CLAS in Health Care:

Implementation of the National Standards for Culturally and Linguistically Appropriate Services in Health Care at the Alameda Alliance for Health

EXECUTIVE SUMMARY

Prepared for:

Office of Minority Health
U.S. Department of Health and Human Services

Prepared by:

ORC Macro
11785 Beltsville Drive
Calverton, MD 20705

Contract Number: 282-98-0013

March 31, 2004

Acknowledgments

We would like to acknowledge those who have contributed to the success of this study as follows:

- The Project Advisory Group (PAG) for their expert advice and provision of comments, opinions, and expertise during the preparation of this report. A complete list of PAG members appears in Appendix H.

- Dr. Nathan Stinson, Deputy Assistant Secretary for Minority Health, U.S. Department of Health and Human Services, for his support and commitment to the project.

- Mr. Guadalupe Pacheco of the U.S. Department of Health and Human Services Office of Minority Health (OMH) for his guidance and direction in his role as Project Officer.

- Iris A. Garcia, Ph.D. for her considerable contributions to the study in her capacity as consultant to the project team.

- The Alliance, which graciously agreed to serve as the pilot project site; and Juanita Dimas, Ph.D., former Cultural and Linguistic Program Manager, for her tireless efforts as project site coordinator.

- Yoku Shaw Taylor, Ph.D., for his service as a consultant to the project.

- The core project staff for their labor and efforts throughout the duration of this project:

  — C. Godfrey Jacobs of ORC Macro, who served as project director.

  — William H. Scarbrough, III, Ph.D., of ORC Macro, who contributed as the research coordinator.

  — Bryan B. Rhodes of ORC Macro, who served as research assistant.

Executive Summary

Census 2000 data has revealed, as has long been predicted, significant increases in minority, foreign-born (28 million), and non-English-speaking (44 million) populations across the United States, in both urban and rural areas. The increasing diversity of the Nation brings many challenges experienced increasingly in health care facilities of all kinds. Culture and language are vital factors in how health services are delivered and received. A report by the Department of Health and Human Services (DHHS) Office of Minority Health (OMH) on the National Standards for Culturally and Linguistically Appropriate Services (CLAS) in health care proposed the standards as one strategy to eliminate health disparities among racial, ethnic, and linguistic minority populations that experience unequal access to health services. An area of particular interest to OMH is to explore what evidence can be generated to demonstrate that adoption of the standards for CLAS may contribute to improving delivery of health services that result in positive outcomes for racial, ethnic, and linguistic minority populations.

Methods

In light of the above, this CLAS in health care project looked to address three primary questions:

1. What organizational inputs and processes are associated with the implementation of CLAS standards in a Managed Care Organization (MCO)?
2. How do the organizational inputs and processes interact to affect the MCO outputs?
3. What factors support or inhibit the implementation of CLAS standards with the MCO's provider network?

The managed care organization the Alameda Alliance for Health (the Alliance), was chosen as the subject of this study. The development of the Alliance case study relied on three primary sources of data: (1) organizational documents in the form of policies and procedures, reports, and written materials relevant to CLAS implementation; (2) personal and group interviews with Alliance leadership and staff (including the Chief Executive Officer (CEO), Chief Financial Officer (CFO), and Cultural and Linguistic (C&L) program manager); and (3) extant data addressing consumer (member) satisfaction and clinical outcomes. A variety of qualitative and quantitative methods were used. The primary data collection methods utilized

were document review, coding and classification, personal and group interviews (both telephone and in-person), on-site review and validation, and secondary data analysis.

Documents were selected as a primary data source since they are considered key by-products of interaction among individuals/groups that reflect not only what is meaningful to members in the organization but how the organizational system communicates internally and externally about the processes and actions related to CLAS implementation (Mirvis, 1980; Forster, 1994; Hodder, 1994; Garcia, 2002). In order to carefully review and analyze each document, a coding instrument was developed and tested. The development of instruments and identification of measures were necessary to guide systematic review of documents and analytic activities. The *first stage* of code tool development was to review the literature on existing cultural competence measures. The *second stage* of code tool development used template style methods that required interface with the Alliance documents that generated inductive codes specific to CLAS implementation activity not found in the literature (Miller and Crabtree, 1992; Strauss and Corbin, 1990). The *third stage* of code tool development involved creation of a criterion rating scale that also applied the template style methods. Each CLAS standard was rated based on responses to specific items referenced in the 147-item code tool. The core project team conducted two inter-coder tests of the coding and criterion-rating tools to examine the reliability of the tools.

In order to buttress the written documentation provided by the Alliance, ORC Macro designed, implemented, and analyzed a series of individual and group interviews with Alliance staff. In addition to the documentary information and telephone, in-person, and group interviews conducted and gathered, ORC Macro also identified and gathered consumer (member) satisfaction and clinical outcomes data from existing sources. In the Fall 2002, (October 28, 2002 and October 29, 2002) the ORC Macro team conducted a 2-day site visit at the Alliance, in Alameda, CA, to present a draft of the Alliance CLAS case study prepared by the ORC Macro team and to discuss the case study's accuracy, completeness, and interpretability.

Case Description

The Alliance is a public health plan that offers locally based health care services to low-income residents of Alameda County. Alliance demographics indicate that 87 percent of its members are people of color (of over 78,000 plan members, 36 percent are African-American, 22 percent Latino/a, 13 percent White, 9 percent Vietnamese, 5 percent Chinese, 3 percent Cambodian, 2 percent Laotian, and 8 percent other Asian/Pacific Islander) with over 40 percent who have a primary language other than English (the largest groups being 15 percent Spanish, 7 percent Vietnamese, and 6 percent Cantonese). The Alliance has had a C&L program in place since the organization was formed in 1996.

Findings

Using the criterion rating scales, four levels of CLAS implementation were identified: Level 1-No Implementation, Level 2-Preliminary Implementation, Level 3-Intermediate Implementation, Level 4-Expanded Implementation. Using this translation of the criterion rating scales, overall, the Alliance's implementation of the CLAS Standards achieves a rating of Level 3-Intermediate Implementation. This rating suggests that the Alliance is operating in a way that is both consistent with as well as achieving many of the suggested goals and objectives of the CLAS Standards. It is important to note that each of the standards was being implemented to some degree by the Alliance (that is, there were no Level 1-No Implementation ratings). The level of implementation for each standard as derived from the analysis is provided below.

1) CLAS Definition Statement. The implementation of this standard was judged to be at the preliminary level because the mission statement of the whole organization did not make specific reference to member cultural health beliefs and practices and preferred languages.

2) Workforce Diversity. The implementation of this standard was judged to be at the intermediate level because the Alliance's plans for recruitment, training, and promotion of a diverse staff and leadership have resulted in a diverse and culturally competent staff.

3) Staff Training and Education. The implementation of this standard was judged to be at the preliminary level because the study team did not find information regarding specific training in cultural competency and CLAS issues for Alliance staff members.

4) Interpreter Services. The implementation of this standard was judged to be at the intermediate level because the Alliance has documented a systematic interpreter services plan and is further developing that plan based on provider and member feedback.

5) Notice of Right to Interpreters. The implementation of this standard was judged to be at the expanded level because the Alliance has developed specific policy and procedures to ensure notice of a right to interpreters for each member and provider.

6) Qualified Interpreters. No interpreter training curriculum or skill assessment concerning an interpreter code of ethics, interpretation of medical terminology, or cross-cultural communication is provided in Alliance documents. Based on these findings, the implementation of this standard was judged to be at the preliminary level.

7) Member Materials and Translation. The implementation of this standard was judged to be at the intermediate level because all member and provider documents are translated into all threshold languages and because there are existing policies and procedures for ensuring understandable materials and signage for members.

8) CLAS Organizational Framework. The implementation of this standard was judged to be at the expanded level because the C&L program organization, policies, procedures, and oversight/accountability are designed to ensure that the Alliance can deliver culturally and linguistically appropriate services.

9) Performance Monitoring. The implementation of this standard was judged to be at the intermediate level because there are specific policies and procedures in place at the Alliance to carefully assess the cultural and linguistic competence of their staff, providers, and provider organizations, and the performance of their programs serving members.

10) Data Collection. The implementation of this standard was judged to be at the intermediate level because the Alliance has developed a management information system, as well as policies and procedures for the collection and analysis of race/ethnicity and language data as they pertain to the operation and outcomes of Alliance programs.

11) Community Needs Assessment Profiling. The implementation of this standard was judged to be at the expanded level because the Alliance conducts periodic needs assessments of the communities it serves and has in place policies and procedures that guide the development of services in response to the cultural and linguistic needs of their members.

12) Community Partnerships. The implementation of this standard was judged to be at the expanded level because the Alliance maintains participatory and collaborative partnerships with the communities it serves as well as its members and providers.

13) Grievance Policy and Procedures. The implementation of this standard was judged to be at the intermediate level because the Alliance has in place specific policies and procedures to identify, monitor, and resolve grievances and conflicts with members (and providers).

14) CLAS Communication Strategy. The implementation of this standard was judged to be at the expanded level because the Alliance has developed and manages a number of successful strategies to regularly inform the public about its progress and the availability of that information.

15) Proposed standard for Provider Network Management. During the course of this study the project team found that much of an MCO's "public face" is its provider network. Therefore, the management of its provider network is an important feature of the MCO. The project team saw that a standard of this kind was implemented at the preliminary level, as some activities are done, but no in-depth provider training in C&L issues is conducted and recruitment of providers who reflect the diversity of the Alliance's membership is conducted only informally.

General Systems Model

This pilot study also explored what system features—in the form of inputs, processes, and outputs—are associated with the implementation of CLAS standards in a managed care setting. These features are grounded in assumptions of systems theory, which asserts that organizations having specific structures and interaction among these structures contribute to improved performance and productivity (Harrison and Shirom, 1999; Nolan, 1998; Donabedian, 1995; Institute of Medicine, 2001). The systems model developed for this project illustrates a framework that depicts the inter-relationship among the managed care organization (MCO), its provider network, and the outcomes relevant to the MCO. The managed care organization, as the administrative structure, must strive to adapt sufficient organizational inputs and processes to adequately develop and support products, services, and a care-delivery system that is responsive to the needs of culturally and linguistically diverse consumers (DHHS, 2001; Chambers, 1998). The systems model shows that the MCO must rely on formal contracting with a network of individual practitioners and organizational providers for delivering care to members on their

behalf. The model also reflects that the ability to organize, coordinate, and support CLAS over time requires the managed care entity to establish internal mechanisms that sustain a continuous link among its governance/leadership, administrative, and internal/external operations to anticipate and adequately respond to competing external demands (Garcia, 2002).

In addition to examining Alliance implementation of activities that address each of the CLAS standards, selected services and activities were examined and their component parts and relationships among those parts were noted. These services were: CLAS Management Strategy, Provider Network Management, Data Collection and Quality Monitoring, and Language Services.

CLAS Management Strategy. The Alliance approaches CLAS from both the top down (through an official C&L department and program director), and from the bottom up (in that every department has a hand in the C&L activities with which it is associated). This approach gives a focus and drive to C&L, while at the same time making sure everyone is invested in providing culturally and linguistically appropriate services as a good business practice rather than just an edict handed down from management. The CLAS management strategy is guided by the C&L program's mission statement which, in turn, helps to define the C&L program's operational work plan. That work plan includes goals and objectives addressing virtually every type of service delivered by the Alliance—translation; interpreter services; grievance monitoring; QIP's; staff training; monitoring regulatory compliance; and data collection and management for race, ethnicity, and language.

From a cost point of view, the Alliance spends only a small portion of its overall budget on culturally and linguistically appropriate services. For FY 2004, the Alliance estimates that the total costs of the C&L effort will be $1,191,506. As a percent of total costs, the C&L program indirect costs are nearly 10 percent and have been decreasing since 2002.

The focus of the Alliance, is to provide the best possible health care for its members. As such, health care quality is a primary measure of the Alliance's success in managing its C&L efforts. Alliance member perceptions of the quality of their health care plan varies by race/ethnicity as well as language spoken, but generally less than half of all members believe their health plan is the best. More than half of all African-American members believe that their health plan is the best, whereas nearly half of all Spanish-speaking members also believe their health plan is the best.

Provider Network Management. An MCO's contact with members typically occurs indirectly through the providers. For this reason an MCO's provider network management strategy is very important. At the Alliance, the Provider Services Department, headed by the Medical Director, is the primary liaison between the health plan and its provider network. Provider Services handles provider contracting and offers training and general assistance to the provider network. The Alliance, and more specifically Provider Services, monitors the race and ethnicity of providers through the provider profiles. This information, along with the language capabilities of the providers and their staff, is currently being updated through a provider survey. At present, basic training is given to providers on cultural competence and the use of the interpreter services. The Alliance also interacts closely with providers through the interpreter services. Recently, in order to increase the use of the interpreter services, the Alliance has initiated a policy to give incentives to providers who use an interpreter. Provider CLAS activity is monitored through the provider site assessment conducted when the provider is first contracted and then every 2 years. The site assessment reviews several areas related to CLAS.

Since providers are the ones ultimately responsible for the health care of the members, member clinical outcomes can be a reflection of the effectiveness of the providers. Immunization rates at the Alliance have increased between 2000 and 2003 overall and for all racial and ethnic sub-groups, except for the White population. Figures also show that pre-natal and postpartum rates have increased from 2001 to 2003 to come in line with national averages.

Data Collection and Quality Monitoring. Data collection and tracking at the Alliance includes various cultural and linguistic information items that are then coded, sorted, and entered into a centralized, automated data warehouse system. Data is entered into the Health Access Library (HAL) system from various databases including subcontracted databases (pharmacy and lab data) as well as the Alliance's Diamond database, which is the Alliance's operational database used to gather member enrollment, capitation data, and claims processing. The Alliance is able to produce reports from HAL on demand. It is able to generate these reports customized to the specifications of the user (e.g., all African Americans under age 12 with an emergency asthma admittance this year). These reports are often used as quality indicators by staff at the Alliance. To date, the Alliance has executed several interventions based on these data.

Language Services. The interpreter services framework is composed of three major components operating within the MCO environment; two major interfaces with the external environment (interpreter service vendors and the provider network); oversight and management provided by Member Services; as well as the involvement of other Alliance divisions and offices, including the CFO/legal, C&L program, Operations, Human Resources, Marketing, Information Systems, and Clinical Services. The organizational documents evidenced a variety of interpreter services staffing mechanisms, including bilingual Alliance staff, face-to-face and telephone interpretation services provided by a private vendor, and an after-hours nursing hotline. The organizational documents also provided evidence of formal policies addressing or relating to interpreter services across a variety of Alliance functions, including the C&L program, member services, marketing, clinical services, health promotion, human resources, and provider relations. The organizational documents reviewed showed that the Alliance collects and analyzes data regarding the languages spoken by members and providers via the member enrollment forms, provider survey, member satisfaction surveys, and HEDIS indicators. Review of data collected and analyzed from CAHPS and HEDIS in 2001 and 2002 show that nearly one-fifth of all members require an interpreter to talk with their doctors, and a vast majority (approximately 80 percent) of those members requiring an interpreter say they actually receive one.

Evidence uncovered during the systematic analysis of the Alliance documents included descriptions of translated materials such as the member handbook, health education materials, the provider directory, and written as well as verbal translations of the notice to members regarding the right to interpreters. The translations services function at the Alliance is managed by the marketing division, and as such, staff from the marketing division are dedicated to the task of translation of Alliance materials. Review of available data suggests that more than half of all Alliance members can find and understand the written materials developed by the Alliance.

Translation of Findings and Lessons for the Field

Close examination of the Alliance's implementation of the CLAS Standards provides some clues as to how managed care organizations may provide culturally and linguistically appropriate health care services. The following is a list of lessons learned from the case study of the Alliance.

- *CLAS as operational philosophy—a way of doing business*. In part because of the strong leadership and vision at the Alliance, and in large measure because the Alliance sees the CLAS Standards as complementing their operations, CLAS and cultural competency are an integrated part of the Alliance's overall strategy.
- *Implementation involves the entire organization—not just member services or the medical staff.* Implementation of the Alliance's C&L program/philosophy involves the work of virtually every organizational entity at the Alliance. Various programs and departments all contribute to implementation of the CLAS Standards at the Alliance, and staff regularly meet in interdisciplinary workgroups to address a variety of quality of health care issues.
- *Map each organization's component parts and their contributions to CLAS implementation*. When examining an organization's implementation of CLAS, it is important to understand each department's or service's independent as well as shared contributions to meeting CLAS goals and objectives.
- *Gather, analyze, and report race, ethnicity, and language data as it relates to programs and services*. The Alliance has established a systematic process by which race, ethnicity, and language data are regularly collected for all members and providers and analyses is conducted.
- *CLAS implementation assessment is crucial to understanding where the MCO stands.* Whether it be self-assessment or assessment conducted by an outside organization, the periodic assessment of a health care organization's compliance with the CLAS Standards is valuable for understanding not only what is being implemented and how, but what impact it is having on the organization, local community, health care providers, and members. The CLAS Standards Assessment Tool (Code Tool) developed for this study is based on a careful review of the literature and the CLAS Standards themselves.

The Alliance has taken steps toward implementing all 14 CLAS Standards. The methods used by the Alliance in doing so, outlined in this report, can be a useful "tip sheet" for other health care organizations wishing to implement the 14 CLAS Standards.

Conclusions and Recommendations

The Alliance's mission includes evaluation, implementation, and integration of cultural and linguistic competency throughout plan operations in order to create a culturally competent organization, increase access to care, enhance quality of care and health outcomes, maximize patient satisfaction and retention, and reduce health disparities. Toward that end, the Alliance created a C&L program with full-time dedicated staff. The C&L program develops strategies and provides guidance in the implementation of culturally and linguistically appropriate health care services, including organizational assessment and C&L program development, a Cultural Competency Initiative, and a Linguistic Competency Initiative, as well as ongoing C&L services.

The Cultural and Linguistic Competency Initiatives are programs designed to assess and train skill-based competencies among providers, and to evaluate the effectiveness of such training on the acquisition of new skills, as well as the quality of health care. Ongoing C&L activities include translation of all member materials, payment for qualified medical interpreter services, payment to providers for the use of qualified medical interpreters, training for providers and Alliance staff, and internal consulting services to integrate and support C&L efforts across departments.

As a result of the study conducted over the past 18 months, the following conclusions were reached:

- **The Alliance has developed an infrastructure, operational principles (philosophy), policies and procedures for addressing each of the 14 CLAS standards.** Analysis of Alliance documentation and direct observation of the Alliance's implementation of the 14 CLAS Standards revealed that specific policies and procedures exist that address each of the CLAS Standards as well as programs and activities designed to achieve specific

CLAS goals and objectives. Additionally, the strength of the Alliance's efforts to implement the CLAS Standards rests with the fact that the C&L program coordinates the Alliance's CLAS efforts, and that the organization takes seriously the responsibility to provide culturally and linguistically appropriate, high quality health care services for the residents of Alameda County.

- **Analysis of the Alliance case yielded five strategies and an overall system for implementing CLAS.** The overall systems model presented in Figure 2 on Page 23 is not only generally applicable to the Alliance case, but for all health care organizations as well. The model is designed to describe organizational inputs, processes, and outcomes associated with implementing CLAS Standards, as well as the relationships that exist among those systems inputs, processes, and outcomes. Further, the general systems model specifies each of its components as relating to the health care organization level, provider level, or member/patient level—important distinctions that assist in understanding how the health care organization achieves CLAS Standards.

- **The Alliance strategy for data collection and quality monitoring (i.e., the collection of race, ethnicity, and language information) has resulted in important new program efforts (interventions) that improve the quality of health care for Alliance members.**
  One of the cornerstones of successful CLAS implementation is the capability to create, adapt, and improve programs and activities serving members and providers. The Alliance has developed a sophisticated data collection, management, and analysis system that permits a better understanding of members—provider relationship and ways to improve service delivery. Language concordance studies (where the language of the member and provider are compared), analysis of cultural or language group health care needs and services, and monitoring of health indicators for each cultural and language group in the Alliance service area are but a few examples of the work conducted by the Alliance to carefully examine the various needs, expectations, and delivery of services to their members. These analyses and studies can be conducted only because the Alliance values the collection of race, ethnicity, and

language data and have designed specific uses for that information as it pertains to improving the quality of health care services for their members.

