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

FINAL REPORT
EXECUTIVE SUMMARY

Prepared for the

U.S. Department of Health and Human Services
Office of Minority Health
1101 Wootton Parkway, Suite 600
Rockville, MD 20852

August 2003

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EXECUTIVE SUMMARY

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.*[1] A managed care organization (MCO) is *any entity that utilizes certain concepts or techniques to manage the accessibility, cost, and quality of health care*.[2] 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.

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.

INTRODUCTION

Background

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 the rest of the U.S. population, and to coordinate across DHHS the development and implementation of policies, programs, and practices that will address health disparities that place 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.

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[1]Office of Minority Health (OMH), *Recommended National Standards for Culturally and Linguistically Appropriate Services in Health Care: Final Report,* Washington, DC, March 2001.

[2]American Association of Health Plans, *AAHP Directory of Health Plans*, Dorland Healthcare Information, 2001.

health care system to manage escalating health care costs, and the ever-increasing racial, ethnic, cultural, and linguistic diversity of the Nation's population.

Also, persistent disparities exist in health *care* among racial and ethnic groups. 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.

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.[3] 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.

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."[4] (Cross et al. 1989).

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-

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[3]U.S. Bureau of the Census, 1995.

[4]Cross, T., B. Bazron, K. Dennis, and M. Isaacs, "Towards a Culturally Competent System of Care," Vol. 1, Washington, DC: Georgetown University Child Development Center , 1989.

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.

Important Factors that Influenced the Study

During the time of the study's inception (mid to late 1990s), there were 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. Health care reform was a primary issue of the administration at that time, and sweeping changes were 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.[5,6,7]

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[5]Center for Health Care Policy Research, *Negotiating the New Health-Care System: A Nationwide Study of Medicaid Managed Care Contracts*, Washington, DC, 1997.

[6]Gold, Marsha, Amy Frazer, and Hillary Klein, *Information Needs Associated with the Changing Organization and Delivery of Health Care: Summary of Perceptions, Activities, Key Gaps, and Priorities*, Mathematica Policy Research, April 30, 1997.

[7]Rowland, Diane, and Kristina Hanson, "Medicaid: Moving to Managed Care," *Health Affairs*, Fall 1996, 15:150-152.

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. At the start of the study, 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.

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.

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 with 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.

STUDY DESIGN AND METHODS

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 project 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 health care needs of culturally and linguistically diverse populations.

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.

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, and decision-making bodies that reflect the cultural (including racial and ethnic) composition of the populations are important components of CLAS within Domain 1.

Domain 2: CLAS Plans and Policies. The types of formal policies in place—e.g., organizational mission statements that express a commitment to improving CLAS quality, and policies governing written translation and interpretation services—indicate a certain organizational commitment to providing quality health services to diverse populations. Such policies set organizational standards and protocols for service delivery, which in turn improve the quality of care at the service level. 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.

Domain 3: Patient Care. Key elements and study variables under this domain include conditions and services provided that address cultural barriers across the continuum of care. 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). 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. 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.

Domain 4: Quality Monitoring and Improvement (QMI). This domain captures an organization's processes and strategies for monitoring quality of services provided to culturally and linguistically diverse populations. Community and staff needs assessments and routine quality improvement studies may involve: consumer satisfaction surveys, grievance and complaint tracking, consumer focus groups, analysis of outcomes data, and chart reviews or audits. Also of importance 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 (QMI). 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. 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, and linguistic composition of the organization's staff and clientele would be gathered under this domain.

Domain 6: Staffing Patterns. 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. Organizations can improve CLAS quality by providing ongoing staff training in cultural competence, or "staff diversity training."[8,9] 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 a continuous basis.

Domain 8: Communication Support. This domain examines language assistance services provided by health care organizations. Translation and interpretation services are needed to reduce and eliminate communication barriers experienced throughout the continuum of care. 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.

These eight domains reflect the predominant model of cultural appropriateness in health care discussed throughout this Report—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.

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[8]Cultural and Linguistic Standards Task Force, "Cultural Competency Workgroup Policy Recommendations," California Department of Health Services, Medi-Cal Managed Care Division, October 1997.

