highlight promising CLAS practices implemented by these organizations. In addition, the project set out to fill a significant gap in the health care field by identifying and developing a comprehensive conceptual framework that includes essential components of CLAS and by developing an assessment tool that offers sound measures of these components.

1.1 BACKGROUND

In 1983, the annual issue of *Health, United States* (the report card on the health status of the American people) documented significant progress in the overall health picture of the Nation (NCHS 1983). The report reinforced the fact that there were continuing disparities in the burden of death and illness experienced by racial and ethnic minority Americans as compared with the U.S. population as a whole—a disparity that has existed ever since accurate Federal record keeping began more than a generation ago. In response to the report findings, a Task Force was established by the then Secretary of DHHS to investigate the health problems of African Americans, Native Americans, Hispanics, and Asian/Pacific Islanders. The Task Force was charged with reviewing and analyzing the Departmental programs and range of resources available to address the health problems of racial and ethnic minorities, and with recommending ways for the Department to exert leadership, influence, and initiative to close the existing gaps.

The result of the Task Force's efforts and deliberations were presented to the Secretary in August 1985 in the *Report of the Secretary's Task Force on Black and Minority Health* (Heckler 1985). This report subsequently led to the establishment of OMH in 1986 within the Office of the Assistant Secretary for Health (now the Office of

Public Health and Science), headed by the Deputy Assistant Secretary for Minority Health. That Office—which was legislatively established under the Disadvantaged Minority Health Improvement Act of 1990 (Public Law 101-527) and reauthorized under the Health Professions Education Partnership Act of 1998 (Public Law 105-392)—has since served as the focal point within the Department for the implementation and monitoring of recommendations originating from the Report of the Secretary's Task Force, and for providing leadership and coordination of an accelerated national assault on the persistent health disparities between racial and ethnic minorities and the rest of the U.S. population.

Specifically, the mission of OMH is to improve and protect the health of racial and ethnic minority populations, to close the gap in health status between racial and ethnic minority groups and majority populations, and to coordinate across DHHS the development and implementation of policies, programs, and practices that will address health disparities placing a greater burden of disease, disability, and premature death upon minority populations. This mission is as important today as ever. In spite of steady gains in the health status of minority Americans, disparities remain. These disparities are particularly troubling and challenging given the major changes in recent years in the U.S. health care system to manage escalating health care costs, and the ever-increasing racial, ethnic, cultural, and linguistic diversity of the U.S. population.

1.1.1 Persistent Disparities in Health Status and Health Care Quality

Studies conducted in the last decade confirm that racial and ethnic minorities continue to be adversely impacted by multiple health disparities (HRSA 2000; DHHS 1991). For instance, infant mortality rates have declined for all races and ethnic groups in the U.S., but large racial and ethnic health disparities remain. In 1997-1999, the infant mortality rate was highest for infants of non-Hispanic African American mothers (NCHS 2002), and the infant mortality rate for African Americans is more than twice that of Whites (Cohen and Goode 1999). Overall mortality was one-third higher for African Americans than for White Americans in 1999, compared with 37 percent higher in 1990. In 1999, age-adjusted death rates for the African American population exceeded those for the White population by 38 percent for stroke, 28 percent for heart disease, 27 percent for cancer, and more than 700 percent for HIV disease (NCHS 2002).

All cancer rates are higher for African Americans than for Whites (DHHS 1991), and although African American and White women are screened for breast cancer at the same rate, breast cancer mortality was 35 percent higher for African American women than for White women in 1999, compared with 15 percent higher in 1990 (NCHS 2002). Also, the 5-year survival rate for African American women diagnosed in 1989-1997 with breast cancer was 15 percent lower than for White women (NCHS 2002).

Since 1995, death rates for HIV disease declined sharply for African American men and Hispanic men aged 25-44. In spite of these declines, HIV disease was still the leading cause of death for African American men aged 25-44 and the third leading cause of death for Hispanic men aged 25-44 in 1999, and HIV deaths remain much higher for African American and Hispanic men than for non-Hispanic White men in this age group (NCHS 2002).

Despite steady improvements in the overall health of the Nation, racial and ethnic disparities in health status remain. Also, studies have shown persistent disparities in health *care* among racial and ethnic groups. These gaps are described below.

To determine the extent of disparities in health *care,* Congress, in 1999, requested a study (through OMH) from the National Academies' Institute of Medicine (IOM). The research indicates that minority Americans are less likely than Whites to receive needed services, including clinically necessary procedures, as well as routine medical procedures, and are more likely to experience a lower quality of health care services. The report from that study, *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care* (Smedley et al. 2003) found that a consistent body of research demonstrates that racial and ethnic disparities remain even when insurance status, income, age, and severity of medical conditions are comparable. These disparities exist in a number of disease areas, including cancer, heart disease, HIV/AIDS, diabetes, and mental illness. In addition, evidence suggests racial and ethnic disparities in care and treatment for cancer and cardiovascular disease are associated with higher mortality rates among minorities (Bach et al. 1999; Peterson et al. 1997).

Moreover, in the context of these persistent disparities, the Nation is becoming increasingly more racially, ethnically, culturally, and linguistically diverse. Projections suggest that by the year 2050, ethnic minority subpopulations will make up 48 percent of the total U.S. population (U.S. Bureau of the Census 1995). According to the U.S. Census Bureau, ethnic or racial minorities represented 24.9 percent of the U.S. population in 2000. The 2000 Census reported that the U.S. gained more than 10.5 million people who reported they speak little or no English—up from 6.6 million in 1990. Census data also show that over 300 languages are spoken in the U.S., with 17.9 percent of the population speaking a language other than English at home—up almost 14 percent from the previous Census (U.S. Bureau of the Census 1994; 2000; 2001). Consequently, trends in the number of minorities served by health care organizations are significantly changing.

Culturally and linguistically appropriate health care services address the needs of (the increasing) racial, ethnic, cultural, and linguistic minority populations who are affected by the persistent disparities. Integral to culturally and linguistically appropriate services are the concepts of *culture* and *language*.

1.1.2 The Importance of Culture and Language in Health Care

The term *culture* refers to “the thoughts, communications, actions, customs, beliefs, values, and institutions of racial, ethnic, religious, or social groups” (OMH 2001). All individuals have a culture. In fact, one individual is associated with many cultural groups at the same time. Cultural categories and groups often are thought of in terms of race, ethnicity, and/or country of national origin. Similarly, an individual’s “cultural identity” often is associated with groups of individuals along racial and ethnic lines. However, race, ethnicity, and/or country of origin are not synonymous with culture. The term culture is much broader than racial and/or ethnic background, and includes shared attitudes, behaviors, and traditions that are grounded in many other groupings, such as: sex or gender; stage of life (e.g., elderly); socioeconomic status; sexual orientation; religion; geography; persons with physical limitations or disabilities including persons with impaired hearing; or low-literate or illiterate persons. With this recognition, the term culture is used in this study in the more limited way—i.e., most often referring to characteristics and experiences related to individuals’ racial and ethnic backgrounds and/or countries of national origin—because of the known racial and ethnic health care disparities and related issues of language and communications.

Regarding *culturally* appropriate health care, studies have shown that cultural factors influence how individuals perceive the symptoms of illness, how they seek care when ill, and how they respond to treatment regimens (Saint-Germain and Longman 1993). Illness behavior directly affects the health system insofar as it influences the illnesses for which people seek care, the timing of care, and the treatment process. Culture influences an individual’s perception of the risk of becoming ill and the utility of treatment and prevention services (Frye 1993; Saint-Germain and Longman 1993). Cultural perceptions, thus, influence when a symptom is defined as a health problem, the severity of the problem, and whether advice or care must be sought. Culture contributes to an individual’s understanding of the cause of disease. Understanding cultural perceptions about disease is critical to effectively engaging individuals in disease prevention and treatment activities.

Health care providers should recognize that in some cultures, Western medicine is often supplemented or mixed with traditional remedies. Therefore, if providers recognize the need to provide treatment that is in some way compatible with traditional health care beliefs, there is a greater opportunity for more effective care. Also, a provider’s awareness about his or her own values and how they may bias interactions with individuals from different cultures is viewed as key to providing culturally sensitive care (Dilworthanderson et al. 1993; Eliason 1993; May 1992). Price and Cordell (1994) suggest that providers assess their own beliefs and have knowledge of general ethnic, regional, and religious beliefs and practices before discussing health care issues with patients.

Culture influences the way we communicate with each other. *Language* is a method of communication that uses a system of sounds, symbols, and gestures that are organized in a patterned way to express and communicate thoughts and feelings. Language is a part of culture and involves both verbal and written communications. *Language dissonance* (when two individuals—e.g., physician and patient—speak a different language) is only one type of language barrier that may be experienced in the health care setting. Other types of verbal communication barriers may include: lack of linguistic clarity (where physician and patient speak the same language, but an unfamiliar or heavy accent impedes understanding); limited or lack of health literacy (where health concepts conveyed by the physician are unclear, or too complex, for patient understanding); or physicians' use of technical language or jargon (where medical terms are used that are unfamiliar to the patient and result in diminished or total lack of understanding). This study focuses on issues of language dissonance related to health care services because it is easiest to identify and is the greatest barrier to understanding.

Linguistically appropriate health care services—i.e., the provision of translated *written* materials and *oral* interpretation services—are vital to accurate physician diagnosis and appropriate treatment of presenting complaints or conditions, patient understanding, compliance with prescribed actions or treatment plans, and positive health outcomes. Perhaps the most critical component of quality health care is the ability of both the provider and patient to understand and be understood. This notion of understanding and being understood is a critical component of health care quality. Key consequences of language barriers in the health care setting include: 1) inadequate communication from the patient to the provider, making it difficult to obtain a complete medical history and/or to accurately report symptoms; and 2) inadequate communication from the provider to the patient, which interferes with accurately informing (or educating) the patient about the illness and treatment (Woloshin et al. 1995).

Also, studies suggest that accurate communication between patient and provider decreases unnecessary diagnostic testing and increases proper diagnosis, patient compliance, and the retention and use of appropriate services (NCQA 1995, citing the Latino Coalition for a Healthy California and the National Coalition of Hispanic Health and Human Services Organizations). Within this context, researchers raise several points in arguing the need for CLAS. When utilizing the health care system, non-English speaking individuals encounter communication challenges that hinder access to care and effective treatment (Putsch 1985). In addition to language, researchers note that cultural issues are relevant throughout the health care delivery system. Although some studies have suggested reduced access to medical care may be due to language barriers or low socioeconomic status (Brach and Fraser 2000; Gany and Thiel de Bocanegra 1996; The Henry Kaiser Family Foundation 1999), in other studies, the same disparities have been observed in minorities of any socioeconomic status (Brach and Fraser 2000; Smedley et al. 2003).

1.1.3 Culturally and Linguistically Appropriate Services Address Disparities in Health Care

Evidence suggests that interaction of genetic differences, environmental factors, and health behaviors propagates health care disparities. These elements include, but are not limited to, biases of health care workers toward minorities, lack of prevention messages tailored to specific populations, lack of physician awareness of higher risk factors for some illnesses in particular populations (HRSA 2000), lack of physician knowledge of traditional remedies and folk practices, and diagnostic errors due to miscommunication (Brach and Fraser 2000).

Lack of prevention messages may decrease a patient's chances of knowing about certain risk factors, health options, conditions, and screenings (Brown 2001). Lack of awareness of higher risk factors may result in failure to screen or correctly diagnose a patient (The Henry Kaiser Family Foundation 1999; Lavizzo-Mourey and Mackenzie 1996; Smedley et al. 2003). Moreover, insufficient knowledge about traditional remedies or practices may lead to serious medical complications. Drug interactions may occur between prescription medications and folk medicines (Brach and Fraser 2000). A traditional remedy may be counterproductive or even dangerous, such as one for colic involving ingestion of a mixture containing lead (Texas Department of Health 1998a). The practice of coin-rubbing could be mistaken for abuse[1] (Graham and Chitnarong 1997; Orr 1996). Miscommunication—including, but not limited to, verbal language barriers—can cause errors in diagnosis and patient misunderstanding (Gany and Thiel de Bocanegra 1996; Perkins 1999; Putsch 1985; Queseda 1976; Villarruel et al. 1999).

Underlying the argument for CLAS is the premise that linguistic and cultural barriers can adversely affect the delivery of health care. Although this is a relatively new area of scientific inquiry, there is some evidence that these barriers can be reduced or eliminated through culturally sensitive interventions (Julia 1992; Lieberman 1990; Marin 1993; Moore 1992; Redmond 1990).

Such health care interventions require *cultural and linguistic competence*, which is "a set of congruent behaviors, attitudes, and policies, that come together in a system, agency, or among professionals that enables effective work in cross-cultural situations" (Cross et al. 1989). Providers should be knowledgeable about the cultures of their clients—their customs, beliefs, and language (Clermont et al. 1993; Dillard et al. 1992; Fernandez-Santiago 1994; Krajewski-Jaime 1993; Pruegger and Rogers 1994; Redican 1994). For instance, in addressing diabetes in African and Hispanic American communities, Raymond and D'Eramo-Melkus (1993) argue that effective treatment requires a sensitivity to and

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[1] Coin rubbing consists of massaging the skin with tiger balm ointment and then rubbing the skin with a hot coin.

recognition of such cultural patterns as food preferences, spiritual beliefs, and health practices in order to develop a practical and beneficial treatment regimen.

In any interaction between a consumer, patient, or health plan member and his/her health care provider(s) or health care system, the ability of each party to understand and be understood by others is critical for appropriate and timely access and utilization, patient compliance, and positive patient health outcomes. Also, in order for any system of health care—"managed" or otherwise—to be truly effective in serving populations whose national origins, languages, and/or cultural backgrounds differ from those employed or contracted by that health system, the provision of services that are culturally and linguistically appropriate for the consumer are essential. Such services involve efforts to enhance and ensure that health plan providers and other personnel can both communicate with, and clearly understand, the concerns and needs of the consumers or health plan members being served, as well as provide instructions, interventions, treatment modalities, and other recommended actions in a manner and context that will optimize consumer receptivity and compliance.

In sum, although issues of "cultural competence" or "cultural and linguistic appropriateness" in health care often are framed as "minority" issues, they are, in fact, *human* issues affecting all people. Everyone has a culture and a cultural background that shapes one's views about health and illness. Similarly, everyone has a language and language needs. However, because some cultural and linguistic needs are met while others are not, the issue becomes yet another of disparity in addressing the health needs of certain groups—most often racial and ethnic minorities. This disparity directly affects the ability to access high-quality health services.

Given that: 1) disparities in health status and health care services are well-documented among racial, ethnic, cultural, and linguistic minority groups; 2) cultural and language differences may contribute to these gaps; and 3) the racial, ethnic, cultural, and linguistic diversity in the U.S. will continue to increase over time, OMH set out to explore the extent to which health care systems were addressing cultural and linguistic factors in the context of health care delivery.

1.1.4 Important Factors that Influenced the Study

During the time of the study's inception (mid to late 1990s), there only had been limited previous attempts to gather initial data (in any meaningful way on a national scale) to determine the nature and extent of culturally and linguistically appropriate services in the U.S. health care system. Moreover, the concepts of "cultural competence" and "CLAS" were still emerging, and the health care field was divided not only on the definitions of these concepts, but also on which terms should even be used in the context of health care. When OMH began using the term "culturally and linguistically appropriate services," it was seldom used in the literature; "cultural competence" was the more prevalent term. Because the word "competence" may be associated with the "loaded" word "incompetence," OMH sought to promote the more constructive term, i.e., cultural and linguistic *appropriateness.*

Also at the start of the study, the entire U.S. health care system was in a state of transition. Rising health care costs had recently resulted in even greater efforts to "manage" the way health care was delivered in order to contain such costs. There was great interest in health care reform in the 1990s, and changes were then most evident in what seemed to be the direction of managed care.

Although OMH initially wanted to examine culturally and linguistically appropriate services across the entire health care system, the complex and multifaceted evolution that was occurring at that time required a narrowing of the study scope. The decision to focus on MCOs for this *initial* endeavor was made in an effort to follow the trend that had emerged toward managed care as the dominant arrangement for delivering and financing privately-insured care (Center for Health Care Policy Research 1997; Gold et al. 1997; Rowland and Hanson 1996).

In addition, managed care was growing at a particularly rapid pace in Medicaid and Medicare. Between 1983 and 1996, the growth of the Medicaid programs alone increased enrollment in managed care from less than one million persons to over 13 million, or one-third of the Medicaid population (Rosenbaum and Shin 1997). OMH's decision to focus on MCOs for the first study was to explore CLAS provision with a segment of the health care industry that was most likely to continue in the coming years, as parallel increases in the cultural and linguistic diversity of the country occurred.

The intention of this study was to provide OMH and others with information to assist in the development of appropriate policy and programmatic responses to meet the unique health needs of culturally and linguistically diverse populations a large proportion of whom are racial and/or ethnic minorities. The study's aim was to strengthen the growing understanding that access to, and quality of, health care for all people involves not only the availability of health services and mechanisms to pay for such services, but also the provision of services in ways that are culturally and linguistically appropriate for each and every consumer. To achieve the goal of *eliminating*—and not merely reducing—racial and ethnic health disparities, accessible high-quality health care must be available for all people regardless of race, ethnicity, country of origin, or primary language spoken.

1.2 STUDY QUESTIONS AND OBJECTIVES

The study set out to address the following three research questions:

- What is the nature and extent of CLAS currently provided in MCOs?

- Does the provision of CLAS vary among MCOs? If so, how?
- What factors influence the provision or implementation of CLAS in MCOs?

The study was conducted for three purposes. The first objective was to *gather data which provided a "snapshot" of CLAS in MCOs across the country.* An initial study task was to identify a comprehensive set of essential components of CLAS across the health care continuum and collect data on the nature and extent of such services provided in MCOs. As such, the study was implemented to provide an accurate first look at the types and range of services currently provided in MCOs to meet the particular needs of culturally and linguistically diverse groups. The study was designed without expectations for what the descriptive picture of CLAS provision would look like and with recognition that the results may or may not reveal such services in general, or in certain areas. The purpose of such a "snapshot" of CLAS included determining what and how the "picture" should be taken. Using the analogy of the camera, critical concerns included, e.g., where to point the camera, how wide the lens should be, how close to focus, and how many subjects should be included in the photograph.