- **Interpreter and translation services have experienced much success with Spanish-speaking members, yet less success with Chinese-speaking and other Asian-language members.** Careful review of Alliance documents and analysis of available data show that the Alliance has had increasing effectiveness providing interpreter services for Spanish-speaking members since the C&L program has been in existence, yet less success with Asian-language-speaking members. As discussed previously, all materials distributed to members (and those distributed to providers for members) are translated into the Alliance's predominant languages. Available data consistently suggested that persons of Asian culture and language had more difficulty understanding their doctors, required interpreters more frequently, and were not as satisfied with the care they received as compared to English- or Spanish-speaking members.

In addition to these conclusions, the following recommendations are suggested:

- Further Develop and Disseminate the CLAS Implementation Self-Assessment Tool. The CLAS Implementation Self-Assessment Tool (based on the CLAS Criterion Rating Scales) is potentially useful as a self assessment of an organization's implementation of the CLAS Standards. In fact, CLAS Standard 9 calls for "initial and on-going organizational self-assessments of CLAS-related activities…." Based on an extensive review of the literature, review and feedback from a national panel of experts in health care, and testing in the field,

the CLAS Implementation Assessment Tool is comprised of 32 items (and an overall score) designed to provide a snapshot of a health care organization's level of implementation associated with each of the 14 CLAS Standards (as well as the proposed new Standard 15: Provider Network Management).

Operationally, eight of the CLAS Standards are assessed by two or more criterion rating items (for Standards 2, 3, 6, 7, 8, 9, 10, and 15), whereas seven of the CLAS Standards are assessed by a single criterion rating item (for Standards 1, 4, 5, 11, 12, 13, and 14). The coding and scoring instructions have been developed and tested and are presented in Appendixes C and D. In order to most effectively utilize this tool, health care organizations would need to carefully review the instructions for using the CLAS Self-Assessment Tool and identify all of the necessary materials and individuals required for a complete review. This relatively short and simple tool is presented below.

CLAS Implementation Self-Assessment Tool

CLAS CRITERION RATING

	Poor	Fair	Good	Excellent
148. CLAS definition statement	1	2	3	4
149. MCO diversity recruitment	1	2	3	4
150. MCO diversity retention	1	2	3	4
151. MCO CLAS training	1	2	3	4
152. MCO CLAS training objectives	1	2	3	4
153. MCO CLAS training evaluation	1	2	3	4
154. Interpreter service P & P	1	2	3	4
155. Notice of right to interpreters	1	2	3	4
156. Interpreter competency training objectives	1	2	3	4
157. Interpreter competency skill assessment tool	1	2	3	4
158. Member materials	1	2	3	4
159. Bilingual signage	1	2	3	4
160. Translation P & P	1	2	3	4
161. CLAS management strategy	1	2	3	4
162. Operational plans for service functions	1	2	3	4
163. Workgroup mechanisms	1	2	3	4
164. Organizational self-audit	1	2	3	4
165. Targeted CC-QIP	1	2	3	4
166. Patient satisfaction	1	2	3	4
167. Data collection by REL	1	2	3	4
168. Data analysis by REL	1	2	3	4
169. Demographic data	1	2	3	4
170. Epidemiology data	1	2	3	4
171. Community-based partnerships	1	2	3	4
172. Grievance P & P	1	2	3	4
173. CLAS reporting	1	2	3	4
174. Provider network diversity recruitment	1	2	3	4

175. Provider network CLAS training	**1**	**2**	**3**	**4**	
176. Provider training objectives		**1**	**2**	**3**	**4**
177. Provider training evaluation		**1**	**2**	**3**	**4**
178. Provider CLAS contract specs	**1**	**2**	**3**	**4**	
179. Provider manual	**1**	**2**	**3**	**4**	

Subscores:
180. OVERALL CLAS Implementation Score: _____

- Add to the CLAS Standards "Standard 15: Health care organizations should provide leadership and support for their networks of providers regarding knowledge and skill development, translated materials and interpreter services, patient education, and data collection." Health care organizations rely on their providers to administer high quality health care in culturally and linguistically diverse settings. In order for health care providers to deliver those services efficiently and effectively, health care organizations need to recruit and manage contracts with providers, offer training, conduct provider site assessments, and give support to providers whose language and cultural competence is substandard, among other services. While several of the CLAS Standards address, in some manner, aspects of provider network management (e.g., Standards 2, 3, 4, 6, 9, and 10), there is currently no standard that addresses these and other important and specific aspects of provider network management.

- The present study represents a single case with potential application to a wider audience of health care organizations. It is recommended that additional studies of health care organizations (e.g., managed care organizations) be conducted, with particular attention paid to services and outcomes related to improved quality of health care.

- This case study has provided information on the structures and processes necessary for successful implementation of CLAS. What this study does not provide is the various implementation strategies that may be employed by different health systems to meet local demands (as well as associated costs). It is highly recommended that a national survey be conducted to fully garner the scope of implementation strategies and the costs associated with these efforts. Such a survey would provide a nationally representative sample of what

health systems are doing to address cultural and linguistic barriers and what broad national policies might be needed to address pervasive problems in implementation.

CLAS in Health Care:

Implementation of the National Standards for Culturally and Linguistically Appropriate Services in Health Care at the Alameda Alliance for Health

FINAL REPORT

Prepared for:

Office of Minority Health
U.S. Department of Health and Human Services

Prepared by:

ORC Macro
11785 Beltsville Drive
Calverton, MD 20705

Contract Number: 282-98-0013

March 31, 2004

TABLE OF CONTENTS

Appendices (Please see separate volume for appendices)

Acknowledgments

We would like to acknowledge those who have contributed to the success of this study as follows:

- The Project Advisory Group (PAG) for their expert advice and provision of comments, opinions, and expertise during the preparation of this report. A complete list of PAG members appears in Appendix H.

- Dr. Nathan Stinson, Deputy Assistant Secretary for Minority Health, U.S. Department of Health and Human Services, for his support and commitment to the project.

- Mr. Guadalupe Pacheco of the U.S. Department of Health and Human Services Office of Minority Health (OMH) for his guidance and direction in his role as Project Officer.

- Iris A. Garcia, Ph.D. for her considerable contributions to the study in her capacity as consultant to the project team.

- The Alliance, which graciously agreed to serve as the pilot project site; and Juanita Dimas, Ph.D., former Cultural and Linguistic Program Manager, for her tireless efforts as project site coordinator.

- Yoku Shaw Taylor, Ph.D., for his service as a consultant to the project.

- The core project staff for their labor and efforts throughout the duration of this project:

  — C. Godfrey Jacobs of ORC Macro, who served as project director.

  — William H. Scarbrough, III, Ph.D., of ORC Macro, who contributed as the research coordinator.

  — Bryan B. Rhodes of ORC Macro, who served as research assistant.

Glossary of Acronyms

C&L—Cultural and Linguistic

CAC—Community Advisory Committee

CAHPS—Consumer Assessment of Health Plan Study

CC—Cultural Competence

CC-QIP—Cultural Competence Quality Improvement Program

CLAS—Culturally and Linguistically Appropriate Services

DHHS—Department of Health and Human Services

GNA—Group Needs Assessment

HAL—Health Access Library

HEDIS—Health Plan Employer Data Information Set

HIPAA—Health Insurance Portability and Accountability Act

LOS—Length of Stay

MCO—Managed Care Organization

OMH—Office of Minority Health

OSA—Organizational Self-Assessment

PAG—Project Advisory Group

P&P—Policies and Procedures

PCP—Primary Care Provider

QIP—Quality Improvement Program

REL—**Race, Ethnicity, and Language**

I. Introduction

Until the 1990s, managed care entities were the primary establishments for delivering health care to the wealthy and middle class, with most having limited experience in serving racial, ethnic, and non-English-speaking populations (Tirado, 1998; Coye and Alvarez, 1999; Rosenbaum and Shin, 1998; Garcia-Caban 2001). The advent of health care reform, however, has resulted in managed care plans being required to provide services to the States' diverse and growing Medicaid population, who represent a significant portion of racial, ethnic, and non-English speaking populations (Medicaid Managed Care Provisions, 2002). Because the foreign-born population has a higher rate of poverty than the native-born population, many in the foreign-born population receive medical care through a Medicaid program. Unlike traditional fee-for-service models, managed care organizations represent a unique service delivery system based on complex arrangements with provider networks.

Census 2000 data has revealed, as has long been predicted, significant increases in minority, foreign-born (28 million), and non-English-speaking (44 million) populations across the United States, in both urban and rural areas. The increasing diversity of the Nation brings many challenges experienced increasingly in health care facilities of all kinds. Culture and language are vital factors in how health services are delivered and received. Because of this it is important for health care organizations, including managed care organizations, to understand and respond with sensitivity to the needs and preferences of culturally and linguistically diverse patients/consumers. When organizations fail to understand these needs and preferences, it can lead to significant health consequences. In order to avoid negative health consequences, all services provided by health care organizations should attempt to be culturally and linguistically appropriate. Managed care organizations have unique challenges in adapting standards for culturally and linguistically appropriate services.

The report by the U.S. Department of Health and Human Services (DHHS) Office of Minority Health (OMH) on the National Standards for Culturally and Linguistically Appropriate Services (CLAS) in health care proposed the standards as one strategy to eliminate health disparities among racial, ethnic, and linguistic minority populations that experience unequal access to health services. The standards are intended to promote the development of

organizational supports to enhance service delivery practices that are responsive to the individual needs of ethnic minority consumers. While national and local initiatives have emphasized efforts to define concepts of cultural competence and measures to guide evaluation relevant to managed care market models, little activity has focused on examining how attempts to adapt CLAS standards may be impacting the overall structure, operations, behavior, and functioning of the managed care organization.

The OMH report also recommends the need to support activity that seeks to evaluate the approaches and feasibility of implementing the CLAS standards by health care organizations and document an experience base that could be used in other settings (TRD, 1997). An area of particular interest to OMH is to explore what evidence can be generated to demonstrate that adaptation of the standards for CLAS may contribute to improving delivery of health services that result in positive outcomes for racial, ethnic, and linguistic minority populations.

II. Project Objectives, Scope, and Methods

One deliverable of the project was to develop a preliminary system diagnostic profile of the Alliance (henceforth, the Alliance) on CLAS-related activities (see Appendix A for site selection information). The purpose of this profile was to address aspects of the first project goal, which was to identify the factors associated with best practice implementation of CLAS standards. The main questions examined under this goal were:

4. What organizational inputs and processes are associated with the implementation of CLAS standards in a Managed Care Organization (MCO)?
5. How do the organizational inputs and processes interact to affect a MCO's outputs?
6. What factors support or inhibit the implementation of CLAS standards with a MCO's provider network?

Methods

The preparation of this case study relied on a variety of qualitative and quantitative methods. The primary data collection methods utilized were document review, coding and classification, personal and group interviews (both telephone and in-person), on-site review and validation, and secondary data analysis. The document review and analysis process and the interviews conducted were guided by coding instruments and interview protocols developed and tested by the project team. The project team consisted of ORC Macro research staff and a CLAS Project Advisory Group member who served as principal research consultant. Once the case study had been drafted, a site visit with select Alliance staff was conducted to validate the contents of the case study findings. The following section describes details on specific methods used for the case study.

Development of the Alliance case study relied on three primary sources of data: (1) organizational documents in the form of policies and procedures, reports, and written materials relevant to CLAS implementation; (2) personal and group interviews with Alliance leadership and staff (including the Chief Executive Officer (CEO), Chief Financial Officer (CFO), and Cultural and Linguistic (C&L) program manager); and (3) extant (existing) data addressing consumer (member) satisfaction and clinical outcomes. A notable limitation with regard to the case study data is the fact that no original data was collected from providers regarding their satisfaction with the Alliance.

a) Documentation Review and Analysis

Documents were selected as a primary data source since they are considered key by-products of interaction among individuals/groups that reflect not only what is meaningful to members in the organization but how the organizational system communicates internally and externally about the processes and actions related to CLAS implementation (Forster, 1994; Hodder, 1994; Garcia-Caban, 2001). The Alliance provided numerous documents that ranged anywhere from 1-page summaries to multiple bounded manuals consisting of 200-page descriptions of processes, events, and actions occurring along all dimensions of the system, as shown in Table 1 below.

Table 1. MCO Organizational Documents

CLAS Standards	Types of Documents
1. CLAS Definition Statement	C&L program definition statements; operating principles and directives; Medicaid contract specifications
2. Workforce Diversity	Human Resource policy/procedure (P & P) manual and strategic plan; Equal Employment Opportunity (EEO) workforce analysis reports; employee handbook manual; provider language data profiles; program staff job

	descriptions
3. Staff CLAS Training	Workforce training goals/strategies; competency objectives, training evaluation forms; performance evaluation forms; training flyers; staff attendance records
4. Interpreter Services	Interpreter service P & P manual; inter-office communication memos, descriptive reports of operations
5. Notice of Right to Interpreters	Interpreter P&P manual; member materials; provider manuals; provider contracts
6. Qualifications of Interpreters	Interpreter training curriculum and skill assessment tools; interpreter service P&P manual
7. Translation of Materials	Translation P&P manual; sample translation of member handbooks, newsletters, health education materials, posters, etc.
8. Organizational Framework	MCO mission statement, official strategic plan, organizational chart, Board of Directors list; C&L program work plan; reports describing workgroup activity; letters of grant awards
9. Performance Monitoring	Health Plan Employer Data (HEDIS) reports; adult/child CAHPS data results, quality improvement reports; QI grant proposal documents
10. Data Collection for Race, Ethnicity, and Language	Data warehouse maps and codes; Data management procedures; list of standard stratified data extraction reports; provider demographic data P&P
11. Community Needs Assessment	Sample needs assessment reports compiled for Medicaid, S-CHIP and other payers
12. Community Partnerships	Community advisory board list; community health fair announcements; community development grant proposals
13. Grievance Procedures	*Member service grievance policy; payer summary reports; member notices*
14. CLAS Reporting	Sample presentations of national conferences; staff and provider meeting; inter-office communication memos and manuals

The ORC Macro team sorted and categorized documents to determine which sources most reflected valid or stable indicators of actual organizational processes, events, or actions. For example, policy documents that described processes related to interpreter service training were not considered valid indicators for verifying whether activities relevant to CLAS standard #6 (qualified interpreters) were occurring. Rather, curricula that outlined explicit competency objectives, plus sample skill assessment forms that evaluated these components, were considered to be the more stable indicators. The project team also recognizes the limitations of documents as a data source. Since they may represent descriptions of processes/events particular to a point in time, their contents may reflect inconsistencies in the type of language used to communicate activities, and therefore provide a limited representation of the actual occurrences within the organization without some form of validation process.

Code Tool Development. In order to carefully review and analyze each document, a coding instrument was developed and tested. The development of instruments and identification of measures were necessary to guide systematic review of documents and analytic activities. Given the range of knowledge and technical expertise among the core project team members (on the subject matter under study) a standardized code tool was needed to minimize variation in analysis and interpretation of data. Code tool development was accomplished in three stages.

The *first stage* of code tool development was to review the literature on existing cultural competence measures to identify the dominant themes that paralleled systemic and organizational cultural competence performance indicators. This process not only verified the primary input/process indicators outlined in the systems model, but generated deductive codes for each of these indicators and resulted in a preliminary code tool.

The *second stage* of code tool development used template style methods that required interface with the Alliance documents that generated inductive codes specific to CLAS implementation activity not found in the literature (Miller and Crabtree, 1992; Strauss and Corbin, 1990). This process aided in identifying a separate set of indicators and codes for evaluating the functions of provider network management, which are unique to MCO settings. The final code tool highlighted 15 indicators and featured 147 items (see Appendix B) designed to standardize the analysis of documents at hand. This version of the tool used a variety of response scales including dichotomous, nominal, and open-ended formats.

The *third stage* of code tool development involved creation of a criterion rating scale that also applied the template style methods described above to inform the scale categories (see Table 2 below). This scale served as a supplement to the primary code tool. The criterion-rating scale featured 33 items that used a 4-point ordinal response scale (1=no implementation, 2=planning or minimal implementation, 3=implementation limited in scope, and 4=best practice implementation) to guide coders through interpretive analysis on the degree of implementation activity for each CLAS standard. Each CLAS standard was rated based on responses to specific items referenced in the 147-item code tool (see Appendix C). Items rated on multiple indicators used a system of weighting for each item to arrive at a final score that fit into one of the 4-point scale response categories. A detailed coding instruction manual was developed to guide content coding and calculate rating scores (see Appendix D).

Table 2. Select Criterion Rating Indicators

CLAS #1	CLAS #2	CLAS #3	CLAS #4	CLAS #5	CLAS #6	CLAS #7	CLAS #8

CLAS Definition	Workforce Diversity	Staff CLAS Trg	Interpreter Services	**Notice of Right to Interpreters**	**Qualified Interpreters**	**Translation of Materials**	**Organizational Framework**
• Focus on member values, prefer-ences, cultural needs	• Recruitment strategy • Retention strategy • RE staff mix & positions	• Training Curriculum • Staff trg. program • Training Evaluation • Training Frequency	• Mgt. Oversight • Staffing mechanism • Hrs of service • Service mission • Phone vs. FTF • Staff training prog. • Staff training reqts. • Staff trg. objectives • Staff skill assmt. • Trg. frequency • Language DC/DA • Translation P&P	• Verbal • Written • Multilingual	• Training curricula -Language prof. -Medical terminology -Code of ethics -Cross cultural communication • Skill Assmt tools -Language prof. -Medical terminology -Code of ethics -Cross cultural communication	• Types and # of materials • Translation P&P • Bilingual signage • Translation quality	• CLAS Mgt. Strategy • Operational workplan • Workgroup mechanisms

CLAS #9	**CLAS #10**	***CLAS #11***	**CLAS #12**	CLAS #13	**CLAS #14**	**New Standard**
Performance Monitoring • OSA tool • CC-QIP's -QIP foci -QIP intervention -QIP mgt • Patient Satisfaction -type of tool -tool translation -Data Collection and Analysis by REL	***Data Collection & Analysis by REL*** • MIS Standardized reports (HEDIS+) • Analytic activity (HEDIS +)	**Community Needs Assessment** • Census profiles • Health status profiles • Subgroup profiles • (collection & analysis activity)	**Community Partnerships** • Advisory Board • Marketing focus • Service Plg. input	E. F. Grievance P&P • Policy provisions • Type of procedures	G. H. CLAS Communication Strategy • Internal/External audiences • Mechanisms used	**Provider Network Management** • Diversity recruitment • CLAS training program • CLAS training objectives • CLAS training evaluation • CLAS contracting specs. • Provider manual instructions • CLAS site asmt.

Inter-Coder Testing of the Code Tool. The core project team conducted two inter-coder tests of the coding and criterion-rating tools to examine the reliability of the tools built for this study. These tests were conducted using the coding instrument and criterion-rating scales as well as all available documents from the Alliance.

The first test used four project team members. For approximately one-third of the coding items and one-fifth of the criterion rating items, the four coders recorded the same response. Upon discussion among the coders, disagreements were attributable to a variety of factors,

including variation in the content knowledge of the coders, differences in conceptual interpretations of the documentation reviewed, and the inability of coders to find appropriate references in documents. These variations were discussed among the coders, clarifications were presented, adjustments were made to the coding and criterion rating tools, and preparations for a second test were completed.