[9]National Latino Behavioral Health Workgroup, *Cultural Competence Guidelines in Managed Care Mental Health Services for Latino Populations*, December 1996.

A Three-component Instrument

A three-component instrument was developed to be administered to three levels of respondents within each MCO: a *Senior Executive Telephone Interview Protocol*; a *Staffing Questionnaire*; and a *Membership Questionnaire*. 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*.

Items related to organizational governance (Domain 1) and CLAS-related corporate policies (Domain 2) are located in the *Senior Executive Telephone Interview Protocol*. Survey 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.

Universe and Sampling Strategy

Because this study involved data collection from a sample of MCOs, or health plans, the most appropriate sampling frame was identified as the directory maintained by the American Association of Health Plans (AAHP). AAHP represents approximately 1,000 health plans which cover about 170 million individuals in the U.S. 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.

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 most appropriate strategy for selecting the study sample was the most parsimonious one, i.e., a national random selection of 240 MCOs.

Data Collection

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.

In an effort to make the telephone interviews with senior executives even more efficient, the final question posed to the executive was 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 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.

Efforts to Increase Response Rate

To ensure an adequate sample size and account for attrition, the study design included several provisions for increasing response rate. 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). Also, all respondent contact materials and protocols provided clear descriptions of the study, its purpose, and its importance. Introductory letters were signed by the Deputy Assistant Secretary for Minority Health, OMH, DHHS, and included the following enclosures: 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.

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 included four color-coded sections, representing the most likely divisions for sharing. In addition, multiple options were 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.

Extensive and aggressive follow-up contact procedures were utilized in an attempt to increase the study response rate. Reminder postcards and up to three follow-up telephone calls were made to each respondent who did not submit a completed questionnaire in a timely manner. For each respondent, these calls were placed at different times of the day, and voice mail messages were left when the option was available. Each follow-up contact restated the importance of participation and offered to redistribute the questionnaire.

Study Limitations

Several study limitations were recognized and acknowledged prior to the actual data collection process. Select 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 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 project 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.[10]

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

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[10]Dillman, D.A., *Mail and Internet Surveys: The Tailored Design Method*, (2nd edition), John Wiley & Sons, New York, NY, 2000.

run to identify the relationship between the racial, ethnic, and linguistic composition of the service area and actual services provided by the local MCOs. 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, 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).

STUDY RESULTS

Methodological Results

Study Response Rate. The study response rate was 30 percent. 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, and 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.

Health plan types among the participating organizations included 28 Health Maintenance Organizations (HMOs), eight Preferred Provider Organizations (PPOs), two Point-of-Services (POS), and 39 represented mixed health plan types (i.e., comprising more than one health plan type). Among the MCOs that participated in this study, 23 were Independent Practice Association (IPA) models (contracted physicians, or associations of physicians, which in turn contract with their member physicians to treat plan members), and 23 employed network models (contracted group practices may also treat non-plan members). Also, there were six group model (contracted group physicians that treat plan members), two staff model (employed health care providers work only with plan members), and nine mixed model MCOs (two or more of the four model types). 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.

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. As such, descriptive analyses in the form of numeric graphs or figures are not presented in the text, even though the data collected for this study are primarily quantitative.

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 Nature and Extent of CLAS in MCOs

Types and Range of Services Related to Organizational Governance (Domain 1). 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.

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.

Promising Practices Related to Organizational Governance (Domain 1).

- *FUNDED STAFF POSITION FOR CLAS PROMOTION AND COORDINATION*
- *INTERNAL WORKING GROUP FOR CLAS PLANNING AND EVALUATION*

Types and Range of Services Related to CLAS Plans and Policies (Domain 2). Having an organizational mission statement that addresses CLAS specifically, and policies that govern written translation and interpretation services, are 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.

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. Also, different staff types—including physicians and nurses, membership services staff, corporate managers, and front-line personnel—provide input on CLAS policies in these organizations.

Promising Practices Related to CLAS Plans and Policies (Domain 2).