The second objective was to *design and implement a study with sound methods, measures, and results that can be used as a baseline study for future research efforts.* Because this was the first attempt to examine the nature and extent of CLAS provision on a national level, it was important to develop a conceptual framework, methodological design, and survey instruments that provide an appropriate foundation for future research efforts in this area. As described above and illustrated in Chapter 2, at the point of the study's inception, definitions (and measures) of cultural competence were limited, and the term *culturally and linguistically appropriate services* was only an emerging concept. More importantly, there were no models that described the components of CLAS in the context of health care, i.e., what such services look like in actual practice. Therefore, two significant contributions of this study to the health care field would be to develop a comprehensive framework that illustrates essential components of CLAS and to develop assessment tools that offer sound measures of these components. The conceptual framework, its development, and the study instruments are described in Chapter 3.

A third study objective was to *educate respondents in the process of conducting the study about their organizational CLAS practices.* The study instruments were purposefully designed to be educational for respondents who participated in the study. Survey questions were written to inform respondents of a broad range of response options that provide examples of strategies and practices (in relation to a particular topic) that *could be* considered culturally and linguistically appropriate services. The survey items themselves provide examples and ideas on which to build and improve one's service provision and quality of care. Examples of how this educational objective was accomplished with the development of the study instruments are described in Chapter 3.

1.3 COLLABORATIVE PROCESS WITH TWO PROJECT ADVISORY GROUPS

Two distinct advisory groups assisted in the completion of this study, including the development of its conceptual framework, study goals and objectives, data collection instruments and plans, analysis plans, and this Report. The Project Expert Panel (PEP) was an advisory committee comprised of researchers and industry representatives who had expertise in at least one of the following areas: survey research and evaluation, cultural competency, health care quality, and managed care plans or organizations. The Federal Project Advisory Group (PAG) was a second advisory body that assisted in the development and progression of this study. The PAG was composed of representatives from DHHS divisions with responsibility for government policies and programs related to health care services, and more specifically, services for diverse populations. While PEP members represented varied expertise and "real-world" experience, PAG members represented a range of interests across DHHS. Appendix A contains a membership list for both of these advisory bodies.

The guidance provided by panel members was invaluable over the course of the study. Meetings were held with the research team, OMH staff, and PEP and PAG members at critical points of the study, e.g., during the development phases for the conceptual framework, methodological design, and instruments, and once raw data and preliminary findings were available. The nature and extent of critical issues raised and deliberated with the study's two advisory groups are presented in Chapter 3.

The report is structured in the following manner: Chapter 2 presents a review of the literature and relevant tools explored at the point of the study's inception to guide its approach. The study design and methodology—that resulted, in part, from information learned through the literature review and from members of the project's two advisory groups—is described in Chapter 3. The study results are presented in Chapter 4. Survey data from the MCO respondents are described as well as methodological results related to the study's design and approach. Finally, Chapter 5 offers recommendations for future research and recommendations on how this study may be useful to health plans, and presents study conclusions.

CHAPTER 2

Literature Review

CHAPTER 2: LITERATURE REVIEW

This chapter presents a review of the literature which informed the project and its design. At the start of this study, two important tasks were to be accomplished: 1) further define the concept of CLAS; and 2) articulate how this definition should be operationalized by identifying key components of CLAS. To provide a starting point for conceptualizing CLAS (and its essential components), relevant literature was reviewed to identify how CLAS had been defined in the health care field to date and the types of services it encompassed. The following sections review the available definitions and descriptive components of CLAS at the start of the study.[1] The literature review provided a knowledge base from which the study conceptual framework and instruments were developed.

2.1 DEFINING CULTURALLY AND LINGUISTICALLY APPROPRIATE SERVICES

As mentioned in Chapter 1, when this study began, the term "culturally appropriate" was seldom referenced in the literature, while "cultural competence" was a more widely accepted term. The use of the term "culturally appropriate" has now become more common, as the term "competence" may be associated with the sensitive term "incompetence."

Exhibit 2-1 provides an overview of various definitions (in the literature at that time) for "culturally appropriate health care services." Most often, these services were described in terms of *a set of skills* related to understanding, and effectively communicating with, persons who have diverse cultural backgrounds (McManus 1998; Tirado 1996). The term "cultural competence" was described in the context of *developing* and *using* these skills (Andrulis 1997; California Department of Health Services 1993; Cross et al. 1989; Orlandi 1995). Other definitions of cultural competence positioned the term in the health care context by emphasizing awareness and integration of three population-specific issues: health-related beliefs and cultural values, disease incidence and prevalence, and treatment efficacy (Adams 1995; Lavizzo-Mourey and Mackenzie 1996).

Linguistically appropriate services include programs, services, and interventions that meet the specific language needs of the service population (OMH 1996). Such services involve communicating with patients in their primary languages and providing language assistance at key points of service throughout the health care continuum (Association of Asian Pacific Community Health Organizations 1996).

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[1] The literature review did not identify particular data collection methodologies that had actually been employed with health care organizations in the field to date.

Exhibit 2-1

SELECT DEFINITIONS OF CULTURAL COMPETENCE AND CULTURALLY APPROPRIATE HEALTH CARE SERVICES

Study	Definition
Tirado, *Tools for Monitoring Cultural Competence in Health Care*, 1996	**Cultural competency:** level of knowledge-based skills required to provide effective clinical care to patients from a particular racial or ethnic group
McManus, ed., "Services to Minority Populations: Cross-cultural Competence Continuum," 1998	**Cross-cultural competency:** "the knowledge and interpersonal skills that allow providers to understand, appreciate, and work with individuals from cultures other than their own. It involves an awareness and acceptance of cultural differences, self-awareness, knowledge of the patient's culture, and adaptation of skills."
Cross, T.L., et al., *Towards a Culturally Competent System of Care: A Monograph on Effective Services for Minority Children Who are Severely Emotionally Disturbed*, Vol. 1, Georgetown University Child Development Center, CASSP Technical Assistance Center, Washington DC, June 1989.	**Cultural and Linguistic Competence**: "a set of congruent behaviors, attitudes, and policies, that come together in a system, agency, or among professionals that enables effective work in cross-cultural situations."
Orlandi, ed., *Cultural Competence for Evaluators: A Guide for Alcohol and Other Drug Abuse Prevention Practitioners Working With Ethnic/Racial Communities*, 1995	**Cultural competence:** a set of academic and interpersonal skills that allow individuals to increase their understanding and appreciation of cultural differences and similarities within, among, and between groups. This requires a willingness and ability to draw on community-based values, traditions, and customs, and to work with focused interventions, communications, and other supports.
Andrulis, "Toward a More Culturally Competent System of Care: Implications for Federal Policy, Managed Care Provider and Communities," 1997	**Cultural competency:** "effectively incorporating the ethnic/cultural characteristics of individuals and their health care needs and in promoting health, and working to achieve the highest quality care."
Association of Asian Pacific Community Health Organizations, *State Medicaid Managed Care: Requirements for Linguistically Appropriate Health Care*, 1996	**Culturally appropriate services:** "effectively identify the health practices and behaviors of target populations to design programs, interventions, and services which effectively address cultural language barriers to the delivery of appropriate and necessary health care services."
Lavizzo-Mourey and Mackenzie, "Cultural Competence: Essential Measurements of Quality for Managed Care Organizations," 1996	**Cultural competence:** the integration of 1) health-related beliefs and cultural values; 2) epidemiology; and 3) treatment efficacy
Adams, ed., *Health Issues for Women of Color: A Cultural Diversity Perspective*, 1995	**Cultural competence:** Cultural or ethnic competence refers to the development of skills that will help people behave in a culturally appropriate way with a given group, demonstrating both sensitivity to cultural differences and similarities in the effective use of cultural symbols in interactions and effective communications with members of diverse populations. (The definition continues.)
National Maternal and Child Health Resource Center on Cultural Competency, *Journey Towards Cultural Competency: Lessons Learned*, 1996	**Cultural competency:** "a program's ability to honor and respect beliefs, interpersonal styles, attitudes, and behaviors of families who are clients, as well as the multicultural staff who are providing services. It incorporates these values at levels of policy, administration, and practice." Cultural competency is viewed as a continuum, not as a one-time goal. "Competency implies skills which helps to translate beliefs, attitudes, and orientation in action and behavior in the daily interaction with children and families."
Campinha-Bacote, "The Process of Cultural Competence," State of Washington, Department of Health, 1995	**Cultural competency:** "a set of behaviors, attitudes and policies of a system, agency or individual that enables that system, agency or individual to function effectively in trans-cultural interactions...and a person's or programs's ability to honor and respect the cultural differences (beliefs, interpersonal styles, attitudes and behaviors) of individuals and families who are clients, staff administering programs, and staff providing service at state and local levels. In doing so, it incorporates values at the levels of policy, administration, and practice."

2.2 IDENTIFYING KEY COMPONENTS OF CLAS

In addition to informing the study about definitions of cultural competence and CLAS, the literature provided insight for conceptualizing the *essential components* of CLAS. In other words, a challenge for this study would be to identify what CLAS would look like (across the continuum of care) if one were to study it. Research studies and instruments were reviewed that reflected emerging assessment efforts at the start of this study, and served as a starting point for discussions on how best to measure CLAS in managed care organizations. Several characteristics or services emerged as important for health care organizations to be considered "culturally competent." These key components for cultural competence (described below) provided the basis for developing the study conceptual framework (with eight assessment domains) that is detailed in Chapter 3.

Organizational Governance and Policy Development. To be considered "culturally competent," health care organizations should have formal policies such as written mission statements that specifically express a commitment to cultural diversity (Cross et al. 1989) and policies governing translation and interpretation services (The Asian and Pacific Islander American Task Force 1997; NPHHI 1998). Community members should be recruited for policy-making positions, such as general oversite committees and task forces, and should be well represented on new task forces that can be created to study, evaluate, and address issues related to culturally appropriate care (Cross et al. 1989; Roberts et al. 1990). Strategic planning committees and other decision-making bodies should be representative of the community, in race and ethnicity, as well as other characteristics such as gender and age (The Asian and Pacific Islander American Task Force 1997; NLBHW 1996; Washington State Department of Health 1998).

Patient Care. An important strategy for addressing the health care needs of culturally diverse populations is to recognize and learn about a patient's perspective concerning his/her illness (Randall-David 1989). Understanding cultural perceptions about disease is critical to effectively engaging individuals in disease prevention and treatment activities (Frye 1993; Saint-Germain and Longman 1993). Also, providers' understanding of cultural differences in familial relationships and roles is often important for effective treatment plans (Ahn and Gilbert 1992). Moreover, health care providers may collaborate with traditional healers and/or learn more about patients' use of traditional healing methods in an effort to provide more culturally competent care (The Asian and Pacific Islander American Task Force 1997; NLBHW 1996) and utilize practices that are respectful and responsive to patients' cultural backgrounds, e.g, diverse religious services and facilities or dietary options available (NPHHI 1998).

Also important for culturally competent care is a provider's awareness about his or her own values and how they may bias interactions with individuals from different cultures (Dilworthanderson et al. 1993; Eliason 1993; May 1992). To improve patient care, providers are encouraged to assess their own beliefs and have knowledge of general ethnic, regional, and religious beliefs and practices before discussing health care issues with patients (Price and Cordell 1994).

Quality Monitoring and Improvement and Routine Data Collection. To measure progress in providing CLAS, health care organizations should routinely conduct quality monitoring and improvement (QMI) efforts that collect data on community characteristics and needs (Cross et al. 1989; Washington State Department of Health 1998). Such QMI self-assessments should include the organization's past and present performance in attempting to provide culturally and linguistically appropriate services across several areas of care (Kim et al. 1992). Patient focus groups and patient satisfaction surveys are examples of methods used for monitoring CLAS quality (NPHHI 1998). Moreover, the routine collection and analysis of race and ethnicity data on the populations served is vital for effectively monitoring quality of care (Kim et al. 1992; NLBHW 1996; NPHHI 1998; Perot and Youdelman 2001; Smith 1998).

Staff Diversity. Another key component of culturally competent health care is having a racially, ethnically, culturally, and linguistically diverse staff (Washington State Department of Health 1998). Such diversity should be reflected at various staff levels and for various staff types. Although diversity is important regarding staff composition, it may be even more important that staff *reflect* or *represent* the racial, ethnic, cultural, and linguistic composition of the population served (Kim et al. 1992). An additional staffing issue related to culturally competent care involves strategies for recruiting and retaining a culturally competent staff (NLBHW 1996; NPHHI 1998; Texas Department of Health 1998b).

Staff Cultural Competence Training. In addition to recruitment, another strategy for developing culturally competent staff is to provide training. Staff training in cultural competence can serve "to enhance total system performance" (NLBHW 1996). Cultural competence training can be provided to staff on a continuous basis and may address such topics as health care issues of specific ethnic groups, concepts of culture and CLAS, and ways to utilize community resources (Cultural and Linguistic Standards Task Force 1997). Furthermore, policymakers can encourage or require staff training (for all staff levels) in culturally appropriate service provision and can set the standards for the quality and content of such training (Cross et al.1989; Washington State Department of Health 1998).

Linguistic Support Services. Communicating to patients in their own language has been shown to improve: patient compliance and understanding of their disease (Manson 1988); patient self-reported well-being and functioning (Perez-Stable et al. 1997); and access to primary care and preventive services (Jacobs et al. 2001). In addition, patients whose main spoken language is not English are less likely to receive timely eye, dental, and physical examinations (Kirkman-Liff and Mondragon 1991). Also, patients with LEP have been shown to have fewer physician visits (Pitkin Derose and Baker 2000), and are less likely to return for follow-up visits after being seen in the emergency room, when compared to patients with English proficiency (Todd et al. 1993). Given these persistent disparities in health care, the provision of translated written materials and oral interpretation services (e.g., provider or interpreter) to LEP populations are essential components of CLAS (NLBHW 1996; NPHHI 1998).

In sum, at the start of the study, definitions of CLAS were still emerging. Similarly, studies had not yet explored the full range of services in practice—i.e., the nature and extent of CLAS practices implemented in health care settings (across all essential component areas). As such, this study set out to design a conceptual framework and data collection instruments that reflect a broad array of services that can be described as culturally and linguistically appropriate. Chapter 3 discusses the development of the conceptual framework and the study design.

CHAPTER 3

Study Design and Methodology

CHAPTER 3: STUDY DESIGN AND METHODOLOGY

This chapter describes the development of the research design and methodology that was used for the study. The development of the study conceptual framework, as well as the study instruments, sampling frame and strategy, and data collection plan, are discussed. Also, study limitations are described at the end of the chapter.

3.1 STUDY CONCEPTUAL FRAMEWORK

Because this study was the first to attempt a national assessment of CLAS provision in a segment of the U.S. health care system, a conceptual framework was needed to guide the development of the survey instruments and analysis plan. Previous efforts to measure CLAS in health care settings were limited at the time of this study's development. The research team, OMH staff, and the two project advisory groups were challenged with identifying and classifying adequate and appropriate measures that represent a broad array of services that could be used to meet the specific needs of culturally and linguistically diverse populations.

As described in Chapter 2, a review of the literature (CLAS-related studies and assessment tools) was conducted at the beginning of the study planning phase in order to determine the most appropriate and important concepts for inclusion in *any* study of cultural competence, or culturally and linguistically appropriate services, in health care settings. Collectively, the literature suggested that eight "assessment domains" or "study domains" are important in any study of CLAS. The eight domains (identified as essential components of CLAS) were included in the CLAS conceptual framework:

- Organizational Governance;
- CLAS Plans and Policies;
- Patient Care;
- Quality Monitoring and Improvement (QMI);
- Management Information Systems (MIS);
- Staffing Patterns;
- Staff Training and Development; and
- Communication Support.

The intent was to develop a model that comprises an appropriate framework for assessing CLAS in *any* study. That is, an important objective of the current study was to lay the groundwork and contribute to the broader field by investigating and identifying areas of study that are essential for *all* assessments of CLAS in *any* health care setting—not just the current study of CLAS in MCOs. The study domains comprise independent, mutually exclusive categories that allow examination of a broad range of services that can be described as culturally and linguistically appropriate.

Analysis variables, however, are study-specific. Study variables are developed based on the scope and population of the particular study, but are conceptually aligned with related key elements and domains in the broader CLAS assessment framework. Therefore, individual studies may identify specific variables within the broader framework that may be used to answer the research questions of the particular study.

Exhibit 3-1 illustrates the study conceptual framework, including the eight study domains and the key elements to be investigated within each domain (that are applicable for any study of CLAS), as well as the (study-specific) analysis variables that are appropriate for answering the research questions of the current study in MCOs. The eight study domains are described below.

Domain 1: Organizational Governance. This domain is intended to measure the extent to which a commitment to providing services that address the specific needs of culturally and linguistically diverse populations is reflected through the organization's governing structures and bodies. The existence of committees, staff positions, and advisory boards that focus specifically on racial, ethnic, cultural, and linguistic minority health care issues indicates a level of formalization and commitment to health care quality by the organization.

Similarly, decision-making bodies within an organization should reflect the cultural (including racial and ethnic) composition of the population served by the organization (Cross et al. 1989; Roberts et al. 1990). By representing the community within the governing bodies, the needs of the community will likely influence policy formation and decision making, thereby rendering services that meet the particular needs of community members (NLBHW 1996; Roberts et al. 1990).

Domain 2: CLAS Plans and Policies. The types of formal policies in place that express a commitment to diversity indicate a certain organizational commitment to providing quality health services to diverse populations. Policymakers and health plan executives may set a standard of cultural competence, cultural sensitivity, and responsiveness by incorporating such goals into their organization's written mission statement (Cross et al. 1989). Similarly, formal policies may be developed and implemented which govern translation and interpretation services provided by the organization. Such policies set organizational standards and protocols for service delivery, which in turn improve the quality of care at the service level.