For the second test, coders agreed on nearly four-fifths of the coding items and two-thirds of the criterion rating items. The improvement in the inter-coder agreement for the second test was attributed to coders having a better understanding of the content, more consistent interpretations of the documentary information presented, and coders being better able to find information in the documents provided by the Alliance. These levels of inter-coder agreement were acceptable for proceeding with complete coding of the Alliance documents.

b) Interviews With Alliance Staff

In order to buttress the written documentation provided by the Alliance, ORC Macro designed, implemented, and analyzed a series of individual and group interviews with the Alliance staff. Individual telephone interviews were conducted with the Alliance CEO and CFO, as well as in-person group interviews were conducted with the CEO, CFO, medical director, C&L program manager, and selected C&L staff. The interviews covered a variety of topics including the philosophy and operation of the Alliance, costs associated with the C&L efforts, specific program efforts such as translation and interpreter services, data collection and analysis, and staff training.

c) Secondary Analysis of Existing Data

In addition to the documentary information and telephone, in-person, and group interviews conducted and gathered, ORC Macro also identified and gathered consumer (member) satisfaction and clinical outcomes data from existing sources, including Consumer Assessment of Health Plan Study (CAHPS), HEDIS, and selected surveys from the C&L program and the Alliance. These sources of information captured a wide variety of data elements including member satisfaction with their provider and the health care they receive, child immunization rates, and percent of eligible members making well-infant visits, as well as billed interpreter encounters.

d) Site Validation

In the Fall 2002, (October 28, 2002 and October 29, 2002) the ORC Macro team conducted a 2-day site visit at the Alliance, in Alameda, CA. The purpose of this 2-day site visit was to present a draft of the Alliance CLAS case study prepared by the ORC Macro team and to discuss the case study's accuracy, completeness, and interpretability with a variety of Alliance executives and C&L program staff (staff present included: CEO, CFO, Medical Director, and C&L program director). Day one of the site visit began with the presentation of the Alliance CLAS case study by the ORC Macro team. After a brief introduction and overview of the case study, the methods by which the case study was constructed were presented. This overview was followed by presentations concerning each of five major MCO components: CLAS Management Strategy, Provider Network Management, Interpreter and Translation Services, Data Collection and Quality Monitoring, and Customer Focus. Each of the Alliance component presentations was accompanied by graphics.

Validation occurred in three phases. First, the description of each CLAS standard implementation was confirmed. Second, each graphic representation was presented for confirmation, and specific questions were asked in order to fill gaps in information. Third, a further validation and clarification was conducted with MCO executive and program staff concerning specific issues. A transcript of the site visit was produced and utilized in the validation process.

Data Analysis

More than 1,000 pages of the Alliance documented policies, procedures, operations, and activities were coded and analyzed for this project. ORC Macro staff carefully reviewed document text by identifying words related to the codes contained with the standardized code tools for each of the CLAS standards. Content analysis also was used to classify and categorize content in the Alliance documents to define different input, process, and outcome components, as well as relationships that exist among those components. Content analysis was used to analyze responses and patterns of responses from the individual and group interviews conducted with the

Alliance staff. Thematic analysis was used to identify patterns within document text on aspects of system operations (Boyatzis, 1998). For example, thematic analysis of the available documents revealed a variety of formal as well as informal processes operating at the Alliance.

Interpretive analysis was used to develop the criterion rating tool and examine degrees of CLAS standard implementation and to reconstruct descriptions of CLAS implementation status. Using criteria associated with different levels of CLAS implementation, each of the criterion rating items could be assessed as “expanded implementation” (as specified by characteristics associated with fully implementing a particular criterion rating item) to “not implemented” (for example, a lack of documentary evidence that implementation was, in fact, occurring). Interpretive analysis also was used to identify and describe the differences among raters for the 147 coding items and 33 criterion rating items.

For the extant data, analysts utilized descriptive statistical techniques (calculating, for example, percentages, medians, and modal responses) to summarize and present the member satisfaction and clinical data.

III. Case Description: The Alliance

This section presents a description of the Alliance. The Alliance is a public health plan that offers locally based health care services to low-income residents of Alameda County. Since its inception in 1996, the Alliance has been committed to providing care to its diverse membership, comprised of traditionally underserved children and adults in Alameda County, CA. The Alliance's license with the California State Department of Managed Health Care is to provide services in Alameda County. Alameda County is an area of 820 square miles (land and water area), over 50 miles across, containing 16 cities, with an estimated 1,375,850 residents. The largest city is Oakland, with an estimated total population of 390,000. Nearly three-quarters (73 percent) of the county's Medicaid managed care-eligible patients are Alliance enrollees, as are 57 percent of the county's S-CHIP enrollees. Alliance demographics indicate that 87 percent of its members are people of color (of over 78,000 plan members, 36 percent are African American, 22 percent Latino/a, 13 percent White, 9 percent Vietnamese, 5 percent Chinese, 3 percent Cambodian, 2 percent Laotian, and 8 percent other Asian/Pacific Islander) with over 40 percent who have a primary language other than English (the largest groups being 15 percent Spanish, 7 percent Vietnamese, and 6 percent Cantonese).

The Alliance serves its membership through a provider network of more than 1,300 physicians practicing in solo and group practices and in community clinics, more than 100 ancillary providers, 160 pharmacists, and all major hospitals in the county.

The Alliance has had a C&L program in place since the organization was formed in 1996. Under the direction of senior leadership, program staff has been responsible for undertaking a range of initiatives.

IV. Findings

The following sections address three different, yet interrelated classes of findings from this project. First, results of a review and analysis of Alliance documentation regarding implementation of the 14 CLAS Standards is presented. Second, a general model depicting the

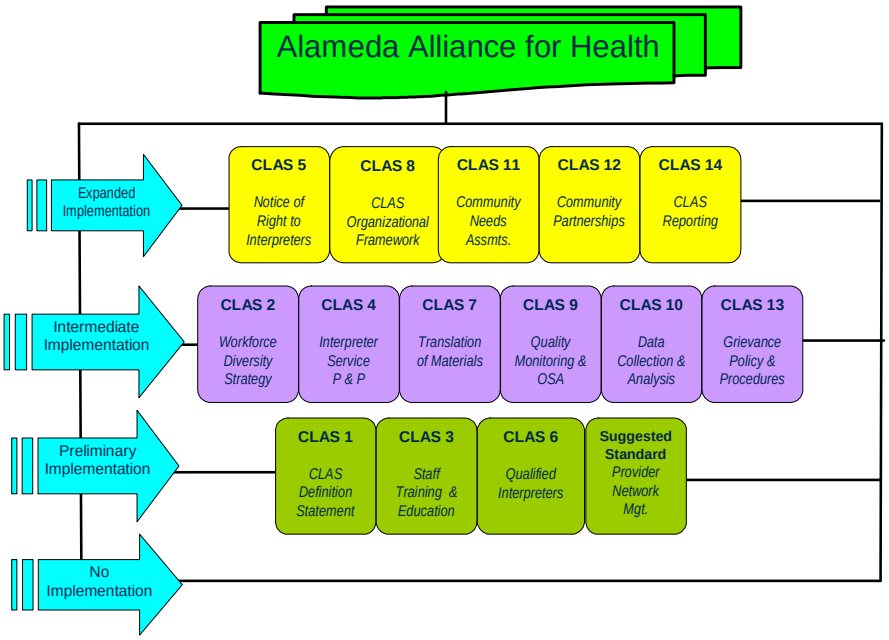
operational components of the Alliance is presented and described. Third, each of five key operational components are modeled and described using available documentation as well as clinical and attitudinal data.

A. The Alliance Implementation of the CLAS Standards

A careful review and analysis of implementation of the CLAS Standards was conducted using available documentation provided by the Alliance (as well as interviews conducted with key Alliance staff. Using the criterion rating scales (see Appendix C), four levels of CLAS implementation were identified. **Level 1-No Implementation** is associated with a criterion rating of "absent or not implementing" (poor). **Level 2-Preliminary Implementation** is associated with a criterion rating of "planning or minimal implementation" (fair). **Level 3-Intermediate Implementation** is associated with a criterion rating of "implementation is limited in scope" (good). Finally, **Level 4-Expanded Implementation** is associated with a criterion rating of "best practice implementation" (excellent).

Using this translation of the criterion rating scales, overall, the Alliance's implementation of the CLAS Standards achieves a rating of **Level 3-Intermediate Implementation**. This rating suggests that THE ALLIANCE is operating in a way that is both consistent with as well as achieving many of the suggested goals and objectives of the CLAS Standards. Figure 1 on the following page summarizes the analysis of each of the CLAS Standards and shows the levels for each. As shown, the Alliance implements 11 of the 14 CLAS Standards at **Level 3-Intermediate** or **Level 4-Expanded**, and 3 of the 14 Standards at **Level 2-Preliminary Implementation**. It is important to note that each of the standards was being implemented to some degree by the Alliance (that is, there were no **Level 1-No Implementation** ratings). In the following paragraphs, short descriptions of each CLAS standard, how the Alliance implements each CLAS standard, and the level of implementation for each standard as derived from the analysis are provided.

Figure 1: Display by Degree of CLAS Implementation



1) CLAS Definition Statement. CLAS Standard 1 recommends, "health care organizations should ensure that patients/consumers receive from all staff members effective, understandable, and respectful care that is provided in a manner compatible with their cultural health beliefs and practices and preferred language." This standard looks to member-specific values within the MCO CLAS definition statement. (For this study it was decided to redefine this standard to reflect a reference to member-specific values as opposed to organizational values, which is related to CLAS Standard 8, given the lack of clarity in the OMH monograph). This can best be seen in the mission statement of the Alliance's C&L program. The Alliance's C&L mission statement asserts, *"to evaluate, implement, and integrate cultural and linguistic competency across plan operations in order to create a culturally competent organization, increase access to care, enhance quality of care and health outcomes, maximize patient satisfaction and retention, and reduce health disparities."* The implementation of this standard was judged to be at the **preliminary level** because the mission statement of the whole organization did not make specific reference to member cultural health beliefs and practices and preferred languages.

2) Workforce Diversity. CLAS Standard 2 recommends, "health care organizations should implement strategies to recruit, retain, and promote at all levels of the organization a diverse staff and leadership that are representative of the demographic characteristics of the service area." The Alliance generally attempts to secure a competent workforce at all levels of the organization. The Alliance makes reference in their Human Resources policies to hire staff who meet the cultural and linguistic needs of their members. The Alliance materials, however, have no specific human resources policy pertaining to the recruitment or retention of diverse staff members. The Alliance does make employment openings available to the public using various methods in order to reach an applicant pool that reflects the surrounding community. The implementation of this standard was judged to be at the **intermediate level** because the Alliance's plans for recruitment, training, and promotion of a diverse staff and leadership have resulted in a diverse and culturally competent staff. Alameda County is a highly diverse community and the Alliance's recruitment efforts in tapping into the local mainstream media readily yield a diverse pool of qualified candidates. The Alliance's already diverse management and general staff tend to perpetuate workforce diversity without an extra effort; however, the study team could not find a specific human resources policy for diverse staff recruitment and retention.

3) Staff Training and Education. CLAS Standard 3 recommends, "health care organizations should ensure that staff at all levels and across all disciplines receive ongoing education and training in culturally and linguistically appropriate service delivery." The Alliance approach to implementing CLAS Standard 3 is to orient internal health plan staff on cultural and linguistic developments through C&L program collaboration in management and staff meetings, special work groups, and individual meetings. No systematic training for staff in cultural competency and CLAS issues is formalized or documented, although several all-staff and management meetings have focused on various C&L topics and policies. The implementation of this standard was judged to be at the **preliminary level** because the study team did not find information regarding specific training in cultural competency and CLAS issues for Alliance staff members. An external C&L trainer has been identified, and a series of staff trainings are scheduled for early 2004. It is important to point out, however, that the Alliance does have a systematic cultural competency training program for its providers and their

office staff. In four two-part sessions held in May 2003, January 2004, and February 2004, 83 physicians have been trained.

4) Interpreter Services. CLAS Standard 4 recommends, "health care organizations must offer and provide language assistance services, including bilingual staff and interpreter services, at no cost to each patient/consumer with limited English proficiency at all points of contact, in a timely manner during all hours of operation." The Alliance has taken a number of steps toward implementing interpreter services for its members. The interpreter services at the Alliance are managed by the Member Services Department. Actual interpretation is done through a subcontracted vendor (face-to-face and telephonic) or the AT&T language line (telephonic only), and is made available 24 hours a day at no cost to the member or the provider. Since October 2001, the Alliance has sought to increase usage of the interpreter services by paying providers who use interpreters arranged by the Alliance. This payment recognizes the additional time and skill required by the provider when using a trained interpreter. Information is gathered about languages requested and is reported annually to the C&L program for analysis. The Alliance also is planning an analysis that will identify those doctor-patient encounters in which a language barrier existed that was not addressed by the Alliance's arrangement of a trained interpreter. As a result of this analysis, an intervention will be designed to educate those particular provider practices on the benefits of patient care and provider payment. The implementation of this standard was judged to be at the **intermediate level** because the Alliance has documented a systematic interpreter services plan and is further developing that plan based on provider and member feedback.

5) Notice of Right to Interpreters. CLAS Standard 5 recommends that "health care organizations must provide to patients/consumers in their preferred language both verbal offers and written notices informing them of their right to receive language assistance services." A multi-pronged effort for informing members of their right to interpreter services has been developed by the Alliance. They developed a clear policy and procedure document outlining how this process will occur for members and providers. The policy states that the MCO will notify members, in the member's preferred language, through new member welcome packets, member newsletters, and through verbal contact with the Member Services Department. This

policy delineates not only that members will be notified of their right to interpreter services, but also the specific methods to be used in meeting this goal. The Alliance also distributes to members "I Speak…" cards in 20 different languages that will inform providers of members' language needs and how providers can access Alliance resources. The Alliance balances its efforts between informing members of their rights and informing providers of their obligation to ensure that language needs are adequately met. The implementation of this standard was judged to be at the **expanded level** because the Alliance has developed specific policy and procedures to ensure notice of a right to interpreters for each member and provider.

6) Qualified Interpreters. CLAS Standard 6 recommends that, "health care organizations must assure the competence of language assistance provided to limited English proficient patients/consumers by interpreters and bilingual staff. Family and friends should not be used to provide interpretation services (except on request by the patient/consumer)." The interpreter service uses a subcontracted vendor to meet most of its interpreter needs, including training and evaluation of the interpreters. Documents mention that interpreters from the vendors used are trained extensively. Vendor contracts require formal interpreter training with a minimum number of hours and adoption of the California Standards for Healthcare Interpreters: Ethical Principles, Protocols, and Guidance on Roles and Intervention. However, no interpreter training curriculum or skill assessment concerning an interpreter code of ethics, interpretation of medical terminology, or cross-cultural communication is provided in Alliance documents. Based on these findings, the implementation of this standard was judged to be at the **preliminary level**.

7) Member Materials and Translation. CLAS Standard 7 recommends that "health care organizations must make available easily understood patient-related materials and post signage in the languages of the commonly encountered groups and/or groups represented in the service area." Policy pertaining to member materials specifies that translation should be done by a translator *and* a separate editor. It also notes that legal and complex documents should be back translated. The Alliance has used this method to translate many types of member materials into several languages. The quality of the translated documents includes whether each translation is determined appropriate for the intended audience in terms of words, literacy levels, idioms (e.g., Puerto Rican versus Mexican) and political implications (e.g., Mainland Chinese versus

Taiwanese). The Alliance produces its non-English documents in the same quality versions as the English versions, rather than a lower quality version. The Alliance also often seeks to translate documents in bilingual or multi-lingual versions to accommodate those households where the Limited English Proficiency (LEP) person seeks assistance/clarification from an English reading person. Alliance policy also notes that document translators are asked to make recommendations concerning the cultural appropriateness of the materials they translate. No policy, however, mentions specific methods for developing culturally equivalent materials. No bilingual signage exists at the MCO facility because of the low number of members who actually visit the facility. They do, however, encourage bilingual signage at other points of contact with members. Specifically, the Alliance looks for bilingual signage at provider offices during the provider site review. The implementation of this standard was judged to be at the **intermediate level** because all member and provider documents are translated into all threshold languages and because there are existing policies and procedures for ensuring understandable materials and signage for members.

8) CLAS Organizational Framework. **CLAS Standard 8 recommends that, "health care organizations should develop, implement, and promote a written strategic plan that outlines clear goals, policies, operational plans, and management accountability/oversight mechanisms to provide culturally and linguistically appropriate services." The strategy for the management of projects relating to CLAS includes a C&L program with a dedicated full-time staff, as well as workgroups to deal with specific C&L issues, including an internal C&L task force, health plan workgroups, and a cultural competency quality improvement program workgroup. The Alliance gives its overall mission statement as follows:**

> **"The Alliance is a public health plan dedicated to providing continuous, comprehensive, high quality care to the traditionally underserved children, families, and individuals in Alameda County. The Alliance values member satisfaction and is committed to high standards of integrity, accountability, and service to its diverse community."**

The C&L program has established a work plan, which gives the major goals and objectives of the program. These goals and objectives focus on improving specific system features and member services. The C&L program staff meets regularly in order to achieve these goals and stays in communication with other departments and workgroups through interdepartmental meetings, memos, and presentations toward this end. The C&L program, along with other departments at the Alliance, has developed a set of policies and procedures to

ensure that the work plan is implemented properly and that the goals of the plan can be met with some efficiency. The implementation of this standard was judged to be at the **expanded level** because the C&L program organization, policies, procedures and oversight/accountability are designed to ensure that the Alliance can deliver culturally and linguistically appropriate services.

9) Performance Monitoring. **CLAS Standard 9 recommends, "health care organizations should conduct initial and ongoing organizational self-assessments of CLAS-related activities and are encouraged to integrate cultural and linguistic competence-related measures into their internal audits, performance improvement programs, patient satisfaction assessments, and outcomes-based evaluations." The Alliance focuses on performance monitoring to improve C&L services with targeted Quality Improvement Program (QIP) activities. The Cultural Competence Quality Improvement Program (CC-QIP) activities focus on improving the MCO structural features (e.g., information systems to better document incoming data), and care coordination and delivery to members (e.g., prenatal care).**

The Alliance's C&L program, along with other appropriate MCO departments (e.g., member information services and the clinical department), manages these CC-QIPs. The Alliance also assesses patient satisfaction on the basis of results obtained from surveys developed in-house (translated into Spanish, Vietnamese, and Cantonese), Consumer Assessment of Health Plans (CAHPS) results, and focus groups conducted with several member groups (e.g., African Americans, Spanish speakers, Vietnamese speakers, and Chinese speakers). Patient satisfaction data are collected and stratified by race, ethnicity, and language. The Alliance also engages in an ongoing cultural competence organizational self-assessment (OSA), which according to Alliance documents, occurs quarterly. The implementation of this standard was judged to be at the **intermediate level** because there are specific policies and procedures in place at the Alliance to carefully assess the cultural and linguistic competence of their staff, providers and provider organizations, and the performance of their programs serving members.

10) Data Collection. **CLAS Standard 10 recommends that "health care organizations should ensure that data on the individual patient's/consumer's race, ethnicity, spoken and written language are collected in health records, integrated into the organization's management information systems, and periodically updated." Various methods are used to collect and record data on member race, ethnicity, and language (REL). The Alliance uses an array of codes for racial, ethnic, and language groups garnered from the Health Insurance Portability and Accountability Act (HIPAA), Medicaid, and the S-CHIP program. They also receive most of their member data on REL from these groups. The Alliance also collects data about provider REL through a voluntary provider survey; these data are then stored in the provider profile. These data are used to produce standardized**

reports on members and providers stratified by REL. These reports incorporate information from internal administrative reports, HEDIS reports, and CAHPS reports.

Patient satisfaction data are also collected and stratified by REL. Data are also collected and analyzed on specific C&L programs, including interpreter services, although this information is only stratified by racial group. Data analysis (defined as examining data collected from the organization's internal information systems [not external data such as census data] to identify and describe differences among consumer groups) is also done by REL for select measurement areas. These measurement areas include member enrollment data, grievance data, asthma admissions, prenatal care, immunizations, breast cancer screening, cervical cancer screening, and well-child visits. To assist in the analysis of prenatal care and cervical cancer screening among REL groups, the Alliance has partnered with academic institutions. The implementation of this standard was judged to be at the **intermediate level** because the Alliance has developed a management information system, as well as policies and procedures for the collection and analysis of race/ethnicity and language data as they pertain to the operation and outcomes of Alliance programs.