- *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*

Types and Range of Services Related to Patient Care (Domain 3). 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, including: 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 (Domain 3).

- *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*

Types and Range of Services Related to Quality Monitoring and Improvement (Domain 4). 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. 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 models for assessments or on-site advisory personnel, and actually conducting the local assessments using corporate personnel.

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 CLAS needs assessments—most often, supervisors and program managers, physicians, membership services staff, and executive-level administrators.

Promising Practices Related to Quality Monitoring and Improvement (Domain 4).

- *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*

Types and Range of Services Related to Management Information Systems (Domain 5). Relatively few of the MCOs report to collect racial and ethnic data on their members. 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.

Among clinical staff types, information on race and ethnicity is most often collected for physicians, nursing professionals, and physician assistants and nurse practitioners. 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.

Promising Practices Related to Management Information Systems (Domain 5).

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

Types and Range of Services Related to Staffing Patterns (Domain 6). Although information on actual staff diversity is unknown for these organizations, the data collected for this domain provide a description of how a number of MCOs employ efforts to develop and/or improve staff diversity. Strategies for strengthening staff diversity often include: identifying non-English language skills as preferred or required; identifying diversity training completion as preferred or required; and documenting non-English language skills of recruits.

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 (Domain 6).

- *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*

Types and Range of Services Related to Staff Training and Development (Domain 7). For this domain, data were collected on the types and range of staff diversity training programs provided by the MCOs. 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.

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 programs are a standard component of employee orientation, or a comprehensive course, is unknown.

Incentives 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. 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 (Domain 7).

- *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*

Types and Range of Services Related to Communication Support (Domain 8). The types of translated materials most often made available in languages of health plan members in addition to 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). 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.

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 (Domain 8).

- *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 by the MCOs are described. Moreover, certain "higher-end" CLAS practices have been highlighted as promising in that existing literature suggests they may improve quality of care and services for culturally and linguistically diverse populations.

RECOMMENDATIONS AND CONCLUSIONS

Based on information learned during the conduct of this study, recommendations are offered for future research in this area and for health plans' use of the study instruments and findings.

Recommendations for Future Investigations and Inquiries

- ***Explore alternative methodologies***. Given the difficulties with capturing the organizational perspective of CLAS in MCOs, future research efforts are encouraged to explore alternative methodologies for collecting these types of organizational data. Qualitative research methodologies, including focus groups, face-to-face interviews, or case studies may be more effectively capture information from private health care organizations.

- ***Conduct in-depth assessments of a single (or a few) domain(s)***. 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 were no provisions 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.

- ***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. Similarly, understanding the perspectives and experiences of *physicians and other staff* would be valuable.

- ***Conduct assessments in other segments of the health care industry***. This study began the exploration of CLAS by looking at MCOs, 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.

- ***Conduct case studies and other research to fully examine the promising practices***. Case 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 impacts and outcomes are especially encouraged. Such studies could serve as an information base from which a compendium of promising CLAS practices could be assembled. Such a compendium of promising CLAS practices might provide MCOs with blueprints for service implementation, maintenance, and evaluation.

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, 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 language assistance 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 to continually improve the level of comprehensiveness of measures.

- ***Use a term other than "patient care" to represent Domain 3***. 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.

Recommendations for Health Plans

- ***Health plans are encouraged to utilize the study instruments as a self-assessment tool***. 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.

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. Regarding 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***. For this "snapshot" of CLAS provision in MCOs, the picture is not blank in any CLAS assessment domain, and the provision of such services is not concentrated in only a few domains.

- ***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.

- ***Formal CLAS-related policies are in place***. 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***. 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***. Many of the MCO respondents report their organizations 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.

- ***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.

- ***Many language assistance services are provided***. Translated materials made available to health plan members most often include: materials on access to, and use of services, benefits materials, and health education materials. Various interpretation services provided include: telephone interpreter language lines and bilingual and/or bicultural (clinical and non-clinical) staff.

To conclude, findings from this exploratory study provide a 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 is presented. In addition, numerous promising practices implemented by many of the MCOs 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 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.