Exhibit 3-1

CONCEPTUAL FRAMEWORK FOR ASSESSING CLAS

DOMAIN / KEY ELEMENT	STUDY VARIABLES
1. **Organizational Governance**	
A. Governing boards, committees and positions	A. Board of directors subcommittee on CLAS Community advisory committee on CLAS Committee recruitment strategies Committee racial/ethnic composition Committee diversity other than race/ethnicity Internal CLAS working group Staff position specifically for CLAS coordination
B. Organizational Structure	B. Organization type – HMO, PPO, POS Corporate status – profit, non-profit Model type - IPA, group, network, staff Membership size - total enrollment
2. **CLAS Plans and Policies**	
A. Corporate planning	A. Formal QI plan for culturally and linguistically diverse members Staff and community input Mission statement addresses CLAS Frequency of committee meetings Committee roles related to CLAS
B. Corporate policies	B. Policy governing written translation Description of translation policy Reasons translation policy exists Reasons translation policy does not exist Policy governing interpretation services Description of interpretation services policy Reasons interpretation services policy exists Reasons interpretation services policy does not exist Formal grievance process for CLAS-related concerns Internal communication strategies for CLAS policies Formal staff diversity plan Formal diversity training program
3. **Patient Care**	
A. Assessment and Treatment	A. Cultural differences and preferences considered during treatment Collaborate with culturally-specific healers on treatment Utilize alternative and complementary treatments
B. Materials and Environment	B. Various culturally responsive strategies implemented Characteristics of written materials
4. **CLAS Quality Monitoring and Improvement (QMI)**	
A. Tracking system	A. Multiple methods for monitoring CLAS quality Quality of care data collection Uses of QI data Link member demographic and outcome data Link member and provider data Link member and (other) staff data
B. Needs assessment (NA) and evaluation	B. Routine member/community needs assessments (NA) conducted Frequency of member NA Types of community/member groups that participate in NA Member/community NA specifically for CLAS Data sources for member/community CLAS NA Staff NA conducted specifically for CLAS-related issues Frequency of staff NA Types of staff who participate in NA Types of corporate support for QI and NA activities

(Continued on next page)

(Exhibit 3-1 Continued)

DOMAIN / KEY ELEMENT	STUDY VARIABLES
5. Management Information Systems (MIS)	
A. Members	A. Members’ race/ethnicity recorded Reasons members’ race/ethnicity not recorded Racial/ethnic composition of membership Members’ primary language recorded Reasons members’ primary language not recorded Percentage of membership that speaks non-English primary language
B. Staff	B. Staff race/ethnicity recorded Reasons staff race/ethnicity not recorded Types of staff for whom r/e is recorded Staff linguistic capability recorded Method of determining staff linguistic capability
6. Staffing Patterns	
A. Staff diversity	A. Racial/ethnic composition of staff Percent of bi- or multi-lingual staff Information on staff diversity available to members
B. Staff recruitment, retainment, and promotion	B. Types of staff covered in corporate diversity plan Strategies utilized to recruit, retain, and promote diverse staff Resources utilized to recruit diverse staff
7. Staff Training and Development	
A. Diversity training programs	A. Frequency of diversity training program Racial/ethnic groups covered in diversity training Diverse groups other than r/e covered in diversity training Topical areas covered in diversity training Resources and activities utilized in diversity training Entities responsible for conducting diversity training Entities responsible for developing diversity training Diversity training review and oversight Diversity training evaluation methods Corporate support for diversity training Budget line for diversity training Various benefits of providing staff diversity training Various challenges of providing staff diversity training
B. Staff development	B. Types of staff for which diversity training is available or required Types of staff receiving one-time or continuous diversity training Strategies for encouraging staff participation in diversity training Strategies for informing staff of diversity training
8. Communication Support	
A. Translation services	A. Types of translated materials available Translation methods utilized Entities responsible for reviewing or approving translated materials Identified minimum threshold for translated materials Methods for determining translation needs Data sources utilized to determine translation needs Members for whom translated materials are available Methods used to inform members of available translated materials Budget line for translation activities
B. Interpretation services	B. Types of interpretation services available Characteristics of interpreters utilized Entities responsible for reviewing or approving staffing and operation of interpretation services Identified minimum threshold for interpretation services Methods for determining interpretation service needs Number of interpreters available for members Members for whom interpretation services are available Points of service where interpretation services are available Methods used to inform members of available interpretation services Budget line for interpretation services

Moreover, utilizing staff and community input on CLAS-related planning and policy development is important for understanding the needs of staff and patients, and effectively addressing those needs, thereby improving overall health care quality. Community advisory boards are useful to health care organizations, including MCOs, for designing and conducting community needs assessments, planning and designing services, monitoring and evaluating quality of services, and developing organizational protocols and policies for addressing the needs of culturally and linguistically diverse populations.

Domain 3: Patient Care. This domain captures characteristics of care that are related to (non-communication) cultural barriers experienced throughout the health care continuum.[1] In this sense, patient care is not limited to services provided during the clinical encounter. Rather, key elements and study variables under this domain include conditions and services provided that address cultural barriers across the continuum of care.

The cultural barriers that exist between providers and patients can be reduced or eliminated through the implementation of culturally appropriate services (Julia 1992; Lieberman 1990; Marin 1993; Moore 1992; Redmond 1990). Such services require providers who are knowledgeable about the cultures of their patients, i.e, their customs, beliefs, and languages (Clermont et al. 1993; Dillard et al. 1992; Fernandez-Santiago 1994; Krajewski-Jaime 1993; Pruegger and Rogers 1994; Redican 1994). Effective assessment and treatment require a sensitivity to, and recognition of, cultural patterns related to food preferences, spiritual beliefs, and health practices in order to develop a practical treatment regimen that will result in compliance. Also, health care organizations may encourage their providers to utilize diverse or complementary clinical practices during patient assessment and treatment (e.g., using acupuncture or acupressure treatments, prescribing herbal therapies, or collaborating with culturally-specific healers).

Also, the physical environment is important to patients' level of comfort and trust. The signage, graphics, and brochures in service areas may reflect the racial, ethnic, cultural, and linguistic composition of the populations served. Similarly, culturally sensitive strategies may be implemented to improve patient care for diverse populations. These strategies may include offering dietary options in food service areas that reflect the cultural beliefs and behaviors of the populations served, or offering facilities or services to accommodate diverse religious faiths.

Domain 4: Quality Monitoring and Improvement (QMI). This domain captures an organization's processes and strategies for monitoring and improving quality of services provided to culturally and linguistically diverse populations. Community and staff needs assessments are conducted to determine appropriate programs and services for implementation (Cross et al. 1989). Routine assessments and evaluations may be employed

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[1] Characteristics of care related to *communication* barriers (across the health care continuum) are covered in Domain 8 (Communication Support).

to continually monitor and improve quality of services. QMI activities that are typically used by organizations to improve health care quality are covered in this domain, and include: consumer satisfaction surveys, grievance and complaint tracking, consumer focus groups, analysis of outcomes data, and chart reviews or audits (NPHHI 1998).

Utilizing various methods to monitor CLAS quality is a vital step toward improving CLAS quality (Smedley et al. 2003). Equally important, however, is how organizations use the data they have collected through QMI studies. As such, this domain includes information on the *uses* of QMI data, which may include: setting priorities for health education and promotion; linking patient and provider data; and setting targets or goals for service units.

Domain 5: Management Information Systems (MIS). This fifth domain—which includes assessment elements related to an organization's data collection efforts for its staff and clientele—is closely related to Domain 4, Quality Monitoring and Improvement. In order to effectively understand, monitor, and improve quality of health care in general, and to promote consistent and similar standards of care for all patients regardless of demographic characteristics (e.g., race, ethnicity, language, gender, age, etc.), information must be collected on the demographic characteristics of health plan staff and the service population (Perot and Youdelman 2001; Smith 1998). Inquiries within this domain include whether the organization collects and records such information for its staff and clientele. If management information systems are in place, actual data on the racial, ethnic, cultural, and linguistic composition of the organization's staff and clientele would be gathered under this domain.

Domain 6: Staffing Patterns. The racial, ethnic, cultural, and linguistic composition of health care staff—both clinical and non-clinical—should reflect and represent the diversity of its service population (Kim et al. 1992). This domain covers level of staff diversity within an organization as well as organizational efforts to recruit, retain, and promote a diverse staff. Also important in an assessment of staffing patterns are the types of organizational efforts to make information on staff diversity available to its service population (again, for MCOs, its members), such as provider directories that publish languages spoken by physicians or show photographs of physicians and other health care staff who "look like" their members.

Domain 7: Staff Training and Development. One way to improve quality of health services for culturally and linguistically diverse populations is to hire staff who represent the cultural composition and speak the languages of the population served, discussed above in Domain 6. Another way organizations can improve CLAS quality is to provide ongoing staff training in cultural competence, or "staff diversity training" (Cultural and Linguistic Standards Task Force 1997; NLBHW 1996). As used in this study, diversity training refers to *any instructional effort that addresses and promotes greater understanding of diversity issues in general (race/ethnicity; sex/gender; religion; region; sexual orientation; etc.), or* *more specifically, the unique needs and preferences of culturally and linguistically diverse groups in the health plan membership.* Participation in these programs often invoke opportunities for staff to reflect on their own beliefs and behaviors and how this background affects the way they deliver services (Dilworthanderson et al. 1993; Eliason 1993; May 1992).

In an organizational assessment of CLAS, measures for examining this domain include topical components covered by the diversity training program, frequency of administration, staff types for whom training is available and/or required, and whether the organization provides such training on a one-time (e.g., during employee orientation) or continuous basis. Other staff training and development issues covered by this seventh domain include whether organizations provide opportunities for staff to learn non-English languages.

Domain 8: Communication Support This domain examines language assistance services provided by health care organizations, including MCOs. Translation and interpretation services are needed to reduce and eliminate communication barriers experienced throughout the continuum of care. Although the terms "translation" and "interpretation" are often mistakenly used synonymously, "translation" refers to *written* materials, and "interpretation" is related to *oral* communication. Areas of inquiry related to communication support include: types of translated materials and interpretation services utilized by the organization; characteristics of interpreters utilized by the organization; methods for determining types and levels of language assistance services needed; and points of service at which language assistance services are available. Perhaps the most critical component of quality health care is the ability of both the provider and the patient to understand and be understood. Linguistically appropriate services—i.e., the provision of translated written materials, and oral interpretation services—are vital to accurate physician diagnosis and appropriate treatment of presenting complaints or conditions, patient understanding, and compliance with prescribed actions or treatment plans, and positive health outcomes (Manson 1988; Perez-Stable et al. 1997).

These eight domains reflect the predominant model of cultural appropriateness in health care discussed in the previous chapters—that cultural appropriateness is much more than speaking, or providing services in, languages other than English. Organizational cultural appropriateness involves a *range of efforts* that span the *entire health care continuum*. Also, strategic planning, staff diversity, data collection for self-assessments, and cultural composition of decision-making bodies, are components of CLAS. Additional discussions of each domain are provided in Chapter 4.

The conceptual framework became the basis for developing the study instruments and overall study design.[2] The study design and its development—including instruments, sampling strategy, data collection plan, and efforts to maximize response rate and reduce respondent burden—are described below.

3.2 STUDY DESIGN

Developing Study Instruments. During the study's design phase, the research team, OMH staff, and the project's two advisory groups recognized the importance of developing appropriate instruments for assessing CLAS in MCOs. Two of the study's goals were directly related to instrument development. The intent was to compile measures that would be useful to researchers for conducting future studies of CLAS or cultural competence in health care settings, and that would be useful to health plans, local public health departments, and other health care entities for conducting self-assessments of CLAS in their organizations. Also, it was important to develop instruments that would be educational for the respondents in the health care settings by providing a "listed display" of a broad range of services that comprise CLAS provision. With these two objectives in mind, the research team, OMH staff, and the two advisory groups worked to develop a set of comprehensive measures (within the broader framework of domains and key elements) for assessing CLAS in MCOs.

With the study domains and key elements established, the next task was to develop survey questions and response options that represent a broad range of known CLAS practices across the entire conceptual framework. The research team and OMH staff held numerous meetings for this purpose. For each survey item, within each of three questionnaire components, the development process involved identifying a comprehensive list of examples that reflect what CLAS provision might look like in relation to the topic of the particular question. This method of instrument development was extremely important for the study's educational objective mentioned above. The intent was to develop a data collection instrument that shows *what culturally and linguistically appropriate services are as reflected in the literature, and based on the advice and expertise of researchers and practitioners who work in this arena.*

The following example helps clarify the process and intent. Rather than asking *"Does your organization's local advisory board participate in CLAS planning?"* (with "yes" and

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[2] The study conceptual framework was developed prior to the release of OMH's *Recommended National Standards for CLAS* (OMH 2001). The OMH recommended standards provide a nationally recognized set of guidelines for cultural competency in health care service delivery. As shown in Appendix B, however, a retrospective crosswalk was conducted and illustrates the complementary nature between the MCOs study conceptual framework—including the assessment domains, key elements, and variables within each domain—and the recommended standards.

"no" response options), the item was worded, *"In which of the following ways does your local advisory board participate in CLAS planning?"* with several response options that illustrate *how* an organization may utilize local advisory boards for CLAS planning. The survey items themselves provide examples and ideas on which to build and improve one's service provision.

By participating in this survey, health care professionals are given the opportunity to examine their own organizational policies and practices in relation to the extensive examples of CLAS practices listed in the survey items. Prior to reading the survey, a respondent may have never thought to review dis-enrollment documents as a method for monitoring and improving health care quality and services. The survey questions and response options inform the respondent of a broad range of strategies and practices related to a particular topic along the continuum of care. Every survey item in each of the three questionnaire components (described below) was purposefully designed in this fashion.

Identifying Appropriate Respondents. An important component of the study's design phase was to determine who, i.e., which MCO staff types, would be most appropriate for answering questions related to the study domains and key elements. Brainstorming exercises were conducted, and extensive deliberations were held among the research team, OMH staff, and the experts from the field to examine the domains and key elements in terms of the types of respondents who would be knowledgeable of, and therefore able to answer questions related to, particular areas of inquiry.

An examination of the domains, key elements, and study variables revealed a clear conceptual division, or categorization of topical inquiries, to be paired with respondent types who would be appropriate for gathering the needed information. The conceptual framework was studied and discussed at length, both in its entirety and within each domain. Through these discussions, the following pattern of topical inquiries emerged: the framework was found to comprise measures of CLAS practices as they relate to: 1) the organization; 2) its staff; and 3) its members. As such, these discussions resulted in a three-tiered approach for collecting data within each MCO. One respondent would be responsible for completing a questionnaire component that covered each of these three main areas of inquiry, so that three respondents per MCO would participate in the study's data collection effort.

Questions related to CLAS practices at the organization level (e.g., CLAS-related corporate planning and policy development) should be directed toward a senior executive within the organization, such as a Chief Executive Officer (CEO) or Medical Director. This decision to identify and approach an MCO's senior executive for the organization-related topics of inquiry was strengthened by the fact that the American Association of Health Plans (AAHP) managed care directory, that would be used as the study's sampling frame maintained by the American Association of Health Plans (AAHP) included contact information for each organization's CEO or Medical Director.

An important consideration was offered by members of the expert panel regarding the level of variation among MCOs and their staffing patterns. Because organizations vary by size and function, identifying the two remaining respondents within each MCO may prove to be more complicated. As such, the panelists recommended that appropriate respondents for completing the questionnaire components covering staff- and member-related CLAS practices be identified by someone within the organization such as a high-level executive.

Also, it was recommended that the appropriate respondents for completing the staff- and member-related components of the instrument be based on *function and knowledge,* not title or position, as titles will likely vary by organization. Therefore, the research team, OMH staff, and the advisory groups agreed that these two respondent types would be described very broadly as "staffing respondents" and "membership respondents." The individuals within each organization would be identified by the senior executive based on individuals' roles, responsibilities, and knowledge that best suit the topical nature of each staff- and member-related questionnaire component.

Designing a Three-Component Questionnaire. Based on the recommendations of expert panel members, a three-component instrument was developed to be administered to the three respondents within each MCO: a *Senior Executive Telephone Interview Protocol* (see Appendix C); a *Staffing Questionnaire* (see Appendix D); and a *Membership Questionnaire* (see Appendix E). An illustration of how each survey question (within the three questionnaire components) represents some portion of the conceptual framework is provided in the third column of Exhibit 3-2.

The *Senior Executive Telephone Interview Protocol* was designed to be brief in order to accommodate the busy schedules of executive respondents. Therefore, the majority of survey items were to be included in the *Staffing* and *Membership Questionnaires* (see Exhibit 3-2 for an overview of study variables shown as items located in each of the three questionnaire components). As indicated, items related to organizational governance (Domain 1) and CLAS-related corporate policies (Domain 2) are located in the *Senior Executive Telephone Interview Protocol*. Questionnaire items related to staffing patterns (Domain 6), staff training (Domain 7), and patient assessment and treatment services (Domain 3) are found in the *Staffing Questionnaire*. The *Membership Questionnaire* includes items related to translation and interpretation services (Domain 8), and the health care environment (Domain 3). Information about Management Information Systems (Domain 5) is asked in both the *Staffing* and *Membership Questionnaires*, and questions about CLAS-related quality monitoring and improvement efforts (Domain 4) are included in all three components.

Selecting an Appropriate Study Universe and Sampling Strategy. Because this study involves data collection from a sample of MCOs, or health plans, the most appropriate sampling frame was identified as the directory maintained by AAHP. AAHP represents approximately 1,000 health plans which cover about 170 million individuals in the U.S.

Exhibit 3-2

STUDY DOMAINS, KEY ELEMENTS, AND VARIABLES COVERED IN THREE ASSESSMENT TOOLS

DOMAIN / KEY ELEMENT	STUDY VARIABLES	SURVEY INSTRUMENT, SECTION, AND ITEM NUMBER*
1. Organizational Governance		
A. Governing boards, committees and positions	A. Board of directors subcommittee on CLAS	E-2
	Community advisory committee on CLAS	E-3
	Committee recruitment strategies	E-3a
	Committee racial/ethnic composition	E-3b/3c
	Committee diversity other than race/ethnicity	E-3d
	Internal CLAS working group	E-7
	Staff position specifically for CLAS coordination	E-8
B. Organizational Structure	B. Organization type – HMO, PPO, POS	**
	Corporate status – profit, non-profit	**
	Model type - IPA, group, network, staff	**
	Membership size - total enrollment	**
2. CLAS Plans and Policies		
A. Corporate planning	A. Formal QI plan for culturally and linguistically diverse members	E-6
	Staff and community input	E-4
	Mission statement addresses CLAS	E-1
	Frequency of committee meetings	E-3e
	Committee roles related to CLAS	E-3f
B. Corporate policies	B. Policy governing written translation	E-9
	Description of translation policy	E-9b
	Reasons translation policy exists	E-10
	Reasons translation policy does not exist	E-9a
	Policy governing interpretation services	E-11
	Description of interpretation services policy	E-11b
	Reasons interpretation services policy exists	E-12
	Reasons interpretation services policy does not exist	E-11a
	Formal grievance process for CLAS-related concerns	E-13
	Internal communication strategies for CLAS policies	S-A-5/5a
	Formal staff diversity plan	S-D-1
	Formal diversity training program	S-C-2
3. Patient Care		
A. Assessment and Treatment	A. Cultural differences and preferences considered during treatment	S-D-6
	Collaborate with culturally-specific healers on treatment	S-D-6
	Utilize alternative and complementary treatments	S-D-7
B. Materials and Environment	B. Various culturally responsive strategies implemented	M-D-1
	Characteristics of written materials	M-D-4
4. CLAS Quality Monitoring and Improvement (QMI)		
A. Tracking system	A. Multiple methods for monitoring CLAS quality	E-6b
	Quality of care data collection	M-A-3
	Uses of QI data	M-A-4
	Link member demographic and outcome data	M-B-6
	Link member and provider data	M-A-8
	Link member and (other) staff data	S-B-22
B. Needs assessment (NA) and evaluation	B. Routine member/community needs assessments (NA) conducted	E-5
	Frequency of member NA	M-A-5a
	Types of community/member groups that participate in NA	M-A-5b
	Member/community NA specifically for CLAS	E-5a
	Data sources for member/community CLAS NA	E-5b
	Staff NA conducted specifically for CLAS-related issues	S-A-4
	Frequency of staff NA	S-A-4a
	Types of staff who participate in NA	S-A-4b
	Types of corporate support for QI and NA activities	M-A-6

(Continued on next page)

* E=Senior Executive Telephone Interview Protocol; S=Staffing Questionnaire; M=Membership Questionnaire.