11) Community Needs Assessment Profiling. According to CLAS Standard 11 "health care organizations should maintain a current demographic, cultural, and epidemiological profile of the community as well as a needs assessment to accurately plan for and implement services that respond to the cultural and linguistic characteristics of the service area." The needs of the community are assessed in several ways. First, they can be assessed by completing a Medicaid Group Needs Assessment (GNA) and a S-CHIP Program GNA, each of which is contractually required. Through these two assessments, a demographic data profile of the Alliance's surrounding community is gathered, which is then stratified by REL. The GNAs also provide data on the public health status of the community, which is stratified and analyzed by race and ethnicity. Additional use of the data gathered in the GNA is to look at health status profiles of racial and ethnic subgroups. The C&L program uses all the data about the community gathered in the GNAs to develop future C&L work plan goals and objectives. The implementation of this standard was judged to be at the **expanded level** because the Alliance conducts periodic needs assessments of the communities it serves and has in place policies and procedures that guide the development of services in response to the cultural and linguistic needs of their members.

12) Community Partnerships. CLAS Standard 12 recommends "health care organizations should develop participatory, collaborative partnerships with communities and utilize a variety of formal and informal mechanisms to facilitate community and patient/consumer involvement in designing and implementing CLAS-related activities." The Alliance has a multifaceted approach to establishing and building community partnerships with groups that represent racial, ethnic, and linguistic minorities. There is a Community Advisory Committee (CAC), composed of representatives from many different sectors of the community. The Alliance's CAC includes consumers, physicians who generally serve a very diverse constituency, leaders of local community-based organizations, and relevant State and local government officials. This committee gives input to the Alliance on a range of issues involving CLAS (e.g., service planning, member materials, and marketing). The Alliance also gains feedback from the community via focus groups with select REL subgroups and contact with community forums and coalition groups. The implementation of this standard was judged to be at the **expanded level** because the Alliance maintains participatory and collaborative partnerships with the communities it serves as well as its members and providers.

13) Grievance Policy and Procedures. CLAS Standard 13 recommends "health care organizations should ensure that conflict and grievance resolution processes are culturally and linguistically sensitive and capable of identifying, preventing, and resolving cross-cultural conflicts or complaints by patients/consumers." Specific policies and procedures have been developed to ensure that member grievances are addressed in a culturally and linguistically appropriate manner. The Alliance informs all members about the grievance policy in the member's preferred language through a variety of means, and provides interpreter services for limited/non-English speaking members who wish to file a complaint or grievance. The C&L program is also consulted on all grievances filed that are related to cultural and linguistic issues. The Alliance monitors grievances from specific racial, ethnic, and linguistic subgroups. The grievance procedures also allow for staff-peer observation, CAC review, a Medicaid managed care ombudsman, Medicaid State fair hearing, and independent medical reviews, as necessary. The implementation of this standard was judged to be at the **intermediate level** because the Alliance has in place specific policies and procedures to identify, monitor, and resolve grievances and conflicts with members (and providers).

14) CLAS Communication Strategy. CLAS Standard 14 recommends "health care organizations are encouraged to regularly make available to the public information about their progress and successful innovations in implementing the CLAS standards and to provide public notice in their communities about the availability of this information." The Alliance communication strategy reports to a variety of stakeholder groups, both internal (MCO staff and management) and external (members, providers, contractor, government agencies, and the public at large), concerning CLAS projects. The C&L program participates in dialogue at the local and national levels about CLAS issues. The Alliance engages in this dialogue already through public reporting of CLAS projects and issues. General public reporting on CLAS is done via member and provider newsletters, organizational reports and documents, stand-alone reports, print media, and conference presentations. This reporting is aimed mainly at providers, community-based organizations, regulatory agencies, and funding sources. The Alliance also uses its Web site to report information about CLAS issues to its members, provider network, and MCO staff. The implementation of this standard was judged to be at the **expanded level** because the Alliance has developed and manages a number of successful strategies to regularly inform the public about its progress and the availability of that information.

15) Proposed Standard for Provider Network Management. During the course of this study, the project team found that much of an MCO's "public face" is its provider network. Therefore, the management of a provider network is an important feature of the MCO, and vital when attempting to implement culturally and linguistically appropriate services in an MCO setting. The Alliance engages in several activities related to CLAS through its provider network management. The Alliance monitors provider race, ethnicity, and language capabilities and attempts to match members with providers who are able to meet their linguistic needs and geographic locations. The Alliance also informs providers of its interpreter services through the provider contract, the provider manual, and other communications such as direct letters, bulletins, and trainings. The Alliance has had four training sessions for 83 physicians with plans to train more physicians and office managers. During provider site assessments the Alliance reviews providers on multilingual signage in their offices, multilingual written materials, and documentation of member language in the medical records. The project team saw that a standard

of this kind was implemented at the **preliminary level**, as some activities are done, but no in-depth provider training in C&L issues is conducted and recruitment of providers who reflect the diversity of the Alliance's membership is done only informally.

B. General Systems Model of the Alliance

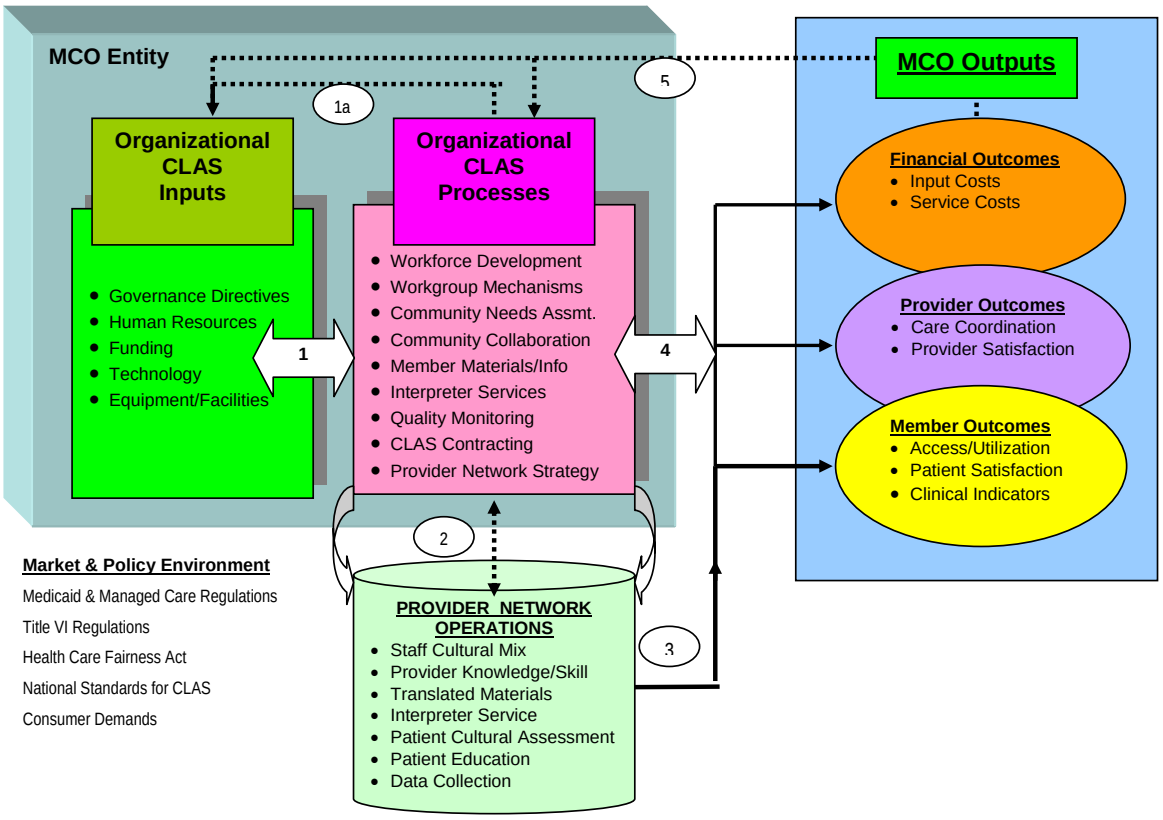
The scientific literature describes a variety of organizational structures and processes essential to adapting standards for delivering culturally and linguistically appropriate services. No studies, however, have examined in-depth the system features that contribute to building organizational support for implementing the CLAS standards in health care organizations.

This pilot study explored what system features, in the form of inputs, processes, and outputs, are associated with the implementation of CLAS standards in a managed care setting. These features are grounded in assumptions of systems theory, which asserts that organizations having specific structures and interaction among these structures contribute to improved performance and productivity (Harrison and Shirom, 1999; Nolan, 1998; Donabedian, 1995; Institute of Medicine, 2001). A systems model that served to guide the study is shown in Figure 2 below.

Figure 2 illustrates a framework that depicts the inter-relationship between the MCO, its provider network, and the outcomes relevant to the MCO. The domains of input, processes, and outputs[1] represent select features and indicators fundamental to all systems based on review of the interdisciplinary literature (Andrulis et al., 1999; Arredondo and Woy, 2002; Garcia-Caban, 2001; CWLA, 1993; Cross, 1993; Henderson, 1994; Hernandez et al., 1991; Lewin, 2002; Mason, 1995; Mendez-Russell et al., 1994; Perkins, 1999; Tirado, 1998; TRD, 1997, Ware, 2000; Chambers, 1998; Wagner, 1999). The lines in Figure 2 suggest the critical interdependencies among the MCO inputs, processes, and outputs.

[1] *Inputs* are defined as the raw materials that organizations obtain to create outputs; *processes* are the way in which the organization transforms inputs into outputs; and *outputs/outcomes* are the result of combined inputs and processes that affect productivity and/or performance of an organizational entity (Harrison and Shirom, 1999).

Figure 2: Systems Model for CLAS Performance in Managed Care Settings



MCO Entity. As shown in Figure 2, the managed care organization, as the administrative structure, must strive to adapt sufficient organizational inputs and processes to adequately develop and support products, services, and a care-delivery system that is responsive to the needs of culturally and linguistically diverse consumers (DHHS, 2001; Chambers, 1998). The model defines *inputs* as the fundamental materials needed by all organizations that facilitate processes to generate outputs. Inputs such as governance/leadership representatives who provide clear directives via a CLAS management strategy that prioritizes program goals, allocates funding, secures bicultural/bilingual human resources, and modifies technology (i.e., information and telecommunication systems) are some of the features essential to enhancing the MCO's administrative capacity. The *processes* and/or manner in which the MCO puts to use these inputs

should result in enhanced planning, strategic implementation, and coordination of services. Processes that seek to emphasize workforce diversity development and the creation of formal workgroup mechanisms are key to building workforce competence, coordinating activities, and communicating about CLAS program directives at the system-wide level. Modifying member materials, arranging interpreter services to facilitate access for non-English speaking enrollees, providing quality monitoring aimed at clinical management of chronic conditions prevalent among ethnic minority populations, as well as conducting periodic evaluation of provider operations are also basic administrative processes that require adaptation and continuous monitoring within the MCO entity (NCQA, 2001). The *outputs* illustrated in the model represent some of the system, provider, and member outcomes that may result from the interaction of CLAS inputs and processes to directly impact productivity or performance.

Provider Network Operations. As illustrated in Figure 2, the MCO must rely on formal contracting with a network of individual practitioners and organizational providers for delivering care to members on their behalf. Providers who serve ethnic minority populations must strive to adapt sufficient organizational inputs and processes to adequately support a care-delivery system that is responsive to the varying subgroups. To achieve this goal, the MCO must be vigilant to identify and execute a provider network management strategy that ultimately seeks to improve outputs along all dimensions depicted in the systems model. Such a strategy must explicitly stipulate expectations (via CLAS contracting processes) for service delivery arrangements as well as engage in collaborative efforts to create the mechanisms or tools (e.g., site reviews, provider manuals) that facilitate providers' meeting such expectations. Contracting specifications that incorporate requirements consistent with Federal/State mandates and provide descriptive language to offer sufficient guidance for implementing select aspects of CLAS standards may aid in reducing administrative burden and facilitating services and products (HRSA, 2001). As shown in the model, provider contract agreements that promote building provider network capacity operations (e.g., bicultural/bilingual primary care staff, core knowledge of multicultural groups in service area, translated materials, interpreter service usage, patient cultural assessment skills, patient education, and data collection) are key to ensuring accountability for the delivery of culturally appropriate services. Provider network strategies that

clearly outline cooperation with the MCO's cultural and linguistic program goals, as well as quality performance/reporting, also contribute to facilitating the desired outcomes.

System Dynamics. The ability to organize, coordinate, and support CLAS over time requires the managed care entity to establish internal mechanisms that sustain a continuous link among its governance/leadership, administrative, and internal/external operations to anticipate and adequately respond to competing external demands (Garcia-Caban, 2001). This internal mechanism is what ultimately constitutes and contributes to best practice features within organizations (Berwick & Nolan, 1998; Harrison, 1994). Governance policy and strategy (as inputs) serve to sanction organizational directives (arrow 1 in Figure 2) to establish and maintain CLAS processes that may be dictated or influenced by external market demands (e.g., regulators, policymakers, and consumers). Managed care organizations that establish feedback loops (arrow 1a in Figure 2) to inform governance about the need to modify structural inputs, administrative processes, or operations are essential to instituting needed actions and ensuring appropriate responses to market and consumer demands. The managed care entity must also negotiate the inputs and processes to coordinate and support provider networks (arrow 2) who, in turn, deliver care to ethnic minority consumer groups. While the MCO ultimately seeks to affect member outcomes, they are interdependent with provider networks to influence these outputs (arrow 3). The outcomes for the members and providers, as well as the financial outcomes for the MCO itself, can have an effect on both system inputs and system processes (arrow 5). Thus, the MCO is in a precarious position of having to simultaneously manage and balance outcomes that are not only relevant to members and its contracted provider network, but also are critical to its own survival in the marketplace (arrow 4). The pilot study examined the dynamics of this system mechanism as a means to explore the relationship among the inputs, processes, and outputs outlined in the systems model.

To meet the needs of their customers, it is important for an MCO to have an overall strategy that is focused on the customer. While it is difficult to see the mindset of an organization in its documents, some specific documents and interaction with management at the Alliance, during the October 2002 site visit and subsequent interviews, were able to give an indication as to the focus of the organization. The mission statement of the Alliance's C&L

program can give an idea of the program's focus. The C&L mission statement of the Alliance lacks a specific customer focus. The statement seems to focus more on system outcomes rather than on member outcomes. The parts that do speak to members are vague in addressing the cultural needs of the members. After discussions with Alliance management, however, it seems that, in fact, a large emphasis is placed on the customer. Discussions revealed that the Alliance has made a commitment to serve the traditionally underserved, and toward that end the Alliance sees cultural and linguistic services as an essential part of providing high quality care to the community they serve.

The Alliance's focus on their customers has resulted in their attaining nearly 70 percent of the market share for health care in Alameda County. The Alliance has attempted to increase services to members whenever possible. They have also made a decision that when faced with budget restrictions they will look to become more efficient internally, rather than cutting services to members or increasing costs. This policy has helped lead the Alliance to administrative costs of around 9 percent, one of the lowest rates for a health plan in California.

The Alliance's customer focus is manifest in several areas. One such area is interpreter and translation services. The Alliance has offered these services since its inception and has made great efforts to see that they are utilized to the greatest advantage of their members. Another way the Alliance is able to focus their policies toward their customers is to conduct a community needs assessment. The Alliance is contractually obligated to conduct two group needs assessments. The Alliance uses the data gathered from these assessments to determine the needs of the community they serve, and then to act to fill these needs. For the Alliance, filling these needs to improve health outcomes and correct health disparities for their members is an important business strategy.

The Alliance also connects with members through partnerships with the community. The Alliance's Community Advisory Committee has member representatives from various segments of the community. Also, representatives from the Alliance are involved in many community activities and events. In these ways the Alliance, as an MCO, has committed to working *with* their members rather than merely *for* them.

C. Analysis of Selected Alliance Operations

In addition to examining Alliance implementation of activities that address each of the CLAS standards, selected services and activities were examined and their component parts and relationships among those parts were noted. While there remain other services and activities that the Alliance conducts on a daily basis, descriptions showing the links between system inputs, processes, and outcomes were developed for four functions relating to CLAS:

- CLAS management strategy
- Provider network management
- Data collection and quality monitoring
- Language services

The following sections address the findings from each of those components.

CLAS Management Strategy

At the larger organizational level, the Alliance attempts to integrate culturally and linguistically appropriate health care services across all departments. The Alliance aims to meet and exceed contractual and regulatory requirements, and strives to model best practices to inform local, State, and national policy. The Alliance attempts to create a health plan infrastructure that supports, develops, implements, and perpetuates services that are responsive to the cultural and linguistic diversity of health plan members. The Alliance does this by gaining commitment from the CEO and Board of Governors, as well as, assuring that plan staff, at all levels, are reflective of the cultural, racial, and linguistic profile of Alameda County and of plan members. The Alliance also actively involves plan members and the community in the development of services, through conducting member surveys and maintaining on-going committees with member and community representatives.

The Alliance approaches CLAS from both the top down (through an official C&L department and program director), and from the bottom up (in that every department has a hand in the C&L activities with which it is associated). This approach gives a focus and drive to

C&L, while at the same time making sure everyone is invested in providing culturally and linguistically appropriate services as a good business practice rather than just an edict handed down from management.

The Alliance does not view CLAS as an addendum or something separate from their day-to-day operations, but rather as a part of doing business. The Alliance's CLAS management strategy involves three inter-related components: member services, culture and language competence, and market growth (see Figure 3). The CLAS management strategy is guided by the C&L program's mission statement which, in turn, helps to define the C&L program's operational work plan. That work plan includes goals and objectives addressing virtually every type of service delivered by the Alliance—translation; interpreter services, grievance monitoring; QIP's; staff training; monitoring regulatory compliance; and data collection and management for race, ethnicity, and language. Finally, through the efforts of interdisciplinary workgroups formed at the Alliance, specific C&L activities are defined and implemented.

The Alliance CLAS Management Strategy addresses 4 of the 14 CLAS standards:

Standard 1:	CLAS Definition Statement
Standard 2:	Workforce Diversity
Standard 8:	CLAS Management Strategy
Standard 14:	CLAS Reporting

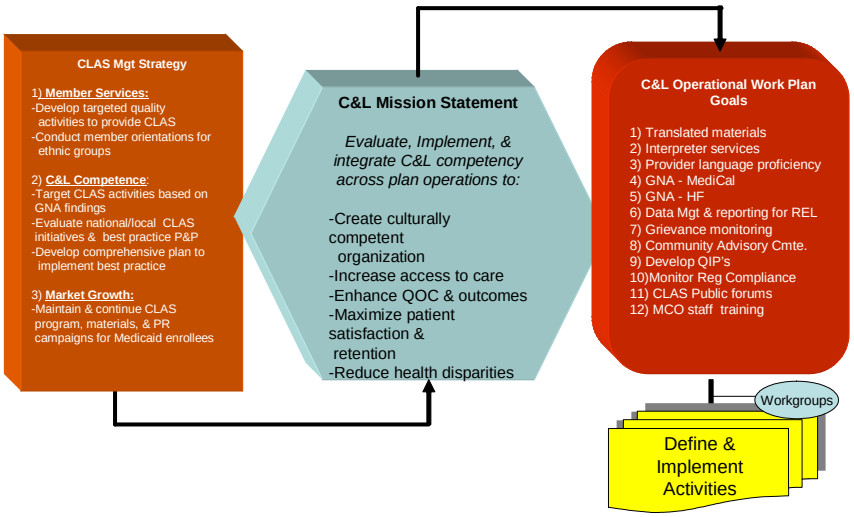
The first standard is addressed by the presence of a mission statement that incorporates language designed to reflect consumer values, preferences, or needs. The Alliance C&L program mission statement reads:

> *Evaluate, implement, and integrate culture and language competence across plan operations to:*
>
> - *Create a culturally competent organization*
> - *Increase access to care*
> - *Enhance quality of care and outcomes*

- *Maximize patient satisfaction and retention*
- *Reduce health disparities.*

The second standard is addressed by having a culturally and linguistically diverse and competent staff, along with materials and services, designed and developed in multiple languages and consistent with the cultural norms and values of the communities served. The Alliance demonstrates this diversity through the qualifications and characteristics of the staff, as well as materials and services that the Alliance provides its members and provider organizations. Standard 8 addresses the Alliance's plans to manage their CLAS activities. Three important

Figure 3: Alliance CLAS Management Strategy



components of CLAS management are clearly defined goals for ethnic subgroups and a relationship to the mission statement, operational plans (including specific tasks and activities) for ethnic minority subgroups, and the formation and operation of workgroups to carry out operational plans.

The Alliance has an operational work plan in place that is anchored in the mission statement. Further, the work plans include specific activities for all ethnic subgroups served by the Alliance. Standard 14 is addressed by the fact that the Alliance reports its CLAS activities, both in written form as well as orally, to internal and external stakeholder groups. This reporting behavior is evidenced by the variety of internal memoranda and reports the Alliance has distributed regarding the C&L program and the services of the Alliance.

Costs Associated With the Culture and Linguistics Department at the Alliance

From a cost point of view, the Alliance spends only a small portion of their overall budget on culturally and linguistically appropriate services. Table 3 summarizes some of the most important cost items available. The total overall budget for the C&L effort (including fixed direct costs such as salaries and variable direct costs associated with translation and interpreter services, and indirect costs) in FY 2002 was $409,093 and $940,492 in FY 2003 (a 230 percent increase largely due to the undertaking of special projects). For FY 2004, the Alliance estimates that the total costs of the C&L effort will be $1,191,506 (a 27 percent increase over the FY 2003 total costs).

Table 3: Selected Costs Associated With the Alliance Culture and Linguistics Program

Budget Item	FY 2002 Actual	FY 2003 Actual	FY 2004 Estimated
C&L Dept. Expense	$205,544	$158,963	$372,610
Special C&L Initiatives	$20,790	$332,916	$293,131
Translation Expenses	$89,142	$227,962	$129,765
Interpreter Services & Salary Differentials for Bilingual or Multi-Lingual Staff Skills	$93,617	$220,650	$396,000
Total C&L Expense	**$409,093**	**$940,492**	**$1,191,506**

Total Alliance Administrative Expense	$9.6 m	$11.1 m	$12.9 m
Discrete Language Access Expense (Includes Special Inititatives)	$203,549	$548,274	$585,641
Language Access Per Member Per Month Expense for LEP Members Only	$0.52	$1.18	$1.17
Other C&L Per Member Per Month Expense for All Members	$0.24	$0.41	$0.58

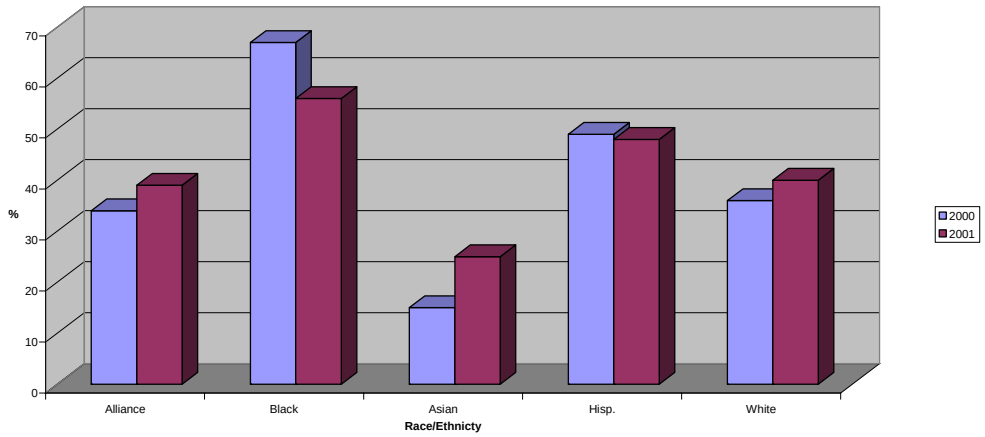
Departmental C&L salaries are the largest component of the total C&L program budget, with translation and interpreter services being the next most costly items. As a percent of total costs, the C&L program indirect costs are nearly 10 percent and have been decreasing since 2002. The expenses related to C&L have increased during this 3-year period due to special projects and to deliberate efforts to promote the use of interpreters, especially from 2002 to 2003. The costs for translations and interpreters are also determined largely by the number of non-English-speaking members. Since the Alliance accurately captures members' language needs, a per member, per month expense can be calculated for the 45-48 percent of total membership, which is non-English or limited English speaking.

These costs do not discretely include the cost of non-C&L staff time spent in meetings or activities, which cover C&L topics, training, specific problem resolution or overall C&L-related strategies. As described earlier, the same approach for departmental financial accountability and oversight is applied to C&L. As such, many elements of C&L, as are financial management, are imbedded in their operational activities and aren't readily distinguishable. As a result, C&L activities don't affect their expenses appreciably and can't be segregated or expensed any more than a department manager's activities relative to her department's budget and expenditures.

Outcomes Associate With Alliance CLAS Management

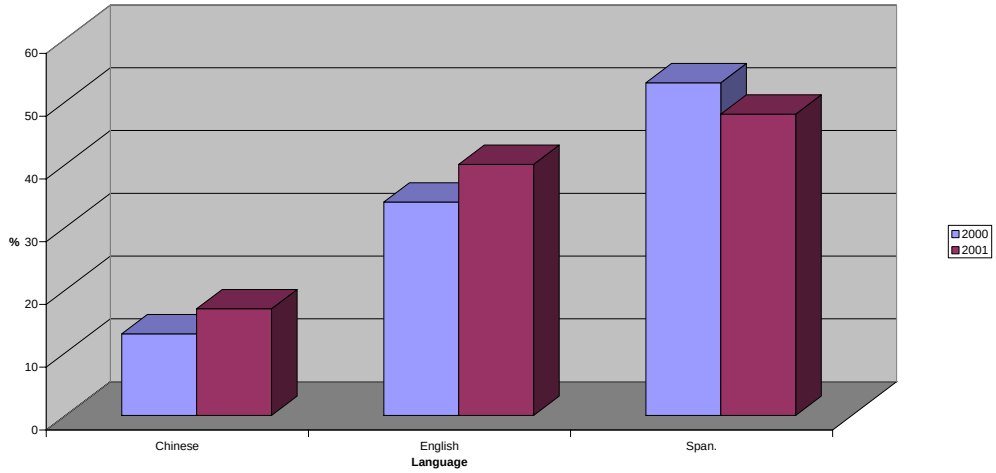
The focus of the Alliance, at the end of each day, is to provide the best possible health care for its members. As such, health care quality is a primary measure of the Alliance's success in managing their C&L efforts. Indicators of health care quality include member perceptions of the quality of the health care they receive as well as clinical indicators of health (e.g., breast cancer screening, blood lead screening, and cervical cancer screening). Figures 4 and 5 display member perceptions of their health care plan. What these figures show is that member perceptions of the quality of their health care plan varies by race/ethnicity as well as language spoken, but generally that less than half of all members believe their health plan is the best. More than half of all African-American members believe that their health plan is the best, whereas nearly half of all Spanish-speaking members also believe their health plan is the best. Figures 6, 7, and 8 show the Alliance rates for breast cancer screening, cervical cancer screening, and blood lead screening as compared to national averages. These figures show that the Alliance has increased its rates in all three of these categories and now meets or exceeds the national average. Increased screening rates could indicate that the MCO is communicating effectively with its members and increasing awareness about screening services.

Figure 4: Member Perceptions That Their Health Care is the Best by Race/Ethnicity



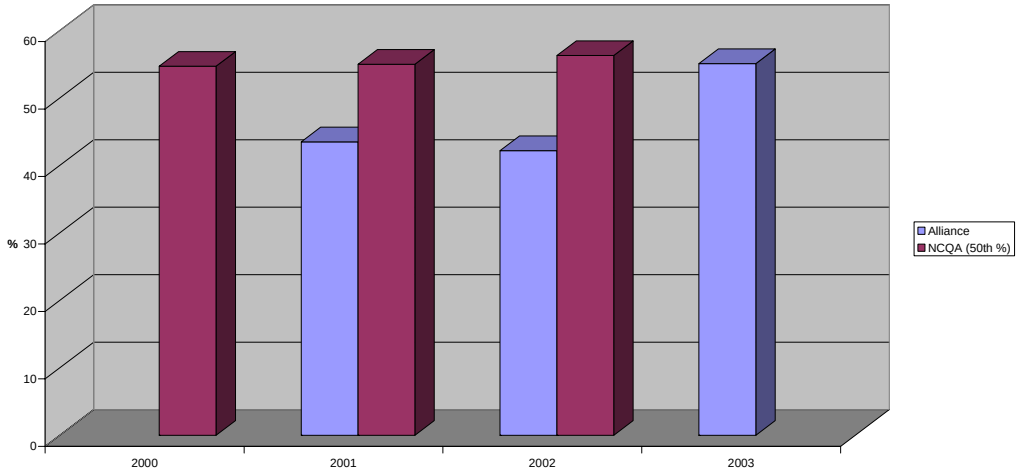
Source: ORC Macro analysis of CAHPS data[2]

Figure 5: Members Perception That Their Health Care is the Best by Language



Source: ORC Macro analysis of CAHPS data

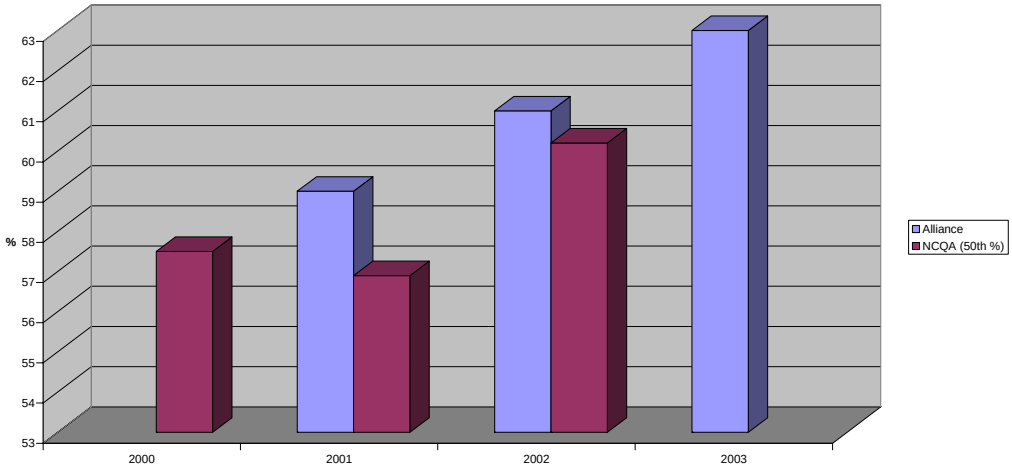
Figure 6: Breast Cancer Screening



Source: ORC Macro analysis of HEDIS data

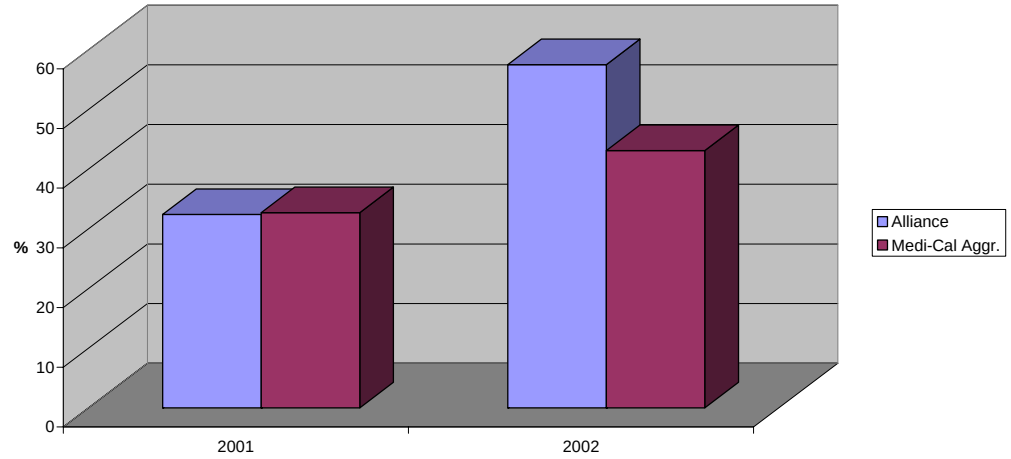
[2] All CAHPS data is based on the Alliance's Healthy Families (S-CHIP) population. These members make up about 10 percent of the Alliance's overall population, and their experiences may be different from other Alliance members.

Figure 7: Cervical Cancer Screening



Source: ORC Macro analysis of HEDIS data

Figure 8: Blood Lead Screening



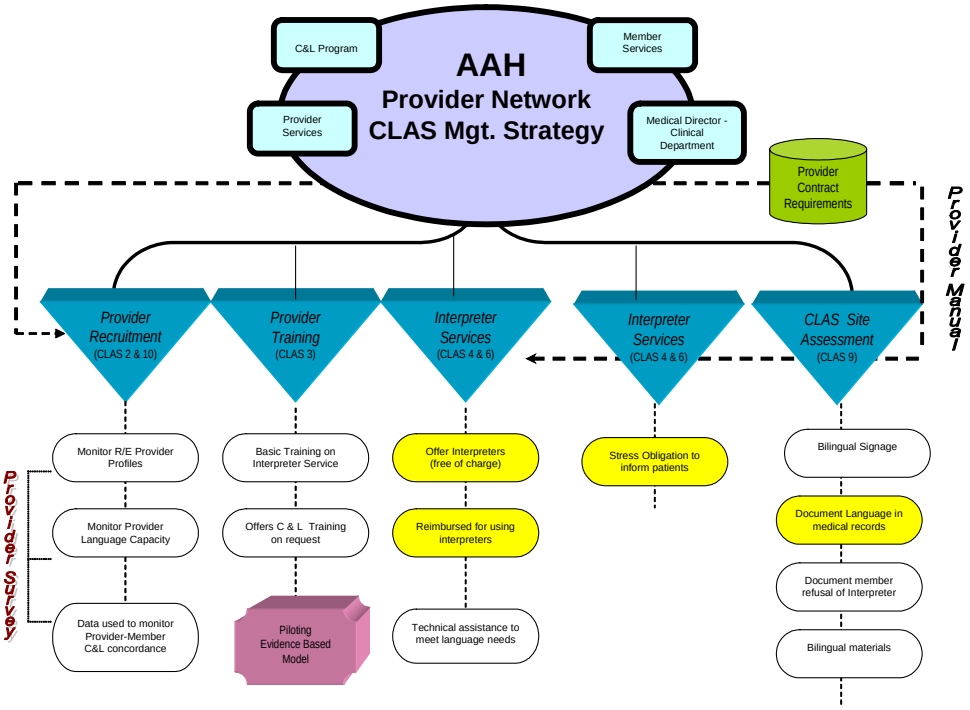
Source: ORC Macro analysis of HEDIS data

Provider Network Management

At the Alliance, the Provider Services Department, headed by the Medical Director, is the primary liaison between the health plan and its provider network. Provider services handles

provider contracting and offers training and general assistance to the provider network. They also perform the provider site assessment, which assures that providers are meeting all contractual requirements. The Alliance also monitors their providers to ensure that provider race and language capabilities are in line with those of the Alliance membership. The Alliance attempts to match members with providers with the appropriate racial, cultural, and linguistic backgrounds. Other departments at the Alliance also work with providers in organizing interpreter services, assessing provider language proficiency, and various tasks (see Figure 9).

Figure 9: Provider Network CLAS Mtg.



An MCO's contact with members typically occurs indirectly, through the providers. For this reason, an MCO's provider network management strategy is very important. Several of the CLAS Standards address, in some manner, aspects of provider network management (e.g., Standards 2, 3, 4, 6, 9 and 10). Specific aspects of the provider network are overseen by the Clinical Department, Provider Services, and the C&L program. The Alliance communicates its provider network management strategy through the provider contract requirements. Specific

methods for meeting these requirements are then explained in the provider manual and through a close relationship between the providers and the medical director (a practicing physician). A portion of the overall provider management strategy is related to CLAS issues. There are four general areas of the provider network CLAS management strategy: provider recruitment, provider training, interpreter services, and the CLAS site assessment. Members seem to be very satisfied with Alliance providers. According to CAHPS data, 73 percent of members gave their personal doctor a rating of 8 or higher on a 10-point scale.

Provider Recruitment. The Alliance, and more specifically Provider Services, monitors the race and ethnicity of providers through the provider profiles. This information, along with the language capabilities of the providers and their staff, is currently being updated through a provider survey. This survey is designed to not only determine what languages are spoken in a provider's office, but the skill level of those bilingual persons. The data gathered are then used by member services to place members with a primary care provider (PCP) with the appropriate language capabilities.

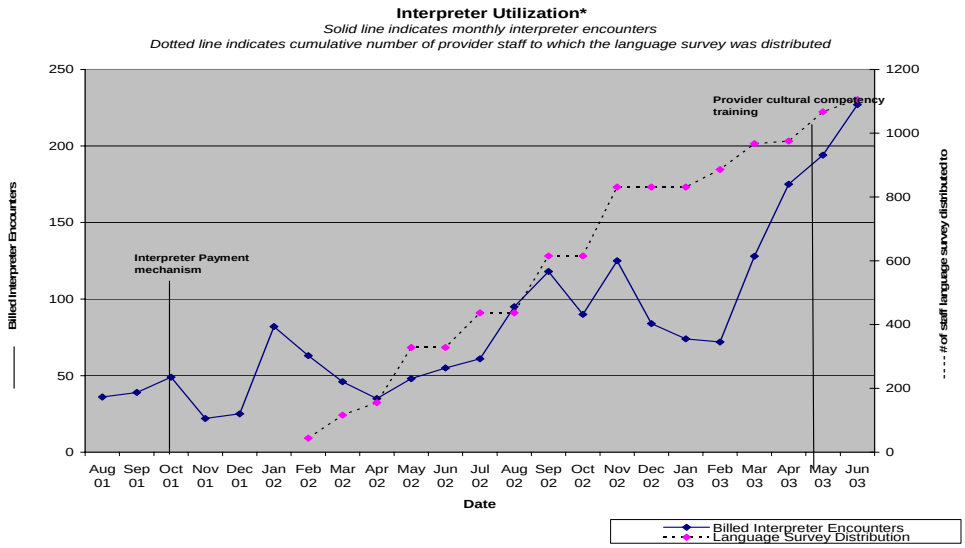
Provider Training. At present, basic training is given to providers on the use of the interpreter services. More general training on C&L issues is given at the request of the provider. Currently, with a grant from the California Endowment, the Alliance is piloting an evidence-based model for in-depth provider training in cultural competence. This study looks to make a business case for cultural competence training and monitoring of providers.

Interpreter Services. The Alliance also interacts closely with providers through the interpreter services. Providers are strongly encouraged by the Alliance to inform all members of their right to interpreter services. Interpreters have been offered free of charge to the providers since the inception of the Alliance. Recently, in order to increase the use of the interpreter services, the Alliance has initiated a policy to give incentives to providers who use an interpreter. Provider contracts require the provider to ensure access to a trained medical interpreter for all limited/non-English-speaking members. The procedure for gaining access to and use of interpreters is explained to providers via the provider manual. The following outcome data analysis is an excerpt from a report produced by the Alliance (2003).

Outcome data from the Alliance Provider Language Survey. The Provider Language Proficiency Survey was designed to assist the Alliance provide language appropriate services to its members. The Alliance began conducting the survey in January 2002. The survey consists of a structured questionnaire designed to collect information on provider staff levels of writing, speaking, and reading proficiency/fluency in languages other than English. It is important to underscore that the context in which respondents were asked to rate their proficiency was in healthcare concepts. In addition, the survey collects demographic information such as gender, race, and ethnicity. Finally, the survey gathers information regarding the use of other languages resources, such as interpreter services and translated written documents.