** Information provided in the AAHP managed care directory.

(Exhibit 3-2 Continued)

DOMAIN / KEY ELEMENT	STUDY VARIABLES	SURVEY INSTRUMENT, SECTION, AND ITEM NUMBER
5. Management Information Systems (MIS)		
A. Members	A. Members' race/ethnicity recorded	M-B-1
	Reasons members' race/ethnicity not recorded	M-B-1a
	Racial/ethnic composition of membership	M-B-2/3
	Members' primary language recorded	M-B-4
	Reasons members' primary language not recorded	M-B-4a
	Percentage of membership that speaks non-English primary language	M-B-5
B. Staff	B. Staff race/ethnicity recorded	S-B-1/8/15
	Reasons staff race/ethnicity not recorded	S-B-1a/8a/15a
	Types of staff for whom r/e is recorded	S-B-2/9/16
	Staff linguistic capability recorded	S-B-5/12/19
	Method of determining staff linguistic capability	S-B-6/13/20
6. Staffing Patterns		
A. Staff diversity	A. Racial/ethnic composition of staff	S-B-3/4/10/11/17/18
	Percent of bi- or multi-lingual staff	S-B-7/14/21
	Information on staff diversity available to members	M-D-3
B. Staff recruitment, retainment, and promotion	B. Types of staff covered in corporate diversity plan	S-D-2
	Strategies utilized to recruit, retain, and promote diverse staff	S-D-1/2/4
	Resources utilized to recruit diverse staff	S-D-3
7. Staff Training and Development		
A. Diversity training programs	A. Frequency of diversity training program	S-C-3
	Racial/ethnic groups covered in diversity training	S-C-8/9
	Diverse groups other than r/e covered in diversity training	S-C-10
	Topical areas covered in diversity training	S-C-11
	Resources and activities utilized in diversity training	S-C-12
	Entities responsible for conducting diversity training	S-C-13
	Entities responsible for developing diversity training	S-C-14
	Diversity training review and oversight	S-C-15
	Diversity training evaluation methods	S-C-16
	Corporate support for diversity training	S-C-17
	Budget line for diversity training	S-C-17
	Various benefits of providing staff diversity training	S-C-18
	Various challenges of providing staff diversity training	S-C-19
B. Staff development	B. Types of staff for which diversity training is available or required	S-C-6
	Types of staff receiving one-time or continuous diversity training	S-C-1c
	Strategies for encouraging staff participation in diversity training	S-C-4
	Strategies for informing staff of diversity training	S-C-5
8. Communication Support		
A. Translation services	A. Types of translated materials available	M-C-1
	Translation methods utilized	M-C-2/3
	Entities responsible for reviewing or approving translated materials	M-C-4
	Identified minimum threshold for translated materials	M-C-5/5a
	Methods for determining translation needs	M-C-6
	Data sources utilized to determine translation needs	M-C-7
	Members for whom translated materials are available	M-C-16
	Methods used to inform members of available translated materials	M-C-8
	Budget line for translation activities	M-C-9
B. Interpretation services	B. Types of interpretation services available	M-C-10
	Characteristics of interpreters utilized	M-C-11
	Entities responsible for reviewing or approving staffing and operation of interpretation services	M-C-12
	Identified minimum threshold for interpretation services	M-C-13/13a
	Methods for determining interpretation service needs	M-C-14
	Number of interpreters available for members	M-C-15
	Members for whom interpretation services are available	M-C-16
	Points of service where interpretation services are available	M-C-17
	Methods used to inform members of available interpretation services	M-C-18
	Budget line for interpretation services	M-C-19

The Association was created in 1995 through a merger of the Group Health Association of America and the American Managed Care and Review Association. AAHP's mission is to advance health care quality and affordability through leadership in the health care community, advocacy and the provision of services to member health plans. AAHP provides a wide range of services to its members, including: Federal- and state-level advocacy within regulatory agencies, a strategic communications program, quality assessment and improvement programs, public policy and research, and educational programs (e.g., the Minority Management Training and Outreach Program) on the latest developments in managed care.

At the time of sample selection (i.e., February 2002), the 2001 edition of the *AAHP Directory of Health Plans* offered the most current and complete coverage of MCOs nationwide and included a total listing of 904 organizations. The directory identifies metropolitan market areas of MCOs and contains information on health plan type, profit status, membership size, and model type. Organizational characteristics of the universe of MCOs are provided in Exhibit 3-3.

Disadvantages associated with using an association's directory as a study sampling frame are shared by any similar directory. First, directory listings typically have a lag of about a year between information collection and publication, which could be especially problematic for this study considering the level of consolidation occurring in the health care system at that time. Second, because directories often serve as a sort of yellow pages where purchasers can seek out organizations in certain geographic locales, listings are often too detailed and repetitious. Such repetition may require a fair amount of file manipulation to remove duplicate listings, at some cost.

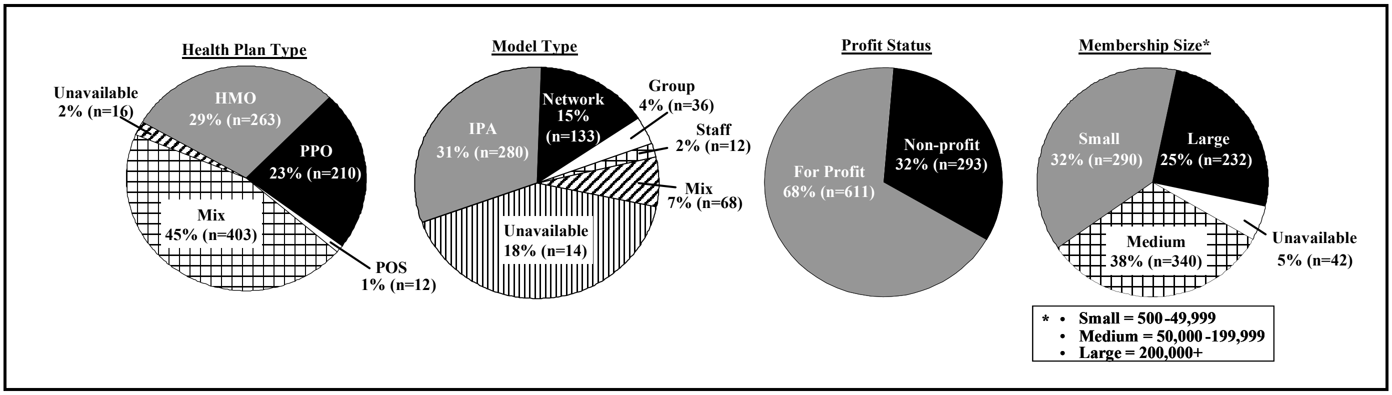
During the study design phase, several characteristics and conditions were explored and considered for developing an appropriate sampling strategy. The most important component was to ensure that the study sample would reflect a nationally representative group of MCOs. A second consideration was that the MCOs selected for study participation should include organizational, membership, and geographic variation.

Discussions were held among the research team, OMH staff, and the project advisory groups to determine the appropriate strategy. Initially, the research team proposed several variables for stratifying the sample of MCOs, including the metropolitan statistical areas (MSAs) in which the organizations reside; organizational characteristics such as health plan type, profit/non-profit status, or membership size of each MCO; and demographic characteristics (e.g., racial, ethnic, cultural, and linguistic composition) of the population served by each MCO.

Following extensive deliberations, members of the expert panel advised that the rapidly-changing landscape of health plans—at both the service and organizational levels—was too complex and uncertain at the time to employ a stratified sampling strategy

Exhibit 3-3

ORGANIZATIONAL STRUCTURE OF MCOS IN THE AAHP 2001 DIRECTORY OF HEALTH PLANS



of any sort. Because the health care system was in a fluid and evolutionary state, many MCOs were merging with other organizations, and many were going out of business. As such, characteristics or conditions that would normally be used to stratify a sample of MCOs were transient during the time of this study. Therefore, the group concluded that the most appropriate strategy for selecting the study sample was the most parsimonious one, i.e., a national random selection of MCOs.

To ensure that the sample drawn would be representative of all MCOs, calculations were performed to determine the degree of precision with which generalizations could be made to the target national population. The most typical measure of survey precision is the widths of confidence intervals for simple univariate estimates and for estimates within analytical subgroups. An analysis of confidence intervals for this study revealed that a sample of 240 MCOs (from the universe of approximately 1,100 at the time) would allow 95 percent confidence intervals for categorical variables that have widths of approximately 4-7 percent. For typical subgroup analyses utilizing six subgroups, a sample of 240 MCOs would yield confidence intervals that range in width from 6-15 percent, depending on the size of the subgroup sample and the particular variable.

Developing the Data Collection Plan. Once the three respondent types (per MCO) were identified, the next challenge in the design phase was to develop a data collection plan which would most likely render a high response rate. Here too, however, the rapidly-changing structure of MCOs at the time—i.e., the evolution of the organizations themselves, as well as changes in the staff within the organizations—influenced the decisions made during the data collection planning phase.

The first point of contact with each MCO would be an introductory letter mailed to the organization's senior executive, as listed in the AAHP directory, with a follow-up telephone call conducted to confirm receipt of the letter and determine the senior executive's availability for study participation. The contact information in the directory provided a starting point for penetrating the MCOs and for determining the appropriate senior executive to complete the telephone interview.

An interview is the most appropriate method for gathering information on an organization's policies, histories, and future plans; because the types of information to be collected typically require the participation of senior-level executives who have busy schedules, these respondents are more likely to agree to a telephone interview than to a face-to-face interview (Marshall and Rossman 2000). The telephone interviews for this study would be conducted using Computer Assisted Telephone Interviewing (CATI) by experienced interviewers who would receive training specifically for this data collection effort. The use of CATI provides a number of time-saving advantages in the data collection process including: electronic recording of a participant's responses (eliminating the manual data entry step); electronic guidance through the interview (e.g., making appropriate skips automatically based on the respondent's answers); and logic checking capability to ensure consistent responses.

In an effort to make the telephone interviews with senior executives even more efficient, the final question posed would be to ask the executive to identify or recommend appropriate staff within the organization to complete the *Staffing* and *Membership Questionnaires*. Because a minimum of 480 Staffing and Membership respondents—i.e., two respondents in each of the 240 MCOs—would be asked to complete a questionnaire (that would be much lengthier than the senior executive's inquiry), these data would be collected by mail rather than telephone, to reduce costs. Once Staffing and Membership respondents were identified by the senior executive at the conclusion of the telephone interview, a personalized introductory letter would be mailed to invite the individuals to participate in the study, along with a copy of the respective questionnaire and instructions for submitting the completed questionnaire.

The need for follow-up contacts with respondents who do not submit a completed questionnaire in a timely manner was considered during the data collection planning phase. The research team, OMH staff, and members of the advisory groups agreed that multiple follow-up contacts may be required with these respondents. As such, a *series* of reminders in *various forms* were determined necessary for this population. Reminder postcards would be disseminated to respondents as a first step, and up to three reminder telephone calls per respondent would become part of the data collection plan.

In order to test the appropriateness of the data collection process and the study instruments, a pilot assessment using cognitive testing techniques was conducted with nine respondent representatives—one Senior Executive respondent, one Staffing respondent, and one Membership respondent from each of three MCOs—between March and June 2001. The six Staffing and Membership respondents completed a *Pilot Test Response Form* (see Appendix F) that was designed to provide respondent feedback on the format and content of the instruments. For each questionnaire component (cover letter; questionnaire cover sheet with instructions; each of four questionnaire sections), respondents were asked to rate certain elements (e.g., layout and design; clarity of instructions; clarity of question wording and response categories; ability to provide requested information) based on the level of appropriateness for presenting each component to someone in a similar staff position as themselves.

An average rating score was used to summarize the responses to the 4-point scale (i.e., 1 = very appropriate; 2 = appropriate; 3 = somewhat appropriate; and 4 = not appropriate). The three Staffing pilot respondents reported an average rate of 1.4, and the three Membership pilot respondents reported an average rate of 1.3. Moreover, there were no responses of "not appropriate" for any component of the *Staffing* or *Membership Questionnaires*. These results demonstrated that for the pilot participants, the *Staffing* and *Membership Questionnaires* were found to be understandable and appropriate—in both format and content—for the purposes of this study.

By implementing the initial data collection plan with a test group of respondents, several methodological changes were found to be necessary. These modifications are described below.

1. Incorporate a confirmation pre-call to MCOs selected in the sample. This adjustment was determined necessary in order to verify and update contact information that was outdated. These limitations however, did not influence the selection of the MCOs into the sample; the procedural modification was needed to expedite the process of reaching the appropriate first contact in the particular MCO.

During the pilot, certain obstacles were encountered when initial contact letters were mailed to each MCO selected for the sample. For example, the information on the identified senior executive (to whom the initial contact letter was addressed) was found to be outdated in two ways: either the individual no longer held the position, or the individual was the correct contact but was located at the health plan headquarters at another address. Also, the telephone numbers listed in the directory for MCO senior executives were sometimes a general number, not a direct line to the senior executive's office. In this situation, it became difficult to ascertain whether the MCO (specifically, the identified senior executive) had received the initial contact letter. Due to these difficulties, the procedure was modified to include a confirmation pre-call to be made before the initial contact letter was mailed to the selected MCOs.

The confirmation pre-call was incorporated to verify the following:

- The telephone number is *not* an automated service, but allows direct contact with the identified senior executive's office to confirm name and address;
- The identified senior executive still holds the relevant position. If not, the current senior executive is identified; and
- The identified senior executive is based in the local office being called. If the identified senior executive is not based out of the local office, another senior person or manager is identified to receive the initial contact letter from OMH.

2. Add an Internet web site option for accessing, completing, and submitting follow-up questionnaires for Staffing and Membership respondents. In the *Pilot Test Response Form*, most respondents (4 out of 6) indicated an option for completing and submitting the (follow-up) questionnaires on the Internet would be useful. Based on these reports, the *Staffing* and *Membership Questionnaires* were converted into HTML format so that the web site submission option would be available to respondents at the time of data collection.

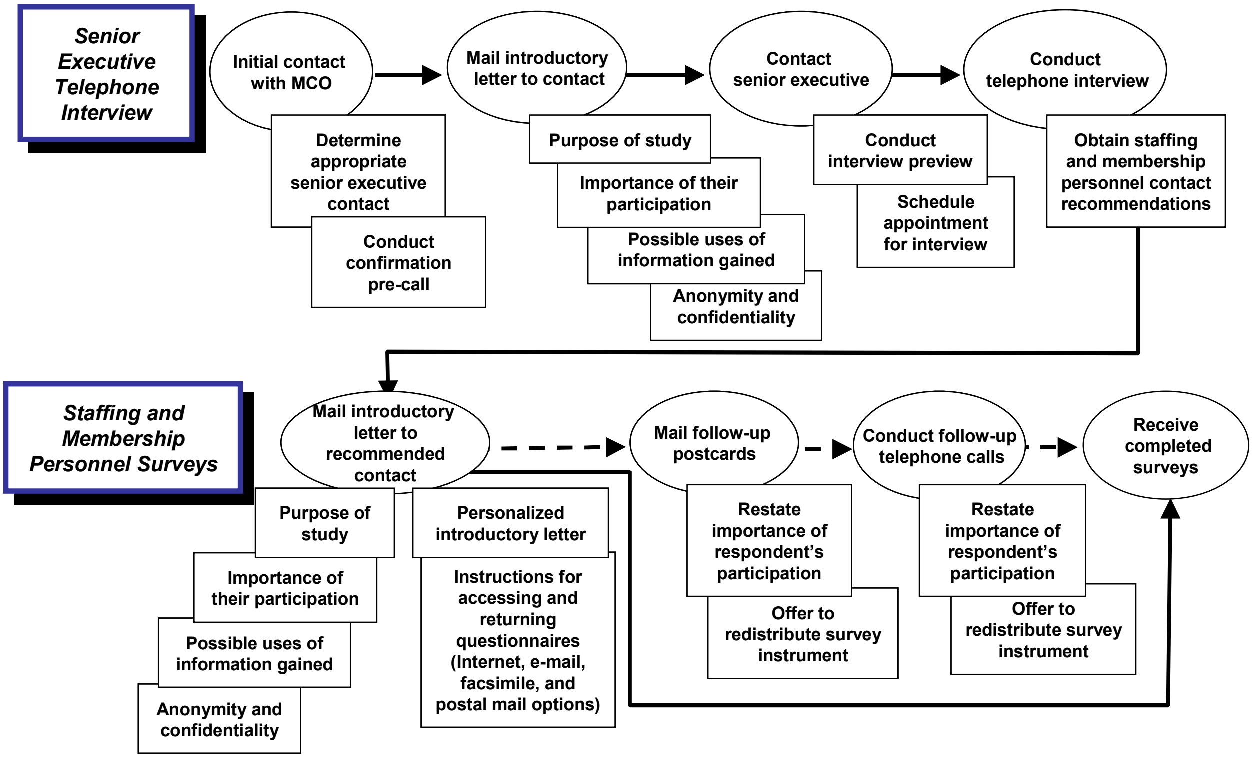
3. Reduce the size of the Staffing and Membership respondent mail packages. During the pilot phase, personnel that were recommended by the senior executive were mailed packages that included a copy of the actual survey. As a result of information learned through the pilot regarding the desirability of completing and submitting the questionnaires electronically (either by electronic mail or Internet web site), hard copies of the instruments were no longer to be included in the initial contact packages for these respondents. Instead, Staffing and Membership respondents would receive an introductory letter from OMH and instructions for participating in the study, including information on options for accessing and completing the questionnaire, through electronic mail, Internet web site, facsimile, or postal mail.