Increase in Interpreter Services Utilization. Data suggests that the language survey may have helped raise awareness of the availability of the Alliance's interpreter services among Alliance providers. The graph below (Figure 10) shows that the number of billed encounters for professional interpreter services has increased along with the number of language survey distribution. This correlation suggests that the dissemination of the language survey may have the effect of increasing awareness of the Alliance interpreter services among providers and their staff. Although it is difficult to pinpoint a causal relationship between the language survey and utilization levels, we believe that this effect is partly attributed to the language proficiency survey (a more detailed analyses is provided in another report, *Interpreter Utilization*).

Figure 10: Increase of Billed Interpreter Encounters After Language Survey Implementation



Provider Directory. The language survey collects information on language proficiency of providers and their staff. The Alliance will use this information to more accurately update and list the languages spoken by providers and their staff. The Alliance network of providers will be informed that information in the language survey will be used to list languages in the provider directory and that if they want their language skills to be listed, they would need to complete the survey. Language proficiency in provider offices will be updated every 6 months as part of the normal verification process of the update of the Provider Directory.

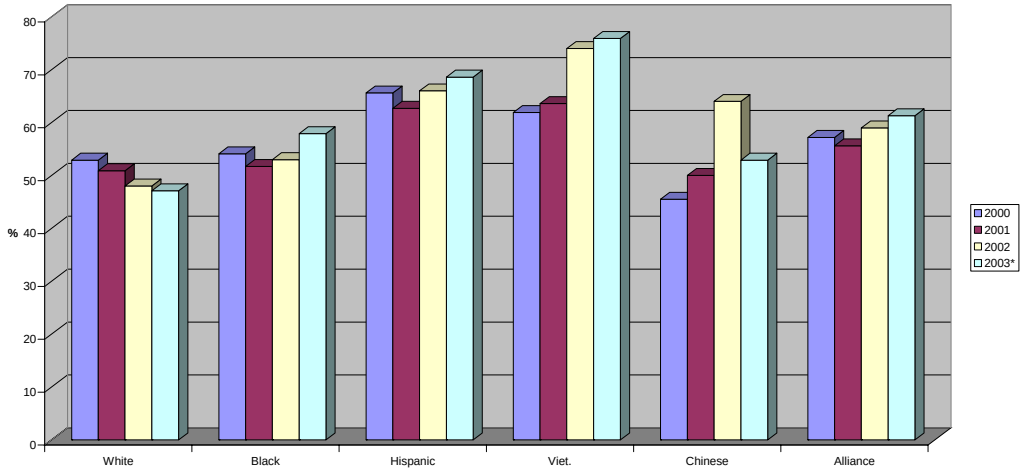
Overall, these efforts are invaluable and serve to reduce cultural barriers to health care among Alliance members. Therefore, continued efforts at the Alliance are warranted as are further analyses and comparisons of data collected at different points in time to fully understand the impact of language-appropriate healthcare service delivery.

CLAS Site Assessment. Provider CLAS activity is monitored through the provider site assessment conducted when the provider is first contracted and then every 2 years. The site assessment reviews several areas related to CLAS. Providers are contractually required to document member language in their medical records. Providers must also document whenever a

member refuses the use of an interpreter. The site review also is used to determine whether the provider has bilingual signage at the facility and that bilingual materials are provided for members.

Since providers are the ones ultimately responsible for the health care of the members, member clinical outcomes can be a reflection of the effectiveness of the providers. The figures below show some selected clinical outcomes. Immunization rates at the Alliance have increased between 2000 and 2003 overall and for all racial and ethnic sub-groups, except for the White population. The figures also show that prenatal and postpartum rates have increased from 2001 to 2003 to come in line with national averages. Well-infant visit rates increased overall for the Alliance from 2001 to 2002 with Hispanic and Vietnamese populations having the highest rates at the Alliance, although rates for Chinese are still below the Alliance average.

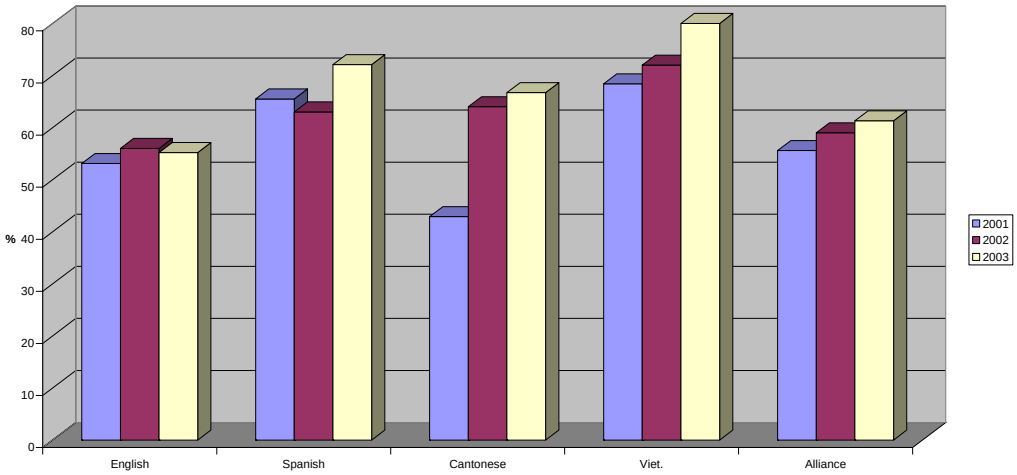
Figure 11: Immunizations by Race



Source: ORC Macro analysis of HEDIS data[3]

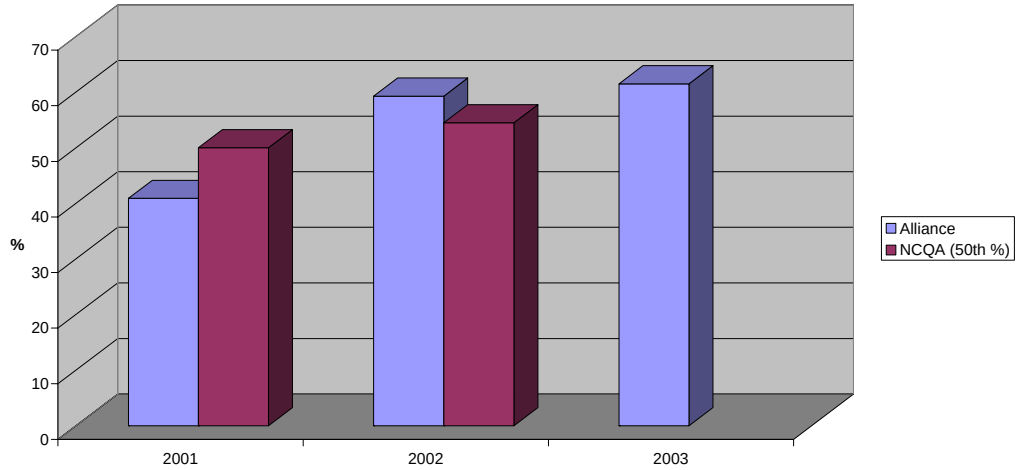
[3] HEDIS samples were not stratified by subgroups and should therefore be viewed with appropriate caution.

Figure 12: Immunization by Language



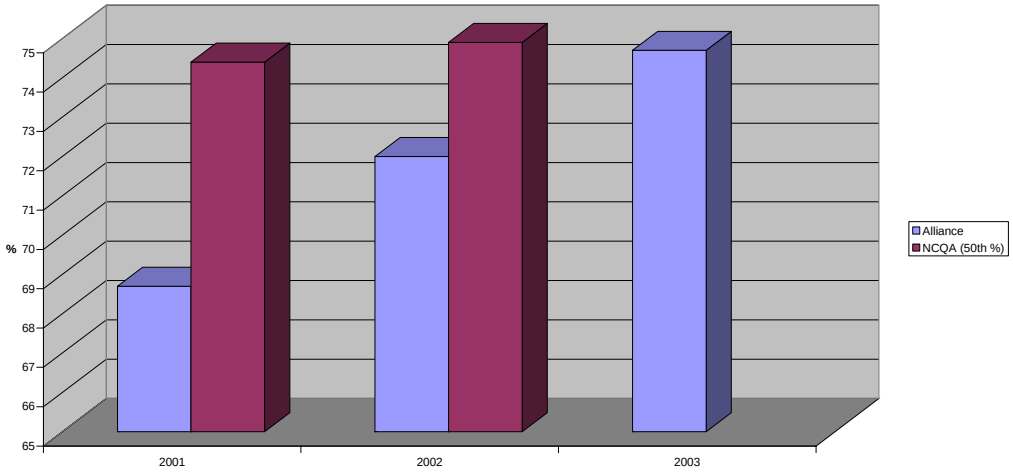
Source: ORC Macro analysis of HEDIS data

Figure 13: Postpartum Care



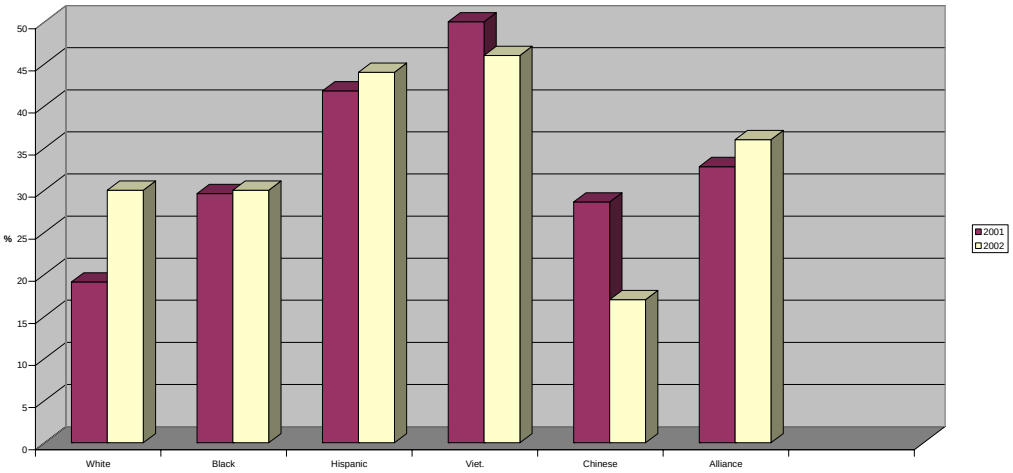
Source: ORC Macro analysis of HEDIS data

Figure 14: Prenatal Care



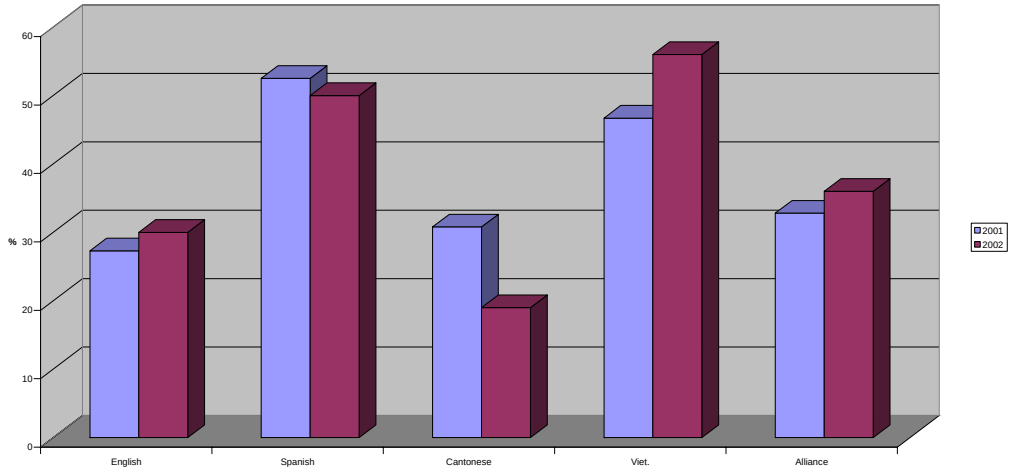
Source: ORC Macro analysis of HEDIS data

Figure 15: Well-Infant Visits by Race



Source: ORC Macro analysis of HEDIS data from Alliance MediCal members

Figure 16: Well-Infant Visits by Language



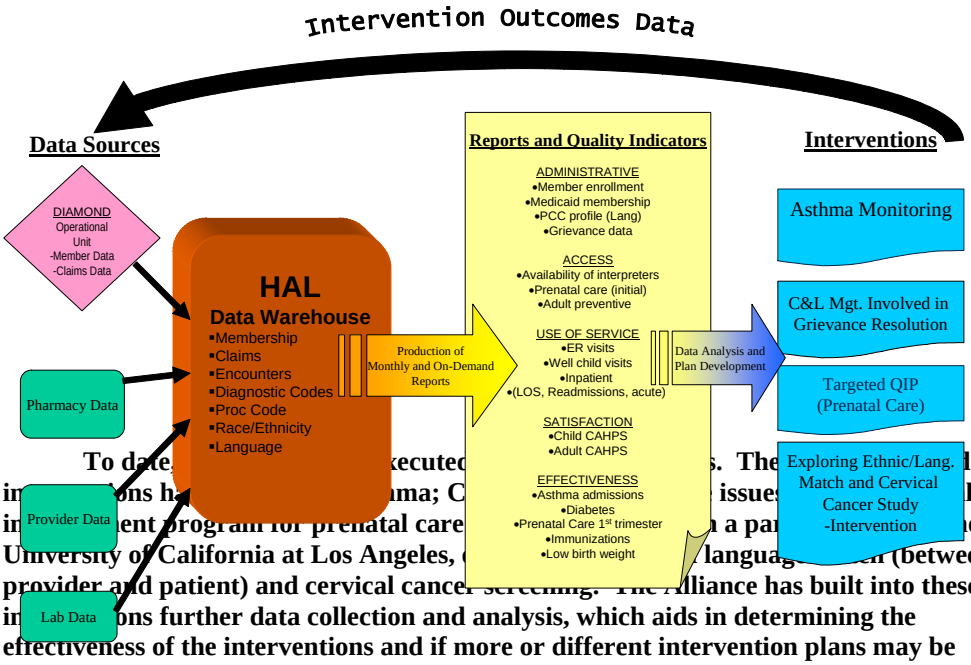
Source: ORC Macro analysis of HEDIS data from Alliance MediCal members

Data Collection and Quality Monitoring

Data collection and tracking at the Alliance includes various cultural and linguistic information items that are then coded, sorted, and entered into a centralized, automated data warehouse system. Data is entered into the Health Access Library (HAL) system from various databases including subcontracted databases (pharmacy and lab data) as well as the Alliance's Diamond database, which is the Alliance's operational database used to gather member enrollment, capitation data, and claims processing. The Alliance also has a separate Provider Database for storing data about the provider network. The HAL system is used to generate monthly management and on-demand reports as needed for administrative purposes (e.g., member enrollment), health care access (e.g., availability of interpreters), service utilization (e.g., inpatient Length of Stay (LOS) and readmissions), member satisfaction, and medical care effectiveness. Cultural identity (i.e., race and ethnicity) and language are coded and stored in the HAL data system from a variety of sources including Medicaid and S-CHIP. Careful examination of the HAL data system reveals a number of important domains of data that are collected and maintained by the Alliance. The major domains include membership, claims, encounters, diagnostic codes, procedure codes, race/ethnicity, and language.

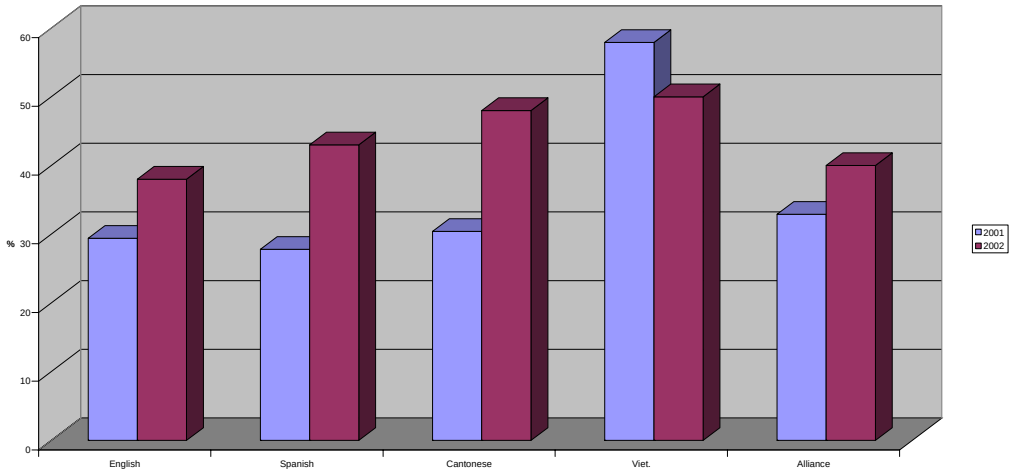
The Alliance is able to produce reports from HAL on demand. It is able to generate these reports customized to the specifications of the user (e.g., all African Americans under age 12 with an emergency asthma admittance this year). These reports are often used as quality indicators by staff at the Alliance. Reports from HAL on asthma admissions, diabetes, prenatal care, immunizations, and low birth weight, as well as data garnered from other sources (e.g., HEDIS, grievance reports, and patient satisfaction surveys) are analyzed in order to determine where specific quality interventions would be most effective. Grievance, patient satisfaction, and HEDIS data are gathered and analyzed by REL. In this way, the Alliance is able to find specific REL health disparities among their members. The Alliance then develops a plan for intervention that attempts to remove these disparities.

Figure 17: Data Collection and Quality Monitoring



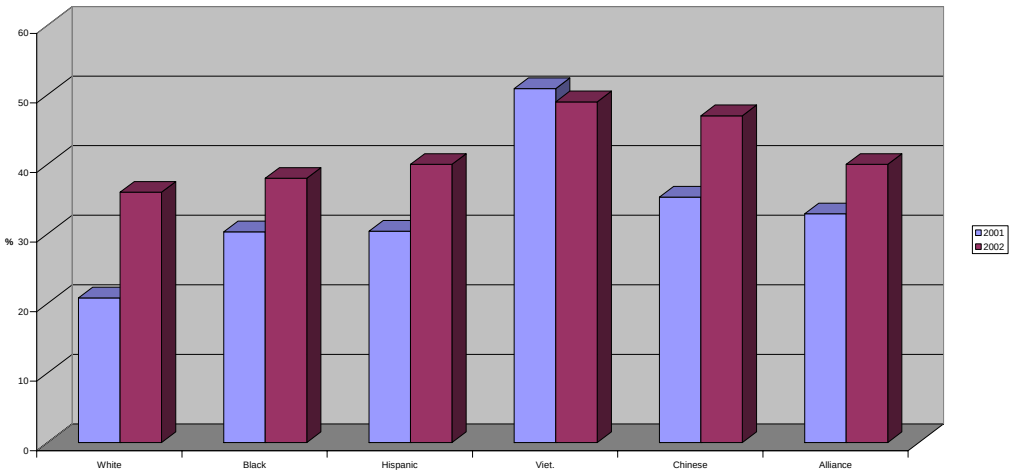
To date, executed s. The l in ons ha ma; C issues lity in ent program for prenatal care a par e University of California at Los Angeles, language en (between provider and patient) and cervical cancer screening. The Alliance has built into these in ons further data collection and analysis, which aids in determining the effectiveness of the interventions and if more or different intervention plans may be needed. This feedback loop allows for an ongoing quality monitoring process. The figures below show some of the clinical outcomes data collected by the Alliance broken down by both race/ethnicity and language.