4. Develop an alternate contact letter for sending two follow-up questionnaires to one individual staff member (to distribute to others in the organization). On one occasion during the pilot, the senior executive requested to recommend only one individual to receive the information for both the *Staffing* and *Membership Questionnaires*. This single designee was to receive the contact materials and then distribute the two questionnaires to the appropriate staff in the organization. To accommodate these unforseen circumstances, a third (alternate) contact letter from OMH was developed to use under these conditions.

The final data collection methodology that resulted from information learned through the literature review; discussions and deliberations among the research team, OMH staff, and the two advisory groups; and the pilot administration, is presented in Exhibit 3-4.

Exhibit 3-4

DATA COLLECTION PROCESS



Incorporating Efforts to Maximize Response Rate and Reduce Respondent Burden. Because of the changing landscape of the health care system at that time, as well as their concerns about obtaining a high response rate, members of the expert panel advised the research team and OMH staff that obtaining the needed sample size of 240 MCOs would be difficult at best. With this caution, a significant attempt was made to anticipate reasons for non-response and incorporate strategies for increasing response rate into the data collection design prior to going into the field. The initial strategies that were included in the original data collection plan are described below. Additional strategies to increase response rate were utilized *after* the actual data collection process started; these efforts are described in Chapter 4.

Sample Over-recruitment. To ensure an adequate sample size and account for attrition, the initial sample of MCOs was over-recruited from the universe of MCOs. The original study sample size was 240, but an over-sampling strategy was employed prior to sample selection to increase the sample size by 20 percent (48 additional organizations).

Respondent Contact Materials and Protocols Provide Clear Descriptions of the Study, its Purpose, and its Importance. To stress the study's importance, a formal introductory letter signed by the Deputy Assistant Secretary for Minority Health would be mailed to all identified senior executives of MCOs selected for study participation. The letter would announce and describe the study, its purpose, and its importance. Several enclosures would accompany the letter to emphasize the credibility of the study. The enclosures would include: 1) a letter from a senior representative of AAHP stating the organization's support for the study and encouraging participation of each MCO; and 2) membership lists of the study's two advisory committees. All materials to be received by respondents (including questionnaires, letters, and postcards), would provide assurance of confidentiality and anonymity. Also, respondents would be assured data would be reported as aggregated summaries without individual or organizational identification. All respondent contact materials are provided in Appendix G.

Varied Modes of Administration and Submission. To minimize individual burden and, as a result, increase the study response rate, the *Staffing* and *Membership Questionnaires* were designed so that more than one individual may share the completion of each survey. Each questionnaire would include four color-coded sections, representing the most likely divisions for sharing (e.g., Management Information Systems and Staff Recruitment and Retention). This technique enables the materials to be readily passed to the most knowledgeable informant with the understanding that each individual is responsible for completing only a relatively small portion of the form.[3] In addition, multiple options would be made available to respondents for submitting completed questionnaires, including Internet web site submission, an option to submit via electronic mail with the questionnaire attached, and options for facsimile or postal mail return with postage paid.

Thorough Follow-up Contact Procedures. Extensive and aggressive follow-up contact procedures would be utilized in an attempt to increase the study response rate. The dates of initial contact and all follow-up correspondence with the MCOs would be thoroughly documented and tracked. Reminder postcards were to be mailed to those respondents who had not submitted completed questionnaires two weeks after the requested submission date. If there was no response within two weeks of the first reminder, up to three follow-up telephone calls would be made to each respondent who still had not submitted a completed questionnaire. For each respondent, these calls were to be placed at different times of the day, and voice mail messages would be left when the option was available. Each follow-up contact would restate the importance of participation and include an offer to redistribute the questionnaire.

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[3] The color-coding technique has an additional benefit in that the questionnaire is both attractive and attention-getting, thus making it less likely to be overlooked and forgotten, should the respondent temporarily set it aside upon receipt.

Incentives for study participation. During the study's planning phase, OMH staff explored several potential options that would allow the data submitted by participating MCOs to satisfy existing reporting requirements related to quality monitoring and improvement. Although this type of incentive would be ideal for the participating MCOs, such a "deeming" effort could not be accomplished. Nevertheless, an effort to offer some type of incentive for participation was needed, so the introductory letter to each MCO senior executive would state that all participating MCOs would receive a copy of the study's Final Report when released. In addition, at the request of any participating senior executive, copies of their organization's completed questionnaires (i.e., raw data) would be provided. The idea for this incentive emerged from the assumption that the organization may use the tool and the actual data submitted for this study for its own monitoring and reporting purposes.

3.3 STUDY LIMITATIONS

Several study limitations were recognized and acknowledged prior to the actual data collection process. These limitations associated with the study's time frame, approach, and methodology, are discussed below.

Transitional Nature of the Health Care System. As described previously, the study was conceived at a time of transition and evolution of the entire health care system. Not only were a number of the MCOs themselves merging or going out of business at a rapid pace, the staff positions and personnel within MCOs were expected to be shifting, and therefore difficult to identify and approach using traditional methods of contact.

Limited Previous Research Efforts to Build On. Because this was the first national study to assess the nature and extent of CLAS provision in any health care setting, there were few previous efforts to guide the development of the study conceptual framework and instruments. The research team and OMH staff started from scratch with a broad and thorough review of relevant literature to ensure appropriate inclusion of necessary concepts to be measured in such an assessment. With any new endeavor such as this study, despite all good efforts to anticipate relevant issues, there may be important omissions that are unknown at the start of the study, and this study is no exception.

Self-administered Data Collection. There are several limitations related to respondent error that are associated with self-administered surveys. Self-reported data may be incomplete, inaccurate, or based on a misunderstood question or response option. Similarly, respondents participating in self-administered surveys are more likely (than interview or focus group participants) to experience attention loss, distractions, and fatigue—all of which may increase respondent error (Dillman 2000).

High Level of Dependence on Adequate Sample Size for Generalizations and Statistical Correlations. In order to generalize study results on the nature and extent of CLAS provision to the national population of MCOs, an adequate sample size would be essential. Similarly, analyses that are conducted to examine or show correlations between study variables (e.g., factors that influence CLAS provision) require high confidence intervals with statistical significance for sub-group comparisons.

Inability to Correlate Community-level Data with Membership Demographic Data and Services. An MCO's membership services cannot be correlated with community-level data. Ideally, community-level U.S. Census data would be used to describe the demographic composition of the MCO service population. Statistical correlations could be run to identify the relationship between the racial, ethnic, cultural, and linguistic composition of the service area and actual services provided by the local MCOs. Census data are free, easily accessible, and include accurate demographic information at the zip code level. However, the expert panelists advised the research team that health plan members often do not reside in the same zip code zone as their MCO (as listed in the AAHP directory). Unlike local public health departments, the community in which the MCO is based is not necessarily its "constituency." To gather information on health plan members' racial, ethnic, cultural, and linguistic composition, this study would rely on self-reported estimates of membership data.

Timing of Study Data Collection Coincides with Important MCO Events. The expert panelists cautioned the research team and OMH staff that an unavoidable study limitation is that no matter what time of year data are collected, MCOs will be participating in some type of event that is more significant than participation in a national study. For example, more than half of the MCOs in the country undergo accreditation surveys and audits by various accreditation organizations such as: the National Committee for Quality Assurance (NCQA), Joint Commission for Accreditation of Healthcare Organizations (JCAHO), and the American Accreditation HealthCare Commission (AAHC).

Although the accreditation process takes only about three to four days, the process is intense and requires that MCOs expend many resources to prepare the necessary documentation and data. Preparation for an accreditation survey takes up to a year and requires CEOs, medical directors, and other key staff to be available for completing interviews and data collection forms. In addition, there are many annual conferences sponsored by the Centers for Medicare and Medicaid Services (CMS), DHHS, and other government agencies that require extensive planning and participation of key MCO staff. These and other year-round events that require the time and resources of MCO staff—such as budget crises and even strikes—are inherent limitations with this study population that are difficult to overcome.

Chapter 4 presents the study results. First, the methodological results are described, including the final sample of MCOs that participated in the study, the study response rate, and additional limitations that resulted from the data. Next, the nature and extent of CLAS in MCOs is described by assessment domain. Types and range of services implemented in the organizations are presented, and promising CLAS practices are highlighted.

CHAPTER 4

Study Results

CHAPTER 4: STUDY RESULTS

This chapter presents the study results, including findings from the data collected in MCOs using the study instruments. Before presenting the actual findings from the data, however, a discussion of *methodological results* of the study's approach is provided. In this first section, study response rate and limitations that resulted from the data collected are described. Also, a description of the MCOs that participated in the study is provided, including the distribution of health plan types, model types, profit status, and membership size, among the organizations. The second section in this chapter describes the study results, i.e., the nature and extent of CLAS in MCOs, from the data collected using the three survey instruments.

4.1 METHODOLOGICAL RESULTS

Study Response Rate. The study response rate was 30 percent. As shown in Exhibit 4-1, of the 288 organizations that were contacted and invited to participate in the study, 77 organizations participated; 32 were determined ineligible; and 179 either refused to participate or failed to respond to multiple contact efforts.

Following the 77 telephone interviews, two additional staff (within each MCO) were contacted to complete follow-up surveys. These follow-up respondents were contacted and recruited; they then submitted their completed surveys independently of the other respondents in the same organization. Among the 77 participating MCOs, 30 respondents submitted a completed *Staffing Questionnaire*, and 24 respondents completed the *Membership Questionnaire*. There were 18 complete cases where all three respondents in the organizations submitted data.

There are several possible explanations for the study's response rate. Some of the reasons were anticipated prior to data collection, such as the transitional nature of MCOs and timing of data collection in relation to other organizational commitments, e.g., accreditation audits. Other reasons for non-response that were unanticipated were directly conveyed by the non-respondents themselves. These challenges are described below.

First, as described earlier, a major challenge to this study was the *transitional nature of the health care system*. The managed care system itself was rapidly changing over the course of this study. At the time of sample recruitment, many organizations had recently merged with other companies or gone out of business entirely. A total of 553 MCOs (approximately two-thirds of the universe) were contacted before 288 eligible participants were identified. Moreover, among the 288 MCOs selected into the study sample, 275 listings required updated information.

Exhibit 4-1

SUMMARY OF MCO STUDY PARTICIPATION

Participation Status		Description
Participated	77	77 interviews completed
Ineligible	32	22 do not have memberships 6 duplicate listings in directory* 4 out of business
Did Not Respond	87	Did not respond to 2 mailings and 3 follow-up telephone calls
Refused to Participate	92	51 no time due to ongoing accreditation audit** 36 do not participate in surveys 5 no reason given
Total	288	

* Six MCO listings were determined to be duplicates. These listings contained invalid contact information in the directory, and as a result, were not flagged during the initial phase of data cleaning.

** Telephone calls requesting study participation were placed February through April, 2002.

Second, the *timing of data collection* proved to be important, as cautioned by the expert panel members during the study's design phase. Ongoing accreditation audits proved to be the reason for refusal for 51 organizations.[1] In addition, *organizational protocols regarding survey participation* resulted in many refusals to participate in the study. Thirty-six MCOs declined because their organizations do not participate in surveys.

There are at least two possible explanations for non-response among follow-up (Staffing and Membership) respondents—both of which were unanticipated. First, many *senior executives could not identify appropriate staff* for completing the follow-up surveys. Information learned during the reminder telephone calls revealed many of the recommended staff were no longer employed by the organization, and the individual currently in the position had not been employed long enough to confidently complete the survey. Second, during the reminder telephone calls, it was discovered that organizations' *internal mail systems produced substantial delays* when delivering study materials—including the follow-up survey package—to respondents. A number of Staffing and Membership respondents reported receiving their survey packages as late as two months after the requested submission date for completed surveys.

During the recruitment period for study participation, the research team realized the response rate was going to be much lower than anticipated. As such, two more strategies

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[1] Telephone calls requesting study participation were placed February through April 2002.

were implemented to increase the response rate in addition to those already implemented as part of the study design (described in Chapter 3). First, the research team conducted additional waves of sampling far beyond the intended sample size of 288. A total of 553 MCOs were contacted in an attempt to recruit participants before 288 eligible organizations were identified. The level of effort required to simply identify eligible participants was extraordinary. With this experience, it is doubtful that many more organizations would have been successfully recruited even if the research team had attempted to contact the entire universe of MCOs. Second, because the research team heard from several Staffing and Membership respondents that the delivery of their survey packages had been delayed, the research team and OMH staff agreed to extend the data collection period by three months.

Moreover, strategies to increase the response rate that were part of the original study design proved to be successful for many study participants. As such, these strategies are recommended for use in future studies with similar populations. For example, 16 respondents utilized the Internet option for survey submission (that was incorporated into the study design as a result of information learned during the pilot assessment). Even more participants accessed and printed the on-line questionnaires and submitted their responses via postal mail or facsimile. Also, each follow-up contact (through reminder postcard and three reminder telephone calls) offered to redistribute the questionnaire to the respondent. A total of 27 respondents requested, and were provided, a second copy of the questionnaire.

Study Participants. Three primary types of health plans are offered through managed care arrangements: Health Maintenance Organizations (HMOs), Point-of-Service (POS), and Preferred Provider Organizations (PPOs). The American Association of Health Plans (AAHP 2001) describes HMOs as health delivery systems that offer comprehensive coverage for health care services for a prepaid, fixed fee. HMOs contract with or directly employ participating health care providers. POS options or products combine HMO features and out-of-network coverage, with economic incentives for using network providers. Out-of-network usage generally has a per-person cap, and that usage is insured as fee-for-service coverage. A PPO is a health care benefit arrangement that provides incentives to use designated health care providers while providing coverage for services rendered by out-of-network providers. Health plan types among the participating organizations included 28 HMOs, eight PPOs, two POS, and 39 represented mixed health plan types (i.e., comprising more than one health plan type).

There are four basic HMO model types of service provision (AAHP 2001). *Staff Model* HMOs employ health care providers directly; the providers are employees of the HMO and work exclusively with plan members. The *Group Model* contracts with one or more group practices that provide services, and each group treats the plan members. The *Network Model* contracts with one or more group practices that provide services, and some or all of the groups provide care to patients who are not plan members. *Independent*

Practice Association (IPA) model HMOs contract with physicians in solo practice, or with associations of physicians which in turn contract with their member physicians, to provide services to plan members. Some HMOs combine two or more of the four basic model types and are considered "mixed model" HMOs. Among the MCOs that participated in this study, 23 were IPA models, and 23 employed network models. There were six group model, two staff model, and nine mixed model MCOs. Regarding profit status; 40 of the MCOs were for-profit organizations. The group of MCOs has an average membership size of 113,563 with a range of 500 to 5.7 million members.

To determine if the characteristics of the participating MCOs (e.g., organizational structure and composition) were equivalent or similar to the characteristics of the collective universe of MCOs, a comparative analysis was conducted. The organizational characteristics among three groups of MCOs were examined: those that participated in the study (n=77); those that were in the sample but did not participate in the study (n=211); and those that comprise the universe of MCOs, or all listings in the AAHP directory (N=904). Exhibit 4-2 provides a summary of these characteristics among the three groups of MCOs. The organizational characteristics of participating MCOs are similar to the characteristics of those organizations comprising the broader universe of MCOs. As shown, representation of different health plan types (HMO, POS, PPO, or mixed) and model types (IPA, Network, Group, Staff, or mixed) are similar for each group (i.e., participating and universe MCOs).

Also, interesting organizational differences emerged when comparing these groups. Participating MCOs, as a group, have a much smaller average membership size (113,563) than the universe as a group (361,318), and the sample as a group (580,729). Moreover, the group of participating MCOs comprised a smaller proportion of for-profit organizations (52 %) than the sample and universe groups of MCOs (63 and 68%, respectively).

Reliability and Validity of Questionnaires. Tests were performed to determine levels of reliability and validity for the study instruments. *Reliability* is the extent to which an instrument (e.g., a survey) yields the same result on repeated trials. *Validity* refers to the degree to which a study accurately reflects or assesses the specific concept(s) that the researcher intended to measure. While reliability is concerned with the accuracy of the actual measuring instrument, validity is concerned with the study's success at measuring the concept(s) that the researcher set out to measure.

As previously described, the questionnaire covers eight major domains, each consisting of two key elements that are measured by multiple variables. Those key elements that represent additive scales—i.e., taken together, the multiple items (variables) constitute a scale designed to capture one unique construct—were tested for internal reliability. Procedures to test validity were conducted during the pilot study; results from these cognitive testing procedures are detailed in Chapter 3. Reliability results are discussed below.

Exhibit 4-2

ORGANIZATIONAL CHARACTERISTICS OF THREE GROUPS OF MCOs

	MCO Group					
	Participating MCOs (n=77)		**MCOs in the sample that did not participate (n=211)**		**Universe of MCOs (N=904)**	
Organizational Characteristics	Number	Percent	Number	Percent	Number	Percent
Corporate Status						
For Profit	40	52%	133	63%	611	68%
Non-profit	37	48%	78	37%	293	32%
Membership Size*						
Small	29	38%	65	31%	290	32%
Moderate	26	34%	80	38%	340	38%
Large	21	27%	58	27%	232	25%
N/A**	1	1%	8	4%	42	5%
Average	113, 563	-	580,729	-	361,318	-
Range	500-5.7M	-	2,500-23M	-	35-23M	-
MCO Type						
HMO	28	36%	69	33%	263	29%
PPO	8	10%	63	30%	210	23%
POS	2	3%	1	0%	12	1%
MIX***	39	51%	78	37%	403	45%
N/A****	-	-	-	-	16	2%
Model Type						
IPA	23	30%	75	35%	280	31%
Network	23	30%	51	24%	133	15%
Group	6	7%	8	4%	36	4%
Staff	2	3%	4	2%	12	2%
MIX***	9	12%	4	2%	68	7%
N/A**	14	18%	69	33%	375	41%

* Membership Size: Small = 49,999 or fewer; Moderate = 50,000 - 199,999; Large = 200,000 and over.

** Data on membership size are not available.

*** Refers to having more than one organizational structure or more than one provider model.

**** Data on MCO type are not available.

Reliability. Several of the key elements within the various domains could be conceptualized as scales (i.e., more "yes" responses means more of the construct), and thus can be tested for reliability as measured by Chronbach's alpha, a measure of internal consistency based on the average inter-item correlation (Chronbach 1951). A high alpha indicates good internal consistency and suggests that there is at least one fairly homogeneous dimension underlying the scores in the construct.

As seen in Exhibit 4-3, the majority of the scales exhibit high reliability, with nine of the 13 testable scales having an alpha of .820 or higher. Altogether, the scales had a mean alpha of .804, with a range of .444 to .999.

Validity. The validity of the instrument was considered in multiple ways. The *face validity*, or extent to which the instrument subjectively appears to be measuring what it is supposed to measure, was rated high, as tested in the pilot study (see Section 3.2).

The *content* validity, or extent to which the instrument includes a representative sample of the content of a construct is good, as each construct is made up of a number of items intended to capture the breadth and depth of the construct. For example, the strength of Diversity Training Programs (7.A) is measured through items that address not only the frequency of training sessions, but the diversity of the groups covered in the training, the topic areas covered, the resources utilized, the evaluation methods used, etc.

Limitations of the Study Data. Due to the low response rate, findings from this study are not generalizable to the national population of MCOs. Although the intent of the study was to describe the nature and extent of CLAS in MCOs across the country, study results describe a snapshot of services *only for those organizations that participated in the study.* Findings are not generalizable to the universe of MCOs and are not presented in this Report as representative of national trends in health care service delivery. Similarly, the low numbers of participating Staffing and Membership respondents (i.e., 30 and 24 respondents, respectively) do not allow for sub-group comparisons.

Also, the low response rate disallows any meaningful comparisons of CLAS provision among MCOs. With the study's second and third research questions—i.e., *Does CLAS provision vary among MCOs, and if so, how?* and *What factors influence the provision of CLAS in MCOs?*—the intent was to not only describe the types and range of services provided (addressed through the first research question), but also to explore relationships between relevant variables using cross-tabulations. With such low numbers, comparative analyses of any sort are not meaningful, and therefore objectives related to answering the study's second and third research questions were not accomplished.

The large differences in the (low) numbers of participants among the subsamples—i.e., 77 Senior Executives, 30 Staffing respondents, and 24 Membership respondents—interfered with intended analyses. Ideally, the description of the nature and extent of CLAS in MCOs

Exhibit 4-3

RELIABILITY OF ADDITIVE SCALES

DOMAIN	KEY ELEMENT/SCALE	ALPHA
1. Organizational Governance	A. Composition of Boards	.996
	B. Organizational Structure	NA*
2. CLAS Plans/Policies	A. Corporate Planning	.672
	B. Corporate Policies	.825
3. Patient Care	A. Assessment and Treatment **	.473 / .654
	B. Materials and Environment	NA*
4. QMI	A. Tracking System	.883
	B. Needs Assessment and Evaluation	.950
5. MIS	A. Members	.444
	B. Staff	.865
6. Staffing Patterns	A. Staff Diversity	NA*
	B. Staffing Policies	.821
7. Staff Training/Development	A. CLAS Training Program	.999
	B. Staff Development	NA*
8. Communication Support	A. Translation Services	.927
	B. Interpretation Services	.947

* Key element is not an additive acale; measures within the key element are independent descriptors.

** In the conceptual framework, "Assessment and Treatment" represents one key element under Domain 3. For reliability testing however, "assessment" and "treatment" may be separated into two testable scales. As such, scores for each scale are presented.

would involve discussions that compare types and range of services among respondent types and across domains. However, such analyses would involve unfair comparisons, citing data from the 77 Senior Executive respondents alongside data from (only) 24 Membership respondents. Many times, one respondent type is responsible for submitting data related to an entire domain (or the majority of components within a domain). For example, all survey questions related to organizational governance (Domain 1) are included in the *Senior Executive Telephone Interview Protocol*, and all questions related to communication support (Domain 8) are included in the *Membership Questionnaire*. Thus, any sort of comparisons related to the range or "level" of CLAS provided between these two domains would not be genuine.

Moreover, the fact that each domain has different numbers of questions (and resulting analysis variables that collectively represent that domain), descriptions across domains would be difficult even with a higher response rate. In order to compare CLAS provision across domains, the two domains being compared would need to begin on equal ground. This means that to render an accurate comparison across domains, measures and variables that reflect CLAS provision in the particular domain should be similar in number, or should represent comparable scales that rank "high" and "low" levels of CLAS provision in the particular domain. In this study, nearly three times as many data were collected from Domains 2 (CLAS Plans and Policies), 7 (Staff Training and Development), and 8 (Communication Support) than for Domains 3 (Patient Care) and 6 (Staffing Patterns). For these reasons, the findings cannot present comparisons across the eight assessment domains.

As discussed in Chapter 3, with any exploratory study such as this one, there necessarily will be lessons learned. A retrospective examination of the data revealed one particular limitation of this kind. Information was not collected on organizations' capacity to provide language assistance in *multiple* languages. In addition to the types and range of language assistance offered by the MCOs, it would have been valuable to know in *how many languages* the services are provided.

The limitations of the study (described in Chapter 3) and of the data (described above) necessarily render study results that are less revealing and less significant than what was intended at the start of the project. Nevertheless, the data provide a rich description of strategies and practices employed by this group of MCOs that address the specific needs and preferences of culturally and linguistically diverse populations. The nature and extent of these efforts are described below.

4.2 NATURE AND EXTENT OF CLAS PROVISION IN MCOs

This section presents study results that answer the research question, *What is the nature and extent of CLAS Provision in MCOs?* The *types* of CLAS practices being implemented, and the *range* of practices (from "low" to "high-end") offered by the MCOs that participated in the study, are described within each of the eight CLAS assessment domains. In addition, the types of "promising practices" (usually "high-end") offered in a number of MCOs are presented.

In each subsection below, study results are presented by domain. For each domain, first, an overview of the components and key elements that were assessed is offered. Second, the types and ranges of CLAS offered by the MCOs are described. Finally, each domain includes "promising" CLAS practices that are highlighted as outstanding efforts on behalf of certain MCOs to address the health care needs of culturally and linguistically diverse members.

Types and Range of Services Related to Each Domain. Findings presented on the types and range of services represent data gathered using the three survey components for this study: the *Senior Executive Telephone Interview Protocol*; the *Staffing Questionnaire*;

and the *Membership Questionnaire* (again, see appendices C, D, and E). Although these data were primarily quantitative, descriptive analyses in the form of numeric graphs or figures are not presented in the text due to the low response rate. Rather, the data are presented more qualitatively as descriptive summaries of the types and range of CLAS offered by the MCOs. However, Appendix H includes a complete inventory of quantitative survey data. In addition, nearly every item in every survey included an open-ended "other" response option to capture services that are being implemented but were not included as a survey response option. A summary of all open-ended responses submitted by respondents is provided (by survey item topic) in Appendix I.

Promising Practices Related to Each Domain. Based on their knowledge of the literature and experience in the health care field, members of the Project Expert Panel, the Federal Project Advisory Group, and OMH staff collaborated to identify 44 promising CLAS practices, which are highlighted in this study. During a face-to-face meeting of the two advisory groups, OMH staff, and the research team, a workshop-style session was conducted to collectively nominate individual practices as promising. Raw data (quantitative and open-ended responses) for more than 450 survey items were examined by the group. The criterion to be considered "promising" was that the practice should be an innovative or extraordinary "higher-end" service that may impact health care quality for culturally and linguistically diverse populations. Consensus among advisory group members and OMH staff members was required to include an item as a promising practice.

The list of promising practices was generated from the pool of study data. As such, those included in this Report represent only a *fraction* of CLAS practices that could be considered "promising." Because the practices identified for this study represent actual survey responses, they were selected, and are reported, based only on the brief wording of survey responses. More detailed descriptions of the activities are not available for this study but may be the subject of future research efforts.

The practices are highlighted within each domain as examples of how some MCOs are addressing the health care needs of diverse populations (e.g., through policies, staffing, and services) in ways that currently are "above and beyond" the typical service provision efforts. A major study finding is that the promising practices are *not* being implemented by only a handful of organizations. Rather, nearly every participating MCO reports implementing one or more of the practices. Appendix J provides an overview of the promising CLAS practices.

4.2.1 Domain 1: Organizational Governance

An MCO's governance is an important base from which the organization is able to provide quality health care to culturally and linguistically diverse members. When governing bodies are culturally and linguistically diverse, it is easier for the organization to define and structure services, activities, and policies which reflect the needs and concerns of diverse populations. In addition, the MCO's mission and operations become more connected to its culturally and linguistically diverse members.

Cross and colleagues (1989) suggest policymakers—including board members, officials, and legislators—should be recruited from the community served. Community members should be recruited for policy-making positions, such as general oversight committees and tasks forces, and should be well-represented on new task forces that can be utilized for decisions related to services that affect culturally and linguistically diverse community members.

In addition, planning committee representatives should include top and middle management, front-line staff, providers, families, and community leaders. Membership composition of such decision-making bodies should be representative of the community population, in race and ethnicity, as well as other characteristics such as gender, age, and religion (NLBHW 1996).

Types and Range of Services Related to Organizational Governance. Types of CLAS-related governing bodies utilized by the MCOs in this study include: community-level CLAS advisory boards; boards of directors' subcommittee on CLAS; and internal working groups for CLAS planning and evaluation. Also, a number of MCOs fund staff positions for CLAS promotion and coordination. Supporting a staff position to focus solely on issues and services related to culturally and linguistically diverse members is another way some MCOs are trying to ensure that the unique health care needs of diverse members are adequately addressed.

The use of community advisory boards for CLAS-related issues is common among this group of MCOs. The board memberships tend to be racially and ethnically diverse. Regarding other types of diverse representation, most community advisory boards include gender diversity, geographic diversity, religious diversity, and persons with disabilities. In addition, a number of MCOs reported their organizations' advisory boards reflected age, linguistic, socioeconomic, and sexual orientation diversity. Also, recent immigrants are valuable members of community advisory groups. As acknowledged by a number of MCOs, immigrants' knowledge of the community's culture and language is a strong asset for planning and evaluating services related to community members' needs.

Several key strategies for recruiting community advisory board members are utilized by the MCOs. Community leaders and liaisons are used most often for recruiting advisory board members. Also, health plan publications, Internet web sites, and local community newspapers are used by many of the MCOs to obtain diverse memberships on their local boards. Local radio or television, and major regional newspapers, are examples of resources utilized by a number of the MCOs to recruit a diverse advisory board.

Promising Practices Related to Organizational Governance.

– *FUNDED STAFF POSITION FOR CLAS PROMOTION AND COORDINATION*

– *INTERNAL WORKING GROUP FOR CLAS PLANNING AND EVALUATION*

4.2.2 Domain 2: CLAS Plans and Policies

MCOs that have formal CLAS plans and policies, in effect, have a foundation for systematically addressing the needs of culturally and linguistically diverse members more efficiently. Written policies may set organizational standards of cultural competence, sensitivity, and responsiveness, and may express an organizational commitment to providing quality health services to diverse populations.

Moreover, organizational plans and policies are more responsive to cultural and linguistic diversity issues when they are developed with the input of consumers, community members, as well as health care staff who understand, and can best express, the needs of the organization's members. Utilizing staff and community input on CLAS-related planning and policy development is important for understanding the needs of staff and patients, and effectively addressing those needs, thereby improving overall health care quality.

Types and Range of Services Related to CLAS Plans and Policies. Having an organizational mission statement that addresses CLAS specifically, and policies that govern written translation and interpretation services, is widespread among the participating MCOs. Other examples of formal organizational plans that focus specifically on CLAS quality include staff diversity plans and quality improvement plans for culturally and linguistically diverse members.

Policies that govern written translation of organizational materials typically state protocols for: ensuring commonly used materials are translated; informing members of available translated materials; and establishing methods for identifying members' need for translated materials. Also, some translation policies establish an organizational entity with programmatic responsibility. This "high-end" practice—of having a staff position for monitoring the accuracy and quality of translated materials, as well as the language assistance needs of the health plan members—is one strategy being used to enforce an organization's formal policies and protocols and improving quality of care for linguistically diverse members.

The range of protocols and standards for providing interpretation services (as stated in formal organizational policies) are similar to the protocols for translation of written materials. Policies that govern interpretation services typically include protocols for:

ensuring a range of oral language options are provided; informing members of available interpretation services; establishing a method for identifying members' (oral) communication needs; and establishing an organizational entity with programmatic responsibility. Many organizational policies that govern interpretation services include protocols to ensure staff are periodically trained on appropriate procedures and practices related to language assistance services.

Community advisory boards are utilized by the MCOs for CLAS planning and policy development through their involvement in identifying and assessing members' needs, monitoring and evaluating quality of services, planning and designing services for culturally and linguistically diverse members, and developing CLAS plans, protocols, and policies. Input on CLAS policies is often gathered from community members, such as: community leaders and liaisons; community civic organizations; local consumer or advocacy groups; community faith-based organizations; and local health or government officials. Different staff types—including physicians and nurses, membership services staff, corporate managers, and front-line personnel—provide input on CLAS policies in these organizations.

Although the existence of such policies and the representativeness of the policy-making committees are important components of CLAS, to be effective, policies and protocols must be fully communicated to, and understood by, staff at all levels. These MCOs use a number of communication strategies for informing staff of CLAS-related organizational policies and protocols. At initial employment orientations, regular staff meetings, and periodic staff workshops, organizations present and discuss these types of policies. Also for some MCOs, descriptions of CLAS policies are made available to staff through organizations' annual reports and other staff publications.

Promising Practices Related to CLAS Plans and Policies.

– FORMAL POLICY ON WRITTEN TRANSLATION

– FORMAL POLICY ON INTERPRETATION SERVICES

– FORMAL STAFF DIVERSITY PLAN

– COMMUNITY ADVISORY BOARD IS UTILIZED FOR CLAS PLANNING AND POLICY DEVELOPMENT

– AS A RECRUITMENT STRATEGY FOR COMMUNITY ADVISORY BOARDS, DISSEMINATION OF MEMBERSHIP INVITATION LETTERS TO THOSE WHO HAVE SUBMITTED COMPLAINTS

4.2.3 Domain 3: Patient Care

Providing health care services that are culturally appropriate can reduce or eliminate cultural barriers between providers and patients (Julia 1992; Lieberman 1990; Marin 1993; Moore 1992; Redmond 1990). Effective assessment and treatment require a sensitivity to, and recognition of, cultural patterns related to food preferences, spiritual beliefs, and health practices in order to develop a practical treatment regimen that will result in compliance.

Also, culturally appropriate services include providing a physical environment in which the signage, graphics, and brochures in service areas reflect the racial, ethnic, cultural, and linguistic composition of the populations served. MCOs may implement strategies to improve patient care for culturally diverse members, such as: offering dietary options in food service areas that reflect the cultural beliefs and behaviors of the population, or offering facilities or services to accommodate diverse religious faiths.

Types and Range of Services Related to Patient Care. MCOs can encourage their providers—e.g., through organizational standards, policies and contracts—to utilize diverse clinical practices (during both assessment and treatment) that are complementary to patients' cultural beliefs and behaviors. Types of complementary clinical practices encouraged by the MCOs range from providing culturally competent guidance on diet/nutrition to using herbal therapies and acupuncture/acupressure treatments. Also, providers are encouraged by a number of MCOs to utilize chiropractic therapies and relaxation techniques.

There are many types of services provided by the MCOs that are in place specifically for addressing particular needs of culturally diverse members. In efforts to improve the quality of the health care setting, environment, and/or experience, such services are designed to be sensitive and responsive to the needs of certain cultural groups. Structuring the environment to better meet the needs of culturally and linguistically diverse members is one important way that MCOs can provide CLAS. Types of services implemented by the MCOs that participated in the study include: services for the hearing impaired; non-traditional hours of operation; signage in Braille at critical points of services; and signage in the predominant languages of members. Other efforts by the MCOs include: designing physical environments that depict cultural diversity, offering diverse dietary options in food service areas, and offering facilities and services to accommodate religious diversity.

The MCOs' written materials often are deliberately designed to reflect racial, ethnic, and other forms of diversity such as gender, socioeconomic, and religious. In many cases, the content of written materials is geared to persons of varying reading levels, and readability testing is performed on written materials in a number of organizations.

Promising Practices Related to Patient Care.

– *SIGNAGE IS TRANSLATED IN THE PREDOMINANT LANGUAGES OF THE SERVICE POPULATION*

– *READABILITY TESTING IS PERFORMED ON WRITTEN MATERIALS*

– *ANNUAL REPORT ON EFFORTS TO PROVIDE CLAS IS PUBLICLY DISSEMINATED*

4.2.4 Domain 4: Quality Monitoring and Improvement

Through self-assessments, an MCO can obtain information on the organization's capacities, strengths, and weaknesses in addressing the health care needs of its members. Such quality monitoring and improvement (QMI) assessments are useful for identifying service needs and areas for improvement, and for developing action plans, programs, and services that directly address the unique health care needs of culturally and linguistically diverse groups.

Routine assessments of the characteristics and needs of the service population are an important component of monitoring and improving quality of care. Ideally, staff and community members are involved in organizational CLAS needs assessments and other QMI studies. Utilizing various methods to monitor CLAS quality is a vital step toward improving CLAS quality. Equally important, however, is how organizations use the data they have collected through QMI studies.

Types and Range of Services Related to Quality Monitoring and Improvement. Various methods for monitoring CLAS quality are utilized by the participating MCOs. These methods range from member satisfaction surveys and grievance tracking to reviews of dis-enrollment and physician change request forms. Such strategies allow organizations to gather information on members' perceptions and experiences related to access and quality of services. Information learned from these types of QMI efforts may be used to develop and implement new programs and practices that address the unique health care needs of culturally and linguistically diverse members. By reviewing members' physician change request forms, for example, organizations can learn specific reasons why members request a different primary care physician and can better understand the specific needs of culturally and linguistically diverse members based on the stated grievances in such forms.

Also, the MCOs have mechanisms in place to systematically address members' grievances and concerns. The use of intermediaries as a strategy for improving communication and resolving conflicts—such as an ombudsman or "cultural navigator"—is common among these organizations. Another strategy utilized by the MCOs to address members' CLAS-related concerns is to disseminate systematic staff notices that promote non-discriminatory practices. These formal "reminders" serve to reinforce the organization's standards, service protocols, and overall organizational commitment to improving quality of care for all its health plan members.