Figure 18: Well-Adolescent Visits by Language



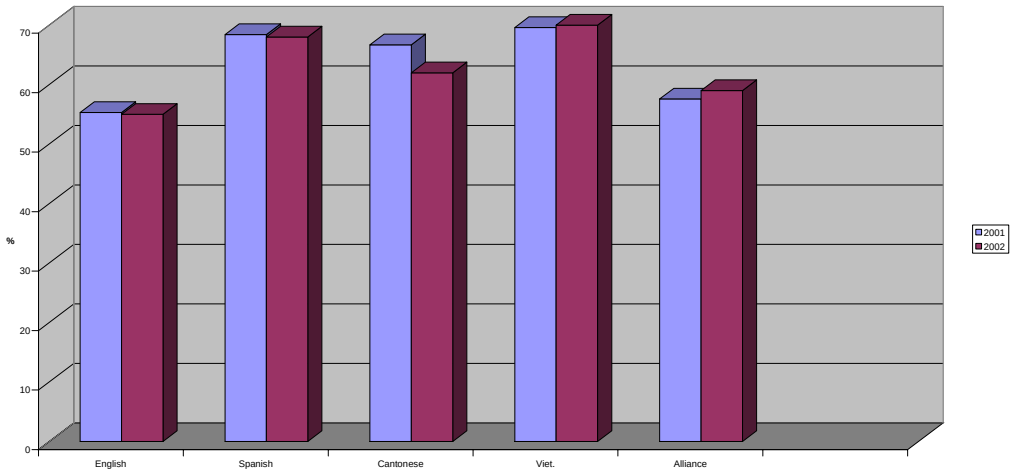
Source: ORC Macro analysis of HEDIS data

Figure 19: Well-Adolescent Visits by Race



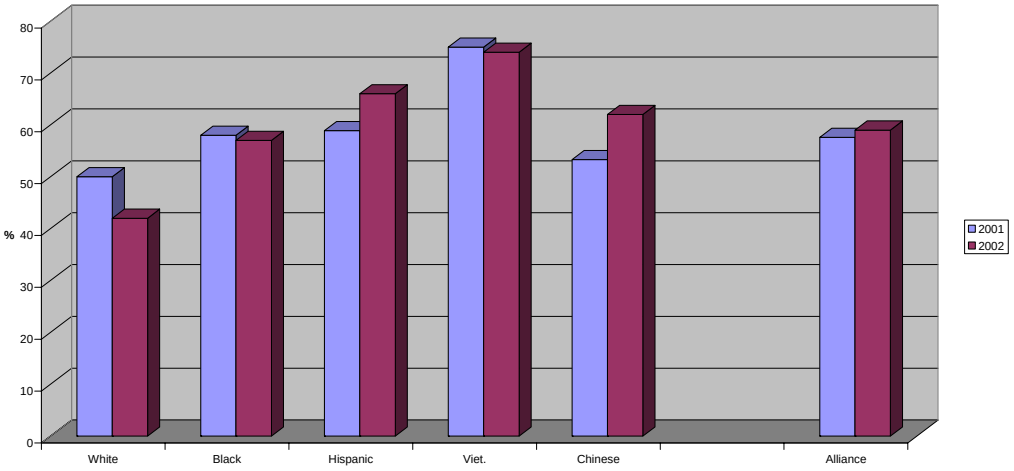
Source: ORC Macro analysis of HEDIS data

Figure 20: Well-Child Visits by Language



Source: ORC Macro analysis of HEDIS data

Figure 21: Well-Child Visits by Race



Source: ORC Macro analysis of HEDIS data

Language Services

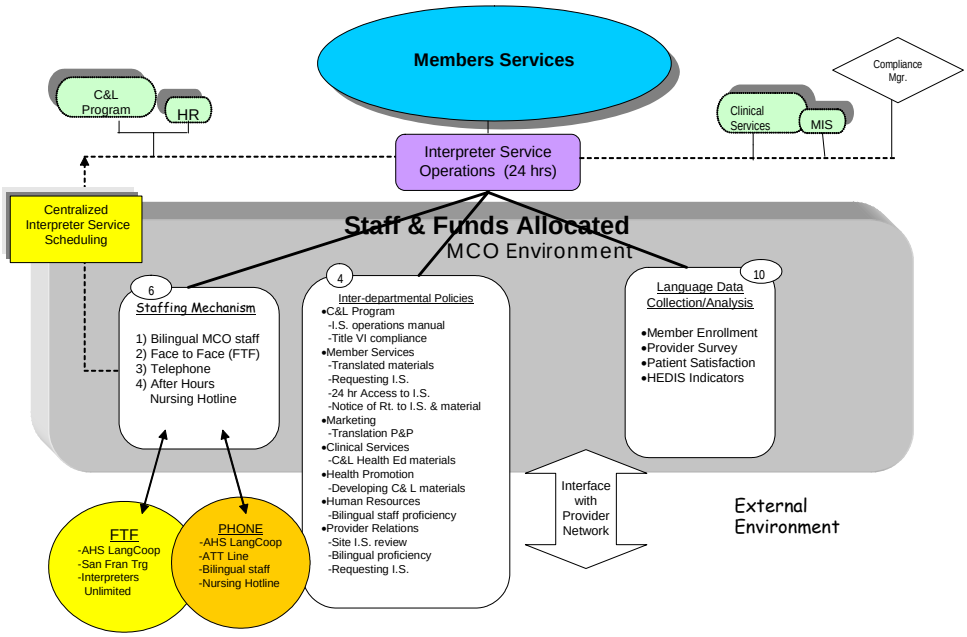
Descriptions of interpreter services and translation services were developed as a result of a systematic analysis of the Alliance documents and discussions with senior management staff at the Alliance during the October 2002 site visit. These descriptions discuss how the Alliance is

operationalizing interpreter services that address CLAS Standards 4, 6, and 10 and translation services that address CLAS Standards 5 and 7.

Interpreter Services

The interpreter services framework is composed of three major components operating within the MCO environment; two major interfaces with the external environment (interpreter service vendors and the provider network); oversight and management provided by Member Services; as well as the involvement of other Alliance divisions and offices, including the CFO/legal, C&L program, Operations, Human Resources, Marketing, Information Systems, and Clinical Services (see Figure 22).

Figure 22: Interpreter Services



The organizational documents suggest a formalized structure under-girding the interpreter services, as well as centralized and formal processes regarding interpreter service coordination and communication. The Alliance documentation also provided evidence of

interpreter services operating on a 24-hour basis and reportedly being responsive to the needs of members and providers when utilized.

The three components of the interpreter services are as follows:

- Staffing (addresses CLAS Standard 6)
- Inter-departmental policies and procedures (addresses CLAS Standard 4)
- Language data collection and analysis (addresses CLAS standard 10).

Staffing. The organizational documents evidenced a variety of interpreter services staffing mechanisms, including bilingual Alliance staff, face-to-face and telephone interpretation services provided by a private vendor, and an after-hours nursing hotline. Many, if not all, of these services are coordinated and managed by Member Services. However, Member Services is responsible for coordinating the efforts of a number of other staff from different organizational functions, including the C&L program, clinical services, human resources, and information services.

Inter-organizational Policies and Procedures. The organizational documents provided evidence of formal policies addressing or relating to interpreter services across a variety of Alliance functions, including the C&L program, member services, marketing, clinical services, health promotion, human resources, and provider relations. Information gathered at the October 2002 site visit further clarified that interpreter services operations were managed by Member Services and, that the various functional areas, departments, and programs of the Alliance were involved in assisting with the implementation of the interpreter services and/or were benefactors of those services within the organization.

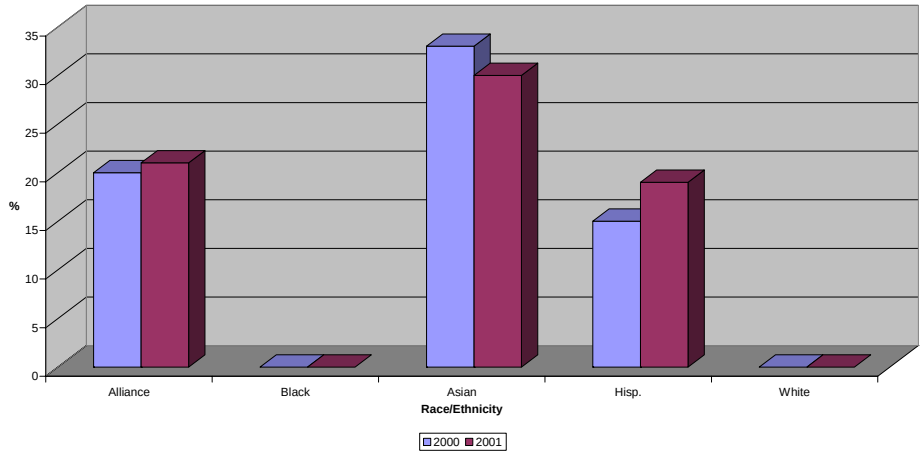
Language Data Collection and Analysis. The third component of interpreter services is language data collection and analysis (addresses CLAS Standard 10). The organizational documents reviewed showed that the Alliance collects and analyzes data regarding the languages spoken by members and providers via the member enrollment forms, provider survey, member satisfaction surveys, and HEDIS indicators.

Review of data collected and analyzed from CAHPS and HEDIS in 2001 and 2002 show that nearly one-fifth of all members require an interpreter to talk with their doctors (see Figure 23). This figure also shows that nearly 30 percent of all Asian-American members and less than 20 percent of all persons of Hispanic heritage report requiring an interpreter to talk with their doctors. Review of responses to this same question by language (Figure 24) shows that approximately 10 percent of the English-speaking members, 20 percent of the Spanish-speaking members, and nearly 35 percent of Chinese-speaking members report needing an interpreter to talk with their doctor.

Figure 25 shows that a vast majority (approximately 80 percent) of those members requiring an interpreter actually receive one.

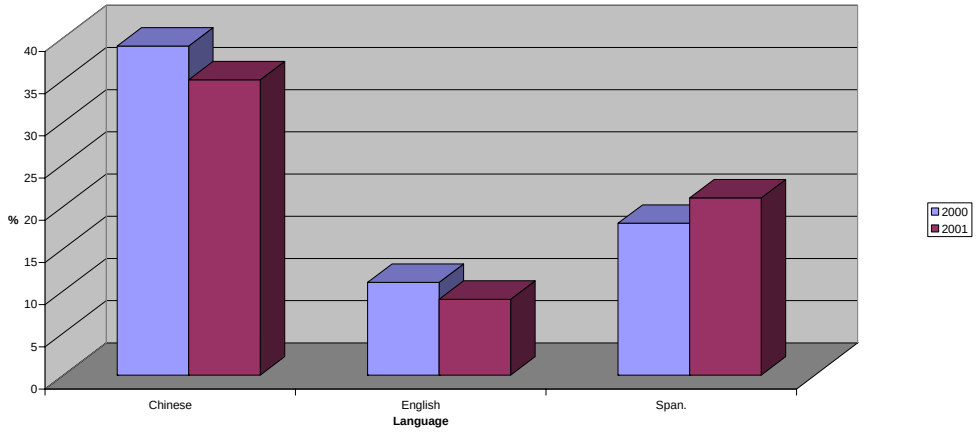
- Few members report difficulty understanding doctors
- Many members report doctors explain things to them sufficiently
- Nearly half of all members report the Alliance health care as the best (more than half of all African Americans and less than one quarter of all Asian Americans)

Figure 23: Percentage of Members Who Need an Interpreter to Speak With Doctors by Race/Ethnicity



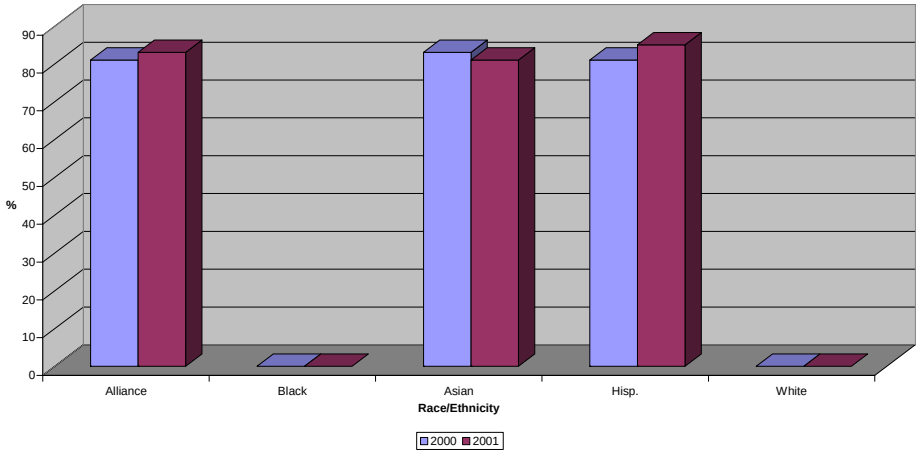
Source: ORC Macro analysis of CAHPS data

Figure 24: Percentage of Members Who Need an Interpreter to Speak With Doctor



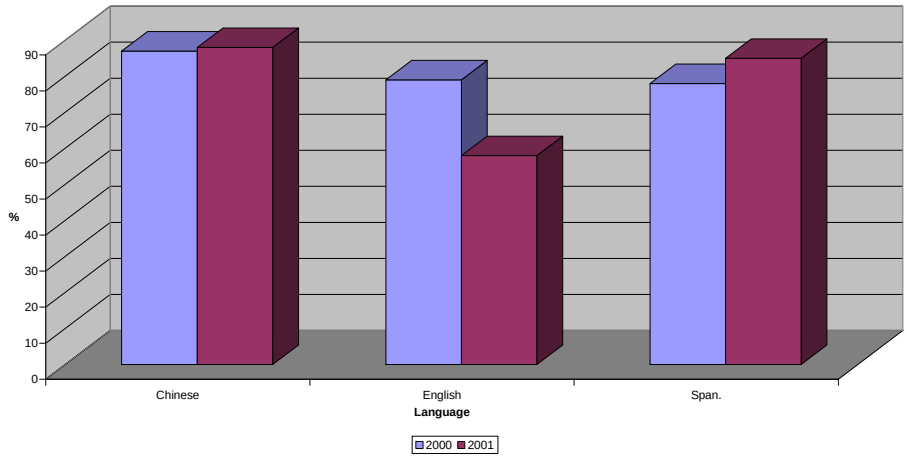
Source: ORC Macro analysis of CAHPS data

Figure 25: Percentage of Members Who Usually or Always Receive an Interpreter When Needed by Race/Ethnicity



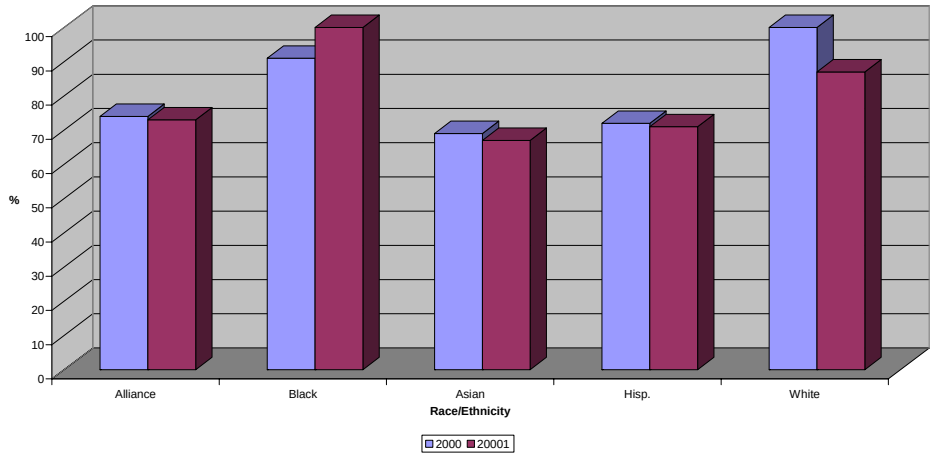
Source: ORC Macro analysis of CAHPS data

Figure 26: Percentage of Members Who Usually or Always Receive an Interpreter When Needed by Language



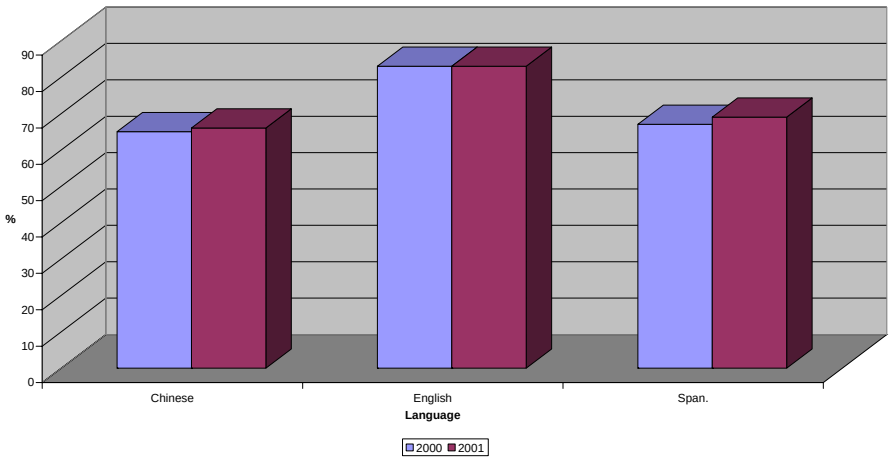
Source: ORC Macro analysis of CAHPS data

Figure 27: Percentage of Members Who Report Never Having a Hard Time Speaking to or Understanding Doctors by Race/Ethnicity



Source: ORC Macro analysis of CAHPS data

Figure 28: Percentage of Members Reporting Never Having a Hard Time Speaking to or Understanding Doctors by Language



Source: ORC Macro analysis of CAHPS data

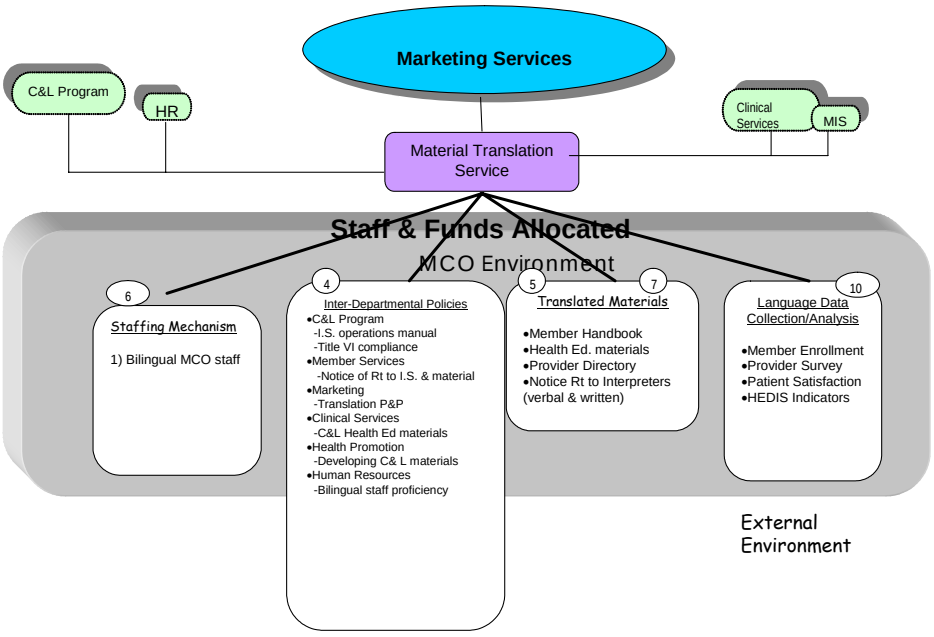
Translation Services

This description of translation services explains the Alliance's functional areas associated with delivering translated materials to Alliance members as well as Alliance staff. Evidence uncovered during the systematic analysis of the Alliance documents included descriptions of translated materials such as the member handbook, health education materials, the provider directory, and written as well as verbal translations of the notice to members regarding the right to interpreters. That evidence also provided organizational information regarding the staffing, policies, and procedures established for translation services, and information management within the Alliance, as well as information regarding how the Alliance interfaces with providers through Provider Relations staff.