Data collected from QMI studies are analyzed and used in various ways to better understand existing needs of culturally and linguistically diverse members and to improve quality of health care services for these members. The organizations use data collected from QMI studies to identify and address racial, ethnic, and other demographic health care differences, and to set priorities for health education and promotion, as well as targets for specific service units. "High-end" uses of QMI data include: linking member and provider data, and linking member demographic data with health outcomes data. These types of analyses provide MCOs with the ability to identify patterns in access, services, and outcomes for certain groups of members, as well as the ability to address and reduce related health care disparities. A major drawback relevant to this domain is that relatively few of the MCOs report to collect racial, ethnic, cultural, and linguistic data on their members (discussed in Domain 5 below).

Organizational assessments to identify the specific health care needs of its culturally and linguistically diverse members are commonly conducted by the MCOs. Many health plans provide corporate support for local CLAS-specific member needs assessments. Examples of corporate support include: allocating financial resources, setting benchmarks for quality and outcome indicators, providing on-site advisory personnel, and actually conducting the local assessments using corporate personnel.

Both community members and health care staff are often involved in organizational CLAS needs assessments. Community advisory boards, local consumer or advocacy groups, local health or government officials, local faith-based organizations, and/or local civic groups are all involved in the CLAS needs assessments conducted by the participating organizations. Also, staff are involved in the organizations' CLAS needs assessments. Most often, supervisors and program managers, physicians, membership services staff, and executive-level administrators are involved in the assessments. Participation by other staff types—such as physician assistants; nurse practitioners; pharmacy, lab, and x-ray staff; accounts/billing staff; and front-line personnel—is less prevalent. A few MCOs in this study report to involve interpreters in their CLAS assessments. Interpreters can contribute valuable information on existing needs related to language assistance services, as well as organizational capacity to meet the language needs of its linguistically diverse members.

Promising Practices Related to Quality Monitoring and Improvement (QMI).

– METHODS ARE UTILIZED FOR MONITORING OR IMPROVING CLAS QUALITY:
– REVIEWS OF DIS-ENROLLMENT
– REVIEWS OF PRIMARY CARE PHYSICIAN CHANGE REQUESTS
– ORGANIZATIONAL ASSESSMENTS OF CULTURAL COMPETENCE
– PROVIDER SURVEYS

– MEMBER DEMOGRAPHIC DATA ARE LINKED WITH OUTCOME DATA

– CERTAIN STAFF TYPES ARE INVOLVED IN CLAS NEEDS ASSESSMENTS:
– PHARMACY, LAB, AND X-RAY PERSONNEL
– ACCOUNTS/BILLING STAFF
– INFORMATION SPECIALISTS AND FRONT-LINE PERSONNEL
– QUALITY MANAGEMENT STAFF

– CULTURAL NAVIGATORS ARE UTILIZED AS A STRATEGY FOR ADDRESSING MEMBERS' CONCERNS

4.2.5 Domain 5: Management Information Systems (MIS)

In order for MCOs to effectively monitor health care quality, it is essential for the organization to record information on: 1) race, ethnicity, and primary language spoken by its members; and 2) race, ethnicity, and linguistic capability for its clinical and non-clinical staff (Perot and Youdelman 2001; Smith 1998). Put simply, without data on members' demographic characteristics—such as race, ethnicity, and primary language spoken—it is impossible to monitor and improve the quality of care for culturally and linguistically diverse members. Lack of member demographic data undermines an organization's ability to identify potential areas of service that need attention, as well as its ability to prevent and avoid health care disparities, and to ensure optimal health care quality for all its members.

The provision of CLAS requires the implementation of strategies and services that are responsive to the unique health care needs of culturally and linguistically diverse members. Before an MCO can begin to identify—much less address—the unique needs of its culturally and linguistically diverse members, the organization must first have an understanding of the cultural and linguistic composition of its membership. By collecting information on staff's and members' race, ethnicity, and linguistic capability (for staff) or preference (for members), MCOs are able to identify and address gaps in service that affect overall quality of care.

***Types and Range of Services Related to Management Information Systems*.** Information on primary language of members is collected and recorded more often by the participating MCOs than information on members' race and ethnicity. Concerns about legal liability, members' privacy rights, and the quality or completeness of data were reported as reasons for *not* collecting and recording information on race and ethnicity for members.

Nevertheless, collecting and recording members' race and ethnicity information are necessary for ensuring optimal quality of health care. As described earlier, the provision of CLAS involves more than offering language assistance services to members who speak non-English languages. Even with English-speaking members, services that are sensitive and responsive to *cultural* differences—e.g., health-related beliefs and behaviors that affect patient compliance and health outcomes—are vital for optimal quality of care. Given the well-documented health care disparities by race, ethnicity, and language spoken, collecting and examining such information from health plan members are very helpful in an organization's QMI efforts.

MCOs were asked whether they collect and record information on race, ethnicity, and linguistic capability (i.e., fluency in languages other than English) for their health care staff. For those organizations that collect information on staff linguistic capability, self-identification is the primary method used for determining capability. Two examples of "higher-end" practices that could be utilized for determining staff linguistic capability are testing in the target language and proof of training completion or certification.

Among clinical staff types, information on race and ethnicity is most often collected for physicians, nursing professionals, and physician assistants and nurse practitioners. Racial and ethnic data are collected less often for allied or associate health professionals and for pharmacy, lab, and x-ray staff. Non-clinical staff types for which race and ethnicity data are collected include: executive-level administrators; supervisors and program managers; information specialists and front-line personnel; membership services staff; interpreters; and accounts/billing staff. Staff privacy rights was the reason cited most often by the MCOs for *not* recording staff race and ethnicity.

This assessment domain involves data collection on the actual racial, ethnic, and linguistic composition of an organization's membership and health care staff. Very few respondents in this study completed the portions of the *Staffing* and *Membership Questionnaires* that request information on the racial, ethnic, and linguistic compositions of the organizations' staff and memberships, even though the option to estimate was offered. Without these data, intended analyses for this study could not be performed that included examinations of possible relationships between an MCO's staff and membership composition, as well as between an organization's membership composition and the types and range of CLAS provided. Clearly, MCOs with a high degree of linguistic diversity in their memberships also have a high degree of bilingual/multilingual capabilities amongst their staff—how well such capabilities match the needs of, and enhance health care quality for, health plan members is unknown.

Promising Practices Related to Management Information Systems.

– *STAFF LINGUISTIC CAPABILITY IS RECORDED*

– *STAFF LINGUISTIC CAPABILITY IS DETERMINED BY PROOF OF TRAINING OR CERTIFICATION*

4.2.6 Domain 6: Staffing Patterns

Health plans that recognize the importance of "racial/ethnic concordance" are more likely to take deliberate, overt steps to recruit, retain, and promote staff who reflect the diversity of the populations they serve. Ideally, the racial, ethnic, cultural, and linguistic composition of health care staff—both clinical and non-clinical—should reflect and represent the diversity of its service population. An organization may improve its culturally appropriate services and overall quality of care by utilizing one or more of the following three strategies: 1) hiring racially and ethnically diverse staff; 2) hiring staff with cultural competence skills and/or experience working in culturally diverse settings; and 3) providing training to help current staff become better providers of culturally and linguistically appropriate services (staff training is discussed under Domain 7, in the following section).

Recruitment practices are an important mechanism for developing or improving staff diversity. Job descriptions or requirements may be designed to incorporate characteristics associated with skills in non-English languages or experience working with racially, ethnically, culturally, and linguistically diverse populations. In addition, information on staff's (particularly physician's) racial and ethnic background as well as linguistic capability, may be provided to health plan members via provider directories that list such information or include the provider's photograph.

Types and Range of Services Related to Staffing Patterns. Although information on actual staff diversity is unknown for these organizations (as described under Domain 5), the data collected for this domain provide a description of how a number of MCOs employ efforts to develop and/or improve staff diversity. First, staff diversity plans that cover different staff types (e.g., senior administrators; clinical and non-clinical staff; interpreters) are developed and implemented by a number of MCOs.

Second, strategies for strengthening staff diversity often include: identifying non-English language skills as preferred or required in recruitment efforts; identifying diversity training completion as preferred or required; and documenting non-English language skills of recruits. Two examples of "high-end" strategies employed by a number of MCOs for improving staff diversity include: 1) offering incentives for staff who recruit culturally and/or linguistically diverse health care staff; and 2) offering enhanced benefits packages to recruits who possess the language skills and/or cultural background and knowledge needed to better serve health plan members.

Major regional newspapers, Internet web sites, and local community newspapers are resources most often used by the MCOs for recruiting a diverse staff. Also, health plan publications, regional or national recruiting networks, local radio and television, and community leaders and liaisons are used for recruitment.

When a health plan makes information on its staff's racial, ethnic, and linguistic backgrounds available to members—particularly information on physicians—members can make more informed decisions when selecting individual providers and services. Staff's proficiency in non-English languages, racial/ethnic background, and certification in cultural competency are types of information made available to members of participating MCOs. Provider directories—many of which feature photographs of physicians and other clinical staff— are useful tools for sharing information with members and providing options for members related to provider choice.

Promising Practices Related to Staffing Patterns.

- *INFORMATION IS MADE AVAILABLE TO MEMBERS:*
  - *STAFF RACIAL/ETHNIC BACKGROUND*
  - *STAFF CERTIFICATION IN CULTURAL COMPETENCY*
- *STRATEGIES ARE UTILIZED TO RECRUIT, RETAIN, AND PROMOTE A DIVERSE STAFF:*
  - *RECRUITMENT INCENTIVES*
  - *ENHANCED BENEFITS PACKAGES*

4.2.7 Domain 7: Staff Training and Development

Many organizations offer staff training in cultural competence, or "diversity training." Again, diversity training refers to *any instructional effort that addresses and promotes greater understanding of diversity issues in general (race/ethnicity; sex/gender; religion; region; sexual orientation; etc.), or more specifically, the unique needs and preferences of culturally and linguistically diverse groups in the health plan membership*.

Diversity training plays a major role in the provision of services that address the unique needs of culturally and linguistically diverse groups. Because health care staff interact with members from diverse cultural backgrounds on a daily basis, it is imperative that staff know the effects of cultural differences on health promotion and disease prevention, as well as diagnosis and treatment.

Diversity training programs may be designed to include components that provide opportunities for staff to reflect on their own beliefs and behaviors and how this background affects the way they deliver services. A key component to providing culturally sensitive health care is providers' awareness about their own values and how such values may bias interactions with individuals from other cultures (Dilworthanderson et al. 1993; Eliason 1993; May 1992). A strong diversity training program includes components that invoke self-examination of one's own beliefs as well as knowledge of racial or ethnic, religious, and regional beliefs and practices about health care issues. A quality diversity training program educates physicians and other staff on how to work with, and provide services to, patients from different cultural backgrounds who represent a diverse range of health beliefs, approaches to wellness and illness, and healing practices. Such programs teach health care providers how to better communicate with, and deliver services to, members of various cultural groups, including race/ethnicity, gender, age, religion, etc.

Managed care organizations can tailor the content and structure of their diversity training programs according to members' demographic profiles and needs. Training programs are usually conducted through accredited organizations and topics covered during trainings may include: differences in culture, effective communication between consumers and staff of different cultural and linguistic backgrounds, as well as effect of cultural differences on health outcomes and patient satisfaction. When staff receive such training on an ongoing basis, they can be better prepared to deal with diversity issues in practice.

Types and Range of Services Related to Staff Training and Development. For this domain, data were collected on the types and range of staff diversity training programs provided by the MCOs. Respondents were instructed to answer questions about diversity training programs that are either stand-alone or integrated with other training, and whether or not they are operated internally or by contractors. Although the data provide examples of topical components included in diversity training programs, the *extent of coverage*—for program topics specifically (i.e., breadth and depth), and the training program generally (i.e., length and duration)—is unknown.

Diversity training curricula appear to include broader definitions of "culture" and "cultural diversity" than expected. For example, many training programs not only cover topics related to racial and ethnic minority groups—such as patterns of high blood pressure among African Americans, or health beliefs of American Indians—but also cover issues related to the following groups: recent immigrants, women, the elderly, persons with physical disabilities, persons with mental disabilities, and religious and sexual minorities. For example, dietary practices among some religious groups that may render treatment options impractical are covered in such programs. Also, some diversity training programs include topical discussions on low-income or poor populations, low-literate or illiterate persons, homeless persons, persons with end-of-life issues, and rural populations.

Cultural issues covered as components of the MCOs' diversity training programs are quite comprehensive. General topics covered by the training programs include: definitions and concepts related to culture and diversity; cultural beliefs, values, and behaviors; anti-discrimination laws; ethical issues; and organizational CLAS policies and protocols. Health disparities and end-of-life issues are covered by many of the programs' curricula. Topics covered that are of particular importance for clinical assessment and treatment are: different epidemiology and symptomatology, treatment and medication response, and complementary healing practices. The comprehensive range of topics covered in these diversity training programs is noteworthy. Until only recently in the health care field, many of these topics were not considered related to the concepts of "culture" or "cultural competency."

Corporate support for diversity training programs most often takes the form of allocation of financial resources, provision of corporate-level trainers, and provision of standardized curricula and materials. Resources typically used during the training programs include: handbooks and other educational materials, conferences, work directly with interpreters, modules for patient-provider communication, and coordination with traditional healers.

In addition to the types and range of topics covered by diversity training programs in the MCOs, the study examined the staff types for whom diversity training is available and/or required. In cases where MCOs *require* staff to complete diversity training programs, it is most often executive-level administrators, supervisors and program managers, allied health professionals, and information specialists and front-line personnel who are required to participate. Other staff types for whom diversity training is available are: physicians, physician assistants, and nurse practitioners; nursing professionals; and pharmacy, lab, and x-ray staff. Most of the training programs are administered to staff one-time, at hiring. Whether the training is a standard component of employee orientation, or a comprehensive course, is unknown.

The organizations utilize various opportunities—such as initial employment orientation, inservice and professional development sessions, staff meetings, and notices via employee newsletters or bulletin boards—to inform staff of available diversity training. In many of the MCOs, training costs are wholly underwritten by the health plan. Additional efforts used by MCOs to encourage staff participation in diversity training programs include: offering training during work hours and maintaining a registry of, and offering awards or certificates to, employees who complete training.

The organization's corporate parent, a local organizational department, or an outside cultural competence training center is typically responsible for *developing* diversity training programs provided by the MCOs. Similarly, most diversity training programs are *conducted* by the organization's corporate parent; local human resources or membership services departments; or outside organizations or training centers. Multiple methods for *reviewing and evaluating* the programs are utilized, and include: formal review by the corporate parent or internal diversity working group, and evaluation that uses participant and/or supervisor surveys, and pre-post tests to assess program effectiveness.

In addition to providing diversity training for staff, opportunities for staff to learn non-English languages are offered by the MCOs. In a number of these organizations, costs for staff educational development are wholly underwritten by the health plan.

Promising Practices Related to Staff Training and Development.

– COSTS ARE WHOLLY UNDERWRITTEN BY HEALTH PLAN FOR STAFF TO LEARN NON-ENGLISH LANGUAGES

– MODULES FOR PATIENT-PROVIDER COMMUNICATION ARE UTILIZED AS RESOURCES IN DIVERSITY TRAINING

– CORPORATE PARENT PROVIDES STANDARDIZED CURRICULA AND MATERIALS

– DIVERSITY TRAINING COSTS ARE WHOLLY UNDERWRITTEN BY HEALTH PLAN

– DIVERSITY TRAINING PROGRAM IS OFFERED DURING WORK HOURS

– DIVERSITY TRAINING PROGRAM IS REVIEWED BY AN INTERNAL DIVERSITY WORK GROUP

– DIVERSITY TRAINING PROGRAM IS REVIEWED BY MULTIPLE ENTITIES

– DIVERSITY TRAINING PROGRAM IS EVALUATED BY MEMBER SATISFACTION SURVEY

– DIVERSITY TRAINING PROGRAM IS EVALUATED BY PRIMARY CARE PHYSICIAN CHANGE REPORTS

4.2.8 Domain 8: Communication Support

Linguistically appropriate health care typically takes the form of one or more of the following service models: translation of written materials; interpreters; and bilingual or multilingual health care providers. Again, although the terms “translation” and “interpretation” are often mistaken as synonymous, “translation” refers to *written* materials, and “interpretation” is related to *oral* communication. Interpretation services are those which (in the U.S.) ensure effective verbal communication between patients with LEP and health care providers, and may include face-to-face or telephonic interpreters, bilingual providers.

The use of written materials in health care settings is common. Benefits and services materials, enrollment applications, and patient care and medication instructions and forms are documents that are often provided to patients to read and, as necessary, fill out. Additionally, forms related to patient history, consent, and insurance are important to the health care process. Translation of these documents into languages understood by health plan members is therefore another important component of CLAS and overall health care quality.

The methods for translating written materials vary. The method of back-translations—i.e., the process of translating from the source language into the target language, then translating back into the source language, and finally comparing the original to the back translation—is encouraged for all translated materials, including handouts and brochures, signage and other posted information, and medical forms.

Family members—many times, children—often interpret for other family members who are patients with limited or no English skills. The use of a family member as an interpreter is strongly discouraged in the literature (Randall-David 1989; Tirado 1996; Woloshin et al. 1995). Although family members may be available who speak the same language and dialect as the patient, and even speak English fluently enough to accurately interpret medical issues and terminology, family members may censor or edit critical elements of the communication. In addition, issues of privacy influence the level (and sometimes accuracy) of information conveyed when a family member is used as an interpreter, particularly in situations where the family member is of the opposite sex or is much younger or older (Woloshin et al. 1995). Furthermore, when children are asked to interpret the communication between provider and patient, information may be frightening and/or inappropriate for a child to hear.

Also discouraged is seeking and using informal interpreters on an ad hoc basis. Bilingual persons—whether employed by the health care organization or simply available in the waiting room at the needed moment—may be asked to interpret, given their knowledge of the patient's language and immediate availability. Like family members, persons asked on an *ad hoc* basis to serve as interpreters may not have the level of fluency in either language to accurately interpret the communication between the provider and patient. Moreover, personal biases and beliefs may guide or be introduced into the communication; the person may not be concerned with accuracy as the request to serve as an interpreter may have been viewed as unwelcome and/or burdensome (Woloshin et al. 1995).

Another commonly used "interpreter" is no interpreter at all. Health care professionals who speak "a little" of the patient's language may attempt to "wing it" to avoid the process of locating someone more qualified. This strategy compromises the interaction and health care quality and should not be used unless there is no alternative.

One language assistance option sometimes used is a contract with a telephone language line, such as the AT&T Language Line, which offers interpreters in over 140 languages. The interpreters have native-level fluence in English and the target language and are trained in specific telephone interpretation skills, including medical terminology. The AT&T Language Line is particularly useful for patients who speak an uncommon language and at critical points of service including telephone consultations and appointment reminders. Limitations of language lines include the introduction of a greater "barrier" between the provider and patient and its cost (Schmidt et al. 1995; Woloshin et al. 1995).

Ideally, an interpreter should be trained in interpretation in a health care setting. He or she should be proficient in the patient's and provider's languages as well as knowledgeable and respectful of both the provider's and the patient's cultural backgrounds (Randall-David 1989). This person might be a professional health care interpreter, a clinical or non-clinical staff member trained in medical interpretation, or a trained volunteer.

Two additional strategies for providing linguistically appropriate services to members include: 1) hiring bilingual or multilingual clinical and non-clinical staff who reflect the linguistic composition of the population served; and 2) teaching clinical and non-clinical staff languages (or, at minimum, terminology) important to working with individuals with LEP. Bilingual staff can remove the provider-patient language barrier altogether. Hiring and utilizing bilingual staff is cost-effective, as resources are not needed or expended for "outside" interpreters.

When utilizing bilingual staff, it is important to remember that language dissonance (when two individuals speak a different language) is only one type of provider-patient communication barrier. Health care quality is affected by issues of language clarity when provider and patient speak the same language, but one individual speaks with a different dialect or has an accent to the point where miscommunications occur. Moreover, it is important to recognize that bilingual capability does not ensure knowledge and understanding of one's culture, including beliefs and behaviors that shape one's interactions in the health care context as well as affect the patient's overall health care. When bilingual staff are of the same cultural background as the patients, some of the cross-cultural barriers that tend to emerge in the health care setting are addressed and may be resolved, thereby improving health care quality.

Types and Range of Services Related to Communication Support. The MCOs utilize various methods for determining the need for translated written materials and interpretation services. The term "interpretation services" is used to describe oral language assistance services, including bilingual staff, that are offered to members. To determine the appropriate target languages and the extent of translation and interpretation services required, the participating MCOs utilize member requests, staff requests, and number/percent of non-English speaking persons in the community or health plan.

The types of translated materials most often made available in other languages of health plan members besides English include: materials on access and utilization of services, benefits materials, health education materials, enrollment applications, and notification of free language assistance. Other translated written materials that are widely made available to members in different languages are grievance procedures and forms; notifications of service reduction, denial, or termination; member satisfaction surveys; and billing information. A number of MCOs recognize the critical need to translate instructions and forms related to patient care and medication for informed consent purposes and for maximizing patient compliance and health outcomes.

Interpretation services made available to members by the MCOs most often include: telephone interpreter language lines and bilingual and/or bicultural clinical staff and non-clinical staff. Some organizations hire or contract with trained interpreters, and others use trained volunteer interpreters including those who are trained in American Sign Language (for the hearing impaired). The provision of language assistance services using simultaneous interpretation is a higher-end practice that is provided by a number of the MCOs. *Simultaneous interpreting* involves converting a speaker's or signer's message into another language while the speaker or signer continues to speak, as opposed to *consecutive interpreting* which involves converting the message to another language while the speaker or signer pauses (NCIHC 2001). Key points of service where interpretation services are provided include: telephone general information lines and emergency lines, information desks or main lobbies, walk-in clinics, emergency services entrance points, and pharmacy.

MCOs' requirements for utilizing interpreters range from demonstrated proficiency in English and other languages to training in simultaneous interpreting. In addition, interpreters are often required to be trained and/or certified in: ethics of interpreting; medical interpretation; interpreting for persons with LEP; and sequential or consecutive interpreting. Also, interpreters are sometimes required to demonstrate knowledge of specialized terms in both languages.

The organizations often have entities—such as service-level internal working groups, community advisory boards, member focus groups, or corporate-level entities—which conduct formal reviews and/or evaluations of their translated materials and interpretation services. In addition, multiple strategies are used to inform health plan members of available translated materials and interpretation services. These communication efforts include: translated inserts in general plan documents, on-site interpreters, or translated recordings on customer service telephone lines, and translated signage and notices at key points of service.

Promising Practices Related to Communication Support.

- *MEMBER FOCUS GROUPS PROVIDE REVIEW AND/OR APPROVAL FOR TRANSLATED MATERIALS*
- *TRANSLATED MATERIALS ARE BACK-TRANSLATED INTO ENGLISH*
- *MATERIALS ARE ORIGINALLY DEVELOPED IN LANGUAGES OTHER THAN ENGLISH*
- *FULL-TIME INTERPRETERS ARE PROVIDED TO MEMBERS*
- *SIMULTANEOUS INTERPRETATION SERVICES ARE AVAILABLE TO MEMBERS*
- *MEDICAL INTERPRETATION IS PROVIDED BY TELEPHONE AND IN-PERSON*
- *INTERPRETER ATTENDS DOCTOR VISITS WITH CLIENTS*
- *ORGANIZATION REQUIRES INTERPRETERS TO BE CERTIFIED IN MEDICAL INTERPRETATION*
- *ORGANIZATION REQUIRES INTERPRETERS TO BE TRAINED IN SIMULTANEOUS INTERPRETING*

The study findings are important for two reasons: 1) to show that MCOs *are providing many types of services* that address the specific needs of their culturally and linguistically diverse members, and 2) to provide examples of *how* MCOs are doing it. For each of the eight domains, numerous examples of the types and ranges of services and practices implemented in the MCOs are described. Moreover, certain "higher-end" CLAS practices have been highlighted as promising in that existing literature suggests that they may improve quality of care and services for culturally and linguistically diverse populations. Chapter 5 provides recommendations for future research on CLAS and/or in health care organizations, recommendations for how this study's tools and findings may be useful to health plans, and study conclusions.

CHAPTER 5

Recommendations and Conclusions

CHAPTER 5: RECOMMENDATIONS AND CONCLUSIONS

5.1 RECOMMENDATIONS

Based on information learned during the conduct of this study, recommendations are offered for future research in this area. In addition to recommendations for future research, recommendations are offered for health plans to utilize the study instruments and findings in their own efforts to monitor quality of services for culturally and linguistically diverse members.

5.1.1 Recommendations for Future Investigations and Inquiries

Explore alternative methodologies. Given the difficulties with capturing the organizational perspective of CLAS in MCOs (as described in Chapter 4), *future research efforts are encouraged to explore alternative methodologies for collecting these types of organizational data.* Qualitative methods, such as focus groups, face-to-face interviews, or case studies, may more effectively capture information from private health care organizations such as MCOs. Future researchers should consider the data collection challenges identified in this study and explore additional strategies for increasing response rates. One effort that may be fruitful is to assemble and conduct small focus groups with MCO representatives (perhaps on site, in conjunction with attending a national health conference) to gather information on enhancing study response rates in MCOs and other sectors of the health care industry.

Conduct in-depth assessments of a single (or a few) domain(s). Because this was the first study to examine the nature and extent of CLAS provision in MCOs, a goal was to gather data that represent a broad spectrum of related services. The scope of the study required collection of a broad but shallow level of information related to all eight assessment domains in the CLAS conceptual framework. Inquiries were limited by the items in the survey questions, and there was no provision in the study to follow-up or probe for further details on individual practices. However, *future studies that focus on a single domain, or a few assessment domains, are recommended.* These studies would allow for separate, in-depth investigations to more thoroughly describe practices within individual domains, e.g., CLAS planning and policy development (Domain 2), staff diversity training (Domain 7), or communication support (Domain 8). Studies might employ *triangulation of methods* (Yin 2003)—by combining survey data with data from on-site interviews, observations, and document reviews—to fully examine any of the individual domains.

Explore consumer and health care provider perspectives. This study collected data that represents the *organizational* side of CLAS provision. However, equally interesting and important are data that represent the *patient/consumer* side of CLAS provision. *Research is recommended that investigates the perceptions and experiences of culturally and linguistically diverse health plan members who depend on and utilize the services.* A descriptive study on diverse patient populations' perceptions of access to, and quality of, service delivery may be a worthwhile next step. Similarly, *understanding the perspectives and experiences of physicians and other staff would be valuable.* Clinical and non-clinical staff are responsible for the *delivery* of services. Inquiries with this population could shed light on the benefits and challenges associated with providing CLAS, based on real-world experiences delivering services to culturally and linguistically diverse members.

Conduct assessments in other segments of the health care industry. This study *began* the exploration of CLAS by looking at MCOs due to national trends toward managed care at the outset of the study, but recognized the importance of examining such services throughout the entire health care system. The provision of culturally and linguistically appropriate services are equally important, for example, in local public health agencies, hospitals, and mental health clinics. These entities may prove to be more easily accessible regarding penetration and participation for data collection. Because many public health care entities serve more vulnerable populations (including racial and ethnic minorities and persons with LEP) and are often located in the communities they serve, their incentive to participate in these types of studies may be greater.

Conduct case studies and other research to fully examine the promising practices. One way to expand on the findings of this study would be to conduct a follow-up investigation to mine and further explore the existing data on promising CLAS practices. *Studies could be conducted to fully examine the promising practices as well as their histories and outcomes.* Examinations of existing links between the practices and patient/provider satisfaction and other outcomes are especially encouraged. Such studies could serve as an information base from which a compendium of promising CLAS practices could be assembled. Data elements within the compendium could include specific information regarding various practices such as: the genesis and rationale for implementing the practice(s); the populations served by the practice(s); the resources required for their implementation and maintenance; summaries of needs assessment and evaluation data and findings including evidence of impacts on health care quality and patient outcomes; and any improvements or modifications that have resulted from previous evaluations. Such a compendium of promising CLAS practices might provide MCOs with blueprints for service implementation, maintenance, and evaluation.

5.1.2 Recommendations for Refining and Expanding the CLAS Conceptual Framework

Add more detailed variables for certain domains and key elements. For many exploratory studies, including this one, hindsight often brings a wish for additional data to further inform the study. *Future assessments should consider including information on linguistically appropriate services in multiple languages (Domain 8) and on the breadth, length, and duration of diversity training programs (Domain 7).*

Periodically revise the conceptual framework to include measures for new practices and technologies. Since the start of this study, new CLAS-related strategies and services have been introduced, used, and publicized by health care entities, such as videoconferencing interpretation systems and other translation devices for patients who need translation services. *The framework should be periodically revisited—especially at the key element and variable levels—in an effort to ensure that the framework is representative of current CLAS measures and continually improve the level of comprehensiveness of measures*.

For example, an MCO that participated in this study recently implemented one of the nation's first videoconferencing interpretation systems. This practice should be added to the study variables (and survey items) related to types of interpretation services provided. The devices allow doctors, accompanied by an interpreter, to communicate through a video screen to various clinics throughout the hospital. The devices are not intended to replace the (18 full-time and 19 on-call) face-to-face interpreters; rather, the technology allows the interpreters to remain in a centralized location, thereby increasing efficiency of service delivery (Colliver 2003). New and innovative strategies, services, and technologies to improve health care quality are constantly emerging. As CLAS-related research continues and evolves, these new innovations should be incorporated into future frameworks and study designs.

Use a term other than "patient care" to represent Domain 3. One final recommendation related to the conceptual framework is to *replace the term "Patient Care" (Domain 3) with a more appropriate term such as "Culturally Inclusive Health Care Environment and Practices."* In retrospect, the term "patient care" may be misleading in that the measures under this domain are not limited to the actual clinical encounter. Rather, these measures are meant to capture diverse clinical practices or services, such as alternative or complementary treatments, as well as awareness, inclusion, or presentations of cultural differences in the physical environment, dietary options, religious facilities and services, etc. The term "Culturally Inclusive Health Care

Environment and Practices" may better represent what is actually being assessed under Domain 3.

5.1.3 Recommendations for Health Plans

Health plans are encouraged to utilize the study instruments as a self-assessment tool. To effectively monitor and improve services for culturally and linguistically diverse groups, a comprehensive set of data measures is needed. The three-component instrument implemented for this study may be used by organizations in their own quality monitoring and improvement efforts. The instruments may be used in their entirety, or may be customized or expanded to meet particular monitoring needs. The tools may be especially useful to organizations that want to expand their management information systems to more closely and carefully monitor health care services for culturally and linguistically diverse members.

Health plans may use the study findings to better understand the ways some MCOs are addressing the health care needs of diverse groups. Results from this study provide health plans with *examples* of how a number of MCOs are implementing CLAS in their organizations. Health plans and providers are encouraged to examine organizational and service operations implemented or utilized in their own health care settings in relation to the types of practices described in this study. Numerous examples are provided that show how strategies and services that address the health care needs of diverse groups are currently implemented or utilized by MCOs. The study results may provide a resource to health plans for identifying: 1) gaps in their own organization's CLAS-related policies or service provision; or 2) new strategies that expand or strengthen existing services.

5.2 CONCLUSIONS

The study set out to accomplish three objectives: 1) to provide a snapshot of the types and range of CLAS provided in MCOs; 2) to develop a comprehensive conceptual framework for assessing essential CLAS components and sound, valid, and reliable measures and instruments for collecting relevant baseline data for future research; and 3) to provide educational information—in both the study's instruments and Final Report—on the nature and extent of services provided by MCOs that address the specific needs of culturally and linguistically diverse populations. In general, these study objectives were accomplished.

First, although it was not possible ultimately to generalize the findings to the national population of MCOs, the data revealed rich information in the form of real-world examples of the various CLAS practices implemented by the participating MCOs. Second, although the study data cannot be used as a national baseline of CLAS in MCOs, the CLAS conceptual framework and study instruments are important products that resulted from this project. Finally, there are no caveats with the third objective. The instructive design of the instruments may be examined, and the study findings reveal a picture of CLAS in MCOs that is new and informative. Major study findings are summarized below.

> ***The picture is not blank in any domain***. Services that address the specific needs of culturally and linguistically diverse health plan members are found in all eight assessment domains. In each of the eight domains, the MCOs reported to provide *some* examples of CLAS-related practices. For this "snapshot," the picture is not blank in any CLAS component or service area, and the provision of such services is found in all domains, rather than in only a few.
>
> ***A range of "promising practices" is being implemented***. Forty-four strategies or services were identified as promising CLAS practices. In each domain, practices are highlighted as outstanding efforts on behalf of a number of MCOs to address the health care needs of culturally and linguistically diverse members. Nearly every MCO in the study is implementing at least one promising practice. Examples of these "higher-end" services include: a funded staff position for CLAS promotion and coordination; readability testing performed on written materials; reviews of dis-enrollment and primary care physician change request forms as methods for monitoring quality; costs wholly underwritten by health plan for staff to learn non-English languages; offering staff diversity training program during work hours; full-time interpreters available to members; and requiring interpreters to be certified in medical interpretation or trained in simultaneous interpreting. MCOs are encouraged to adopt some of these practices in their own organizational efforts to address and improve health care quality among their members.
>
> ***Formal CLAS-related policies are in place***. As discussed in earlier chapters, CLAS is not limited to language assistance for populations with LEP. As shown in this study, MCOs are providing CLAS when they develop and implement policies that address the health care needs of diverse populations. Many of the MCOs have formal policies in place that address health care quality and service provision for diverse members, including mission statements that specifically express a commitment to diversity issues, staff diversity plans, and policies governing written translation and interpretation services.
>
> ***Multiple methods are utilized to monitor CLAS quality***. MCOs are providing CLAS when they aggressively monitor quality of care and services provided to culturally and linguistically diverse members. Multiple methods are utilized by the MCOs to monitor CLAS quality, including: membership satisfaction

surveys, grievance and complaint tracking, analysis of quality outcomes data, and chart reviews or audits.

Data to monitor and address health care disparities may be lacking. Data from quality improvement studies are used by the MCOs to set priorities for health education and promotion, and to link member and provider information. However, many of the MCOs do not record members' race, ethnicity, or primary language spoken—data which are essential for effective quality monitoring and improvement.

Recognition of, and respect for, cultural diversity are evident in a number of practices. A number of MCOs implement culturally sensitive services and practices that demonstrate a recognition that patients come from a wide variety of cultural backgrounds and ages, with varying levels of functional status. Examples of these services include: access ramps for unfettered entry of persons with physical disabilities; availability of print materials in larger fonts for visually impaired persons; and artwork, graphics, and other architectural or design features in the physical environment that reflect racial, ethnic, gender, age, and religious diversity. Also, organizations offer extended hours of operation—for example, at night and/or on weekends—in an effort to accommodate the needs of more members and their families.

Staff hiring and training practices reflect awareness of increasing cultural diversity. MCOs are increasing their capacity to provide culturally and linguistically appropriate services by hiring bilingual staff and by providing their current staff with diversity training. A number of organizations offer incentives for staff who successfully recruit health care professionals that meet an MCO's particular CLAS needs, or enhanced benefit packages for new hires who meet those needs. Regarding training for current staff, the study found that the staff diversity training programs provided by these MCOs are quite comprehensive in their coverage of relevant concepts and topics. However, MCOs are encouraged to provide diversity training to staff on an ongoing basis, and not only one time at hiring.

Many language assistance services are provided. As suggested earlier, the ability to understand and be understood by others during any health-related encounter is vital. Many language assistance services are provided by the MCOs, including translated written materials and interpretation services for oral communications. Translated materials made available to members most often include: materials on access to and use of services, benefits materials, and health education materials. Various interpretation services provided by organizations include, e.g., telephone interpreter language lines and bilingual and/or bicultural (clinical and non-clinical) staff. Although most of the participating MCOs report that information on staff and/or interpreter linguistic capability is based on self-identification, two examples of "higher-end" practices that could be utilized for determining linguistic capability are testing in the target language, and proof of training completion or certification.

To conclude, findings from this exploratory study provide an initial description of the nature and extent of culturally and linguistically appropriate services provided by a number of MCOs in the U.S. The broad range of services implemented by the MCOs to address the specific needs of diverse groups are presented. In addition, numerous promising practices implemented by many of the MCOs who participated in this study are highlighted as examples of ways MCOs and other segments of the health care arena can better serve their increasingly diverse service populations.

As the nation becomes more increasingly diverse, the provision of health care services that address the unique needs of culturally and linguistically diverse populations will become increasingly more important. MCOs that provide a *comprehensive array* of culturally and linguistically appropriate services *throughout the continuum of care* will be able to more effectively reduce health care disparities and ensure health care quality for all their health plan members.

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