Translation services are similar to interpreter services in that both require staffing, policies and procedures, and language data collection and analysis functions. The translation services function at the Alliance is managed by the Marketing division, and as such, staff from the Marketing division are dedicated to the task of translation of Alliance materials. Other functions within the Alliance (such as Clinical Services, Health Promotion, Provider Relations) that impact

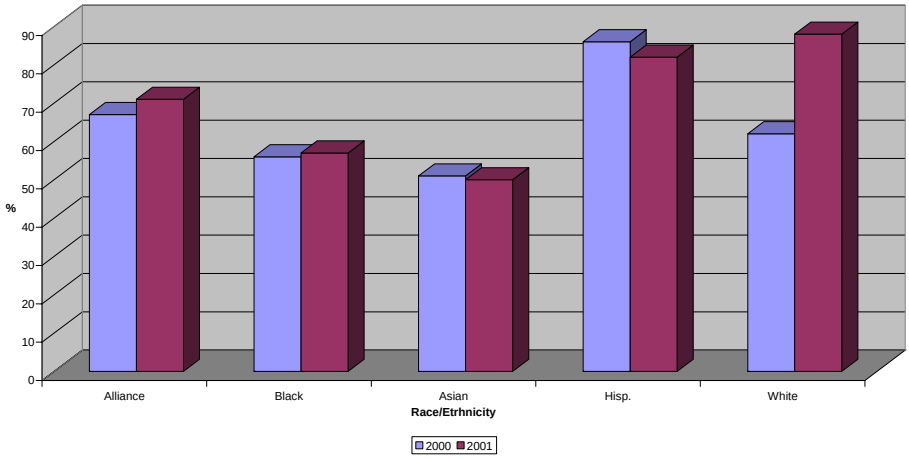
the materials translated or use those materials are managed and coordinated by the Marketing division (see Figure 29).

Figure 29: Translation Services



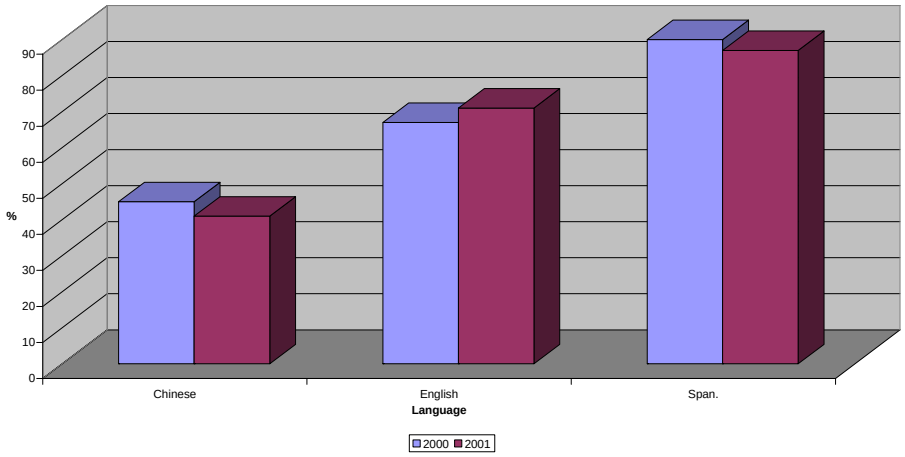
Review of available data suggests that more than half of all Alliance members can find and understand the written materials developed by the Alliance (Figures 30 and 31). Specifically, approximately 50 percent of all Asian-American and African-American members reported having no trouble finding or understanding Alliance written materials, and approximately 80 percent of all Hispanic and Caucasian members reported the same experience. By language spoken, less than 40 percent of Chinese-speaking members, less than 70 percent of English-speaking members, and more than 80 percent of Spanish-speaking members reported having no trouble finding or understanding written materials developed by the Alliance. It is important to note that the Alliance translates *all* written materials developed for members and providers into their threshold languages (for MediCal: English, Spanish, Chinese, and Vietnamese).

Figure 30: Percentage of Members Having No Problems Finding or Understanding Written Materials by Race/Ethnicity



Source: ORC Macro analysis of CAHPS data

Figure 31: Percentage of Members Having No Problems Finding or Understanding Written Materials by Language



Source: ORC Macro analysis of CAHPS data

V. Translation of Findings and Lessons for the Field

Culture and language are vital factors in how health services are delivered and received. It is important for health care organizations, including managed care organizations, to understand and respond sensitively to the needs and preferences of culturally and linguistically diverse

patients/consumers. When organizations fail to understand these needs and preferences, it can lead to significant health consequences.

Close examination of the Alliance's implementation of the CLAS Standards provides some clues as to how managed care organizations may provide culturally and linguistically appropriate health care services. The following is an annotated list of lessons learned from the case study of the Alliance.

- CLAS as operational philosophy—a way of doing business. While the CLAS Standards do not specifically suggest that health care organizations and providers make the Standards the foundation of their operating philosophy, the Alliance did just that. In part because of the strong leadership and vision at the Alliance, and in large measure because the Alliance sees the CLAS Standards as complimenting their operations; CLAS and cultural competency are an integrated part of the Alliance strategy. One example of this integrated approach is the fact that all staff, provider organizations, and providers themselves are offered and encouraged to participate in cultural competency training, learn a second language, and understand the cultural values of the population they serve in Alameda County. Training programs have been developed to ensure that staff and providers can understand, communicate with, and fully assist their members. Meetings among staff are held to discuss new and emerging, as well as existing cultural or linguistic issues and their effective solution. Services, programs, and interventions are designed and developed regularly to address member and provider concerns and to improve the quality of health care for the Alliance members.

- Implementation involves the entire organization—not just member services or the medical staff. Implementation of the Alliance's C&L program/philosophy involves the work of virtually every organizational entity at the Alliance. The C&L department, member services, marketing services, executive/management team, clinical services, human resources, management information systems, compliance services, and other professional and administrative support services all contribute to implementation of the CLAS Standards at the Alliance. The Alliance staff regularly meet in interdisciplinary

workgroups to address a variety of quality of health care issues. Furthermore, data is gathered and analyzed on a regular basis to examine trends in health care among the various cultural and linguistic groups served by the Alliance in order to develop responses designed to improve access, service delivery, and outcomes. Additionally, different combinations of departments work together to provide a specific service—for example, Member Services, the C&L program, Provider Services, and the Accounting Services groups work together to deliver interpreter services for provider and members.

- Map each organization's component parts and their contributions to CLAS implementation. Health care organizations (including managed care organizations) are composed of a number of departments and services that contribute to the overall success or failure of the organization. As such, when examining an organization's implementation of CLAS, it is important to understand each department or service's independent as well as shared contributions to meeting CLAS goals and objectives. In this project, each of the major departments and services were described in detail, particularly regarding what role they play in implementing CLAS.

- Gather, analyze and report race, ethnicity, and language data as it relates to programs and services. The CLAS Standards recommend the gathering and analysis of race, ethnicity, and language data to understand the population served, their needs, and priorities. The Alliance has established a systematic process by which race, ethnicity, and language data are regularly collected for all members and providers and analyses conducted that examine program, service, and intervention effectiveness for each of the cultural and language groups they serve.

- CLAS implementation assessment is crucial to understanding where the MCO stands. Whether it be self-assessment or assessment conducted by an outside organization, the periodic assessment of a health care organization's compliance with the CLAS Standards is valuable for understanding not only what is being implemented and how, but what impact it is having on the organization, local community, health care providers, and members. The CLAS Standards Assessment Tool (Code Tool) developed for this study

is based on a careful review of the literature and the CLAS Standards themselves. Each of the more than 180 items was developed to address a particular operational issue that is, when aggregated with other items, able to provide insight as to the nature and magnitude of the organization's CLAS implementation. Because the assessment tool has been used in a limited number of situations and cases to this point, its complete reliability and validity is still unknown. However, the systematic and objective focus this tool brings to carefully reviewing an organization's implementation of the CLAS Standards is a crucial step forward to nationwide implementation of culturally and linguistically appropriate health care services.

CLAS Standard 1—CLAS Definition Statement

CLAS Standard 1 recommends, "health care organizations should ensure that patients/consumers receive from all staff members effective, understandable, and respectful care that is provided in a manner compatible with their cultural health beliefs and practices and preferred language."

The Alliance has attempted to implement Standard 1 in the following ways:

- The Alliance has developed a mission statement for its C&L program.
- The Alliance looks to increase services to members whenever possible.
- Instead of raising costs for members or reducing services, the Alliance looks to cut costs by becoming more efficient internally.

CLAS Standard 2—Workforce Diversity

CLAS Standard 2 recommends, "health care organizations should implement strategies to recruit, retain, and promote at all levels of the organization a diverse staff and leadership that are representative of the demographic characteristics of the service area."

The Alliance implements Standard 2 in several ways:

- The Alliance advertises job openings to the public at large through mainstream media outlets, which helps to assure an applicant pool, which is representative of the diverse demographic population of their service area.
- A diverse management team within the Alliance tends to perpetuate an overall diverse organization.
- The Alliance hires bilingual staff to meet the language requirements of its members.

CLAS Standard 3—Staff Training and Education

CLAS Standard 3 recommends, "health care organizations should ensure that staff at all levels and across all disciplines receive ongoing education and training in culturally and linguistically appropriate service delivery."

The Alliance implements Standard 3 in a number of ways:

- New staff are informed of Alliance C&L policies and procedures as part of an initial orientation.
- The Alliance orients staff on cultural and linguistic developments through staff meetings, memos, and special work groups.
- Trainings have been provided in cultural competency for providers and their office staff by the Alliance, to educate providers about cultural competence and promote awareness of Alliance cultural and linguistic services.

CLAS Standard 4—Interpreter Services

CLAS Standard 4 recommends, "health care organizations must offer and provide language assistance services, including bilingual staff and interpreter services, at no cost to each patient/consumer with limited English proficiency at all points of contact, in a timely manner during all hours of operation."

In order to implement Standard 4 the Alliance has done the following:

- The Alliance has offered interpreter services free to all members since its inception.
- The Alliance provides for in-person interpreter services through several local vendors.
- Over the phone interpreters are provided by the Alliance 24 hours a day through the AT&T language line when an in-person interpreter is not available.
- Providers who use an interpreter arranged by the Alliance are given a payment to compensate for the additional time and skill required.
- Records of interpreter usage (languages requested, what type of interpretation was used, etc.) are kept and studied by the Alliance in order to monitor interpretation needs.
- Bilingual Alliance staff are hired to meet the language needs of members.

CLAS Standard 5—Notice of Right to Interpreters

CLAS Standard 5 recommends that "health care organizations must provide to patients/consumers in their preferred language both verbal offers and written notices informing them of their right to receive language assistance services."

To implement Standard 5 the Alliance does the following:

- The Alliance has developed a specific policy and procedure document outlining the various methods used to inform members of their right to an interpreter.
- The Alliance informs members in the member's preferred language.
- Members are informed in several ways including through new member welcome packets, member newsletters, and through verbal contact with the Member Services Department.
- The Alliance provides "I speak…" cards in several languages, which members use to inform providers of their language needs and ways they can be met.
- Providers are contractually obligated to inform members of their right to interpreter services.

CLAS Standard 6—Qualified Interpreters

CLAS Standard 6 recommends that, "health care organizations must assure the competence of language assistance provided to limited English proficient patients/consumers by interpreters and bilingual staff. Family and friends should not be used to provide interpretation services (except on request by the patient/consumer)."

The Alliance implements Standard 6 in the following ways:

- Contracts between the Alliance and its subcontracted interpreter services require a minimum number of training hours.
- The Alliance also requires adoption of the California Standards for Healthcare Interpreters: Ethical Principles, Protocols, and Guidance on Roles and Intervention.
- Interpreters are trained in interpretation of medical terminology.
- Providers are informed by the Alliance not to use interpreter services provided by family or friends of the patient except when requested and to never use minors as interpreters.

CLAS Standard 7—Member Materials and Translation

CLAS Standard 7 recommends that "health care organizations must make available easily understood patient-related materials and post signage in the languages of the commonly encountered groups and/or groups represented in the service area."

The Alliance implemented Standard 7 in a variety of ways:

- Alliance policy pertaining to member materials specifies that translation should be done by a translator *and* a separate editor.
- Legal and complex documents are back translated by the Alliance.
- Feedback is obtained from translators about appropriateness (culturally and politically) of the document in regard to the intended audience.
- The Alliance checks provider offices for bilingual signage during site reviews.

- Non-English documents produced by the Alliance are of the same quality as the English version.

CLAS Standard 8—CLAS Organizational Framework

CLAS Standard 8 recommends that, "health care organizations should develop, implement, and promote a written strategic plan that outlines clear goals, policies, operational plans, and management accountability/oversight mechanisms to provide culturally and linguistically appropriate services."

The Alameda Alliance for Health implemented Standard 8 in a number of different ways:

- The Alliance strategy for the management of projects relating to CLAS includes a C&L program with a dedicated full-time staff.
- The Alliance created and manages workgroups to deal with specific C&L issues, including an internal C&L task force, health plan workgroups, and a cultural competency quality improvement program workgroup.
- The Alliance created and maintains a corporate culture that reflects CLAS in staff recruitment, customer service, and business operations.
- Alliance involves the local community and patient groups in the development of the C&L Program strategic plan.
- C&L program staff meet regularly to achieve established goals and stays in communication with other departments and workgroups through interdepartmental meetings, memos, and presentations toward this end.
- The C&L program, along with other departments at the Alliance, has developed a set of policies and procedures to ensure that their strategic plan is implemented properly and that the goals of the plan can be met efficiently.

CLAS Standard 9—Organizational Self-Assessment

CLAS Standard 9 recommends, "health care organizations should conduct initial and ongoing organizational self-assessments of CLAS-related activities and are encouraged to integrate cultural and linguistic competence-related measures into their internal audits, performance improvement programs, patient satisfaction assessments, and outcomes-based evaluations."

The Alliance implemented CLAS Standard 9 in the following ways:

- **The Alliance focuses on performance monitoring to improve C&L services with targeted QIP activities.**
- **The Cultural Competence Quality Improvement Program (CC-QIP) activities focus on improving MCO structural features (e.g., information systems to better manage incoming data) as well as care coordination and delivery to members (e.g., prenatal care).**
- **The C&L program, along with other appropriate MCO departments (e.g., member information services and the clinical services department), manages the CC-QIPs.**
- **The Alliance assesses patient satisfaction on the basis of results obtained from surveys developed in-house (translated into Spanish, Vietnamese, and Cantonese), Consumer Assessment of Health Plans (CAHPS) results, and focus groups conducted with several member groups (e.g., African-Americans, Spanish speakers, Vietnamese speakers, and Chinese speakers).**
- **Patient satisfaction data are collected and stratified by race, ethnicity, and language.**
- **The Alliance conducts a quarterly cultural competence organizational self-assessment (OSA).**

CLAS Standard 10—Data Collection on Patients/Consumers

CLAS Standard 10 recommends that "health care organizations should ensure that data on the individual patient's/consumer's race, ethnicity, spoken and written language are collected

in health records, integrated into the organization's management information systems, and periodically updated."

The Alliance implemented CLAS Standard 10 in the following ways:

- **The Alliance uses an array of codes for racial, ethnic, and language groups garnered from HIPAA, Medicaid, and the S-CHIP program. They also receive most of their member data on REL from these groups.**
- **The Alliance collects data about provider REL through a voluntary provider survey; these data are then stored in the provider profile.**
- **The Alliance produces standardized reports on members and providers stratified by REL. These reports incorporate information from internal administrative reports, HEDIS reports, and CAHPS reports.**
- **Patient satisfaction data are also collected and stratified by REL.**
- **Data are collected and analyzed on specific C&L programs, including interpreter services, although this information is only stratified by racial group.**
- **Data analysis (defined as examining data collected from the organization's internal information systems [not external data such as census data] to identify and describe differences among consumer groups) is also done by REL for select measurement areas (e.g., member enrollment data, grievance data, asthma admissions, prenatal care, immunizations, breast cancer screening, cervical cancer screening, and well-child visits).**
- **The Alliance partners with academic institutions to assist in the analysis of prenatal care and cervical cancer screening among REL groups.**

CLAS Standard 11—Community Needs Assessment Profiling

According to CLAS Standard 11 "health care organizations should maintain a current demographic, cultural, and epidemiological profile of the community as well as a needs assessment to accurately plan for and implement services that respond to the cultural and linguistic characteristics of the service area."

The Alliance implemented CLAS Standard 11 in a variety of ways:

- **The Alliance completes Medicaid and S-CHIP Group Needs Assessments (GNA), each of which is contractually required.**
- **Through these two assessments, a demographic data profile of the Alliance's surrounding community is gathered, which is then stratified by race, ethnicity, and language.**
- **The Group Needs Assessment (GNAs) also provide data on the public health status of the community, which is stratified and analyzed by race and ethnicity.**
- **GNA data is also used to look at the health status profiles of each racial and ethnic subgroup.**
- **The C&L program uses the data about the community gathered in the GNAs to develop future C&L work plan goals and objectives.**

CLAS Standard 12—Community Partnerships

CLAS Standard 12 recommends "health care organizations should develop participatory, collaborative partnerships with communities and utilize a variety of formal and informal mechanisms to facilitate community and patient/consumer involvement in designing and implementing CLAS-related activities."

The Alliance implemented CLAS Standard 12 in a variety of ways:

- **The Alliance convenes a Community Advisory Committee (CAC), composed of representatives from many different sectors of the community. The Alliance's CAC includes consumers, physicians who generally serve a diverse constituency, leaders of local community-based organizations, and relevant State and local government officials.**
- **The CAC provides input to the Alliance on a range of issues involving CLAS (e.g., service planning, member materials, and marketing).**
- **The Alliance conducts focus groups with select community subgroups.**
- **The Alliance maintains close coordination and communication with community forums and coalition groups.**

CLAS Standard 13—Grievance Policy and Procedures

CLAS Standard 13 recommends "health care organizations should ensure that conflict and grievance resolution processes are culturally and linguistically sensitive and

capable of identifying, preventing, and resolving cross-cultural conflicts or complaints by patients/consumers."

The Alliance implemented CLAS Standard 13 in a variety of ways:

- **Specific policies and procedures have been developed to ensure that member grievances are addressed in a culturally and linguistically appropriate manner.**
- **The Alliance informs all members about the grievance policy in the member's preferred language through a variety of means (print, audio, and video media).**
- **The Alliance provides interpreter services for limited/non-English speaking members who wish to file a complaint or grievance.**
- **The C&L program is consulted on all grievances filed that are related to cultural and linguistic issues.**
- **The Alliance monitors grievances from specific racial, ethnic, and linguistic subgroups.**
- **The grievance procedures allow for staff-peer observation, CAC review, a Medicaid managed care ombudsman, Medicaid State fair hearing, and independent medical reviews, as necessary.**

CLAS Standard 14—CLAS Communication Strategy

CLAS Standard 14 recommends "health care organizations are encouraged to regularly make available to the public information about their progress and successful innovations in implementing the CLAS standards and to provide public notice in their communities about the availability of this information."

The Alliance implemented CLAS Standard 14 in a variety of ways:

- **The Alliance communication strategy reports to a variety of stakeholder groups, both internal (MCO staff and management) and external (members, providers, contractor, government agencies, and the public at large).**
- **The C&L program participates in dialogue at the local and national levels about CLAS issues.**
- **The Alliance engages in this dialogue already through public reporting of CLAS projects and issues.**
- **General public reporting on CLAS is done via member and provider newsletters, organizational reports and documents, stand-alone reports, print media, and conference presentations.**
- **Public reporting is aimed mainly at providers, community-based organizations, regulatory agencies, and funding sources.**
- **The Alliance uses its Web site to report information about CLAS to its members, provider network, and staff.**

VI. Conclusions and Recommendations

The Alliance's mission includes evaluation, implementation, and integration of cultural and linguistic competency throughout plan operations in order to create a culturally competent organization, increase access to care, enhance quality of care and health outcomes, maximize patient satisfaction and retention, and reduce health disparities. As part of their commitment to serve a diverse community, the Alliance has taken active steps to design organization-wide and program specific cultural and linguistic infrastructures. Toward that end, the Alliance created a C&L program with full-time dedicated staff.

The C&L program develops strategies and provides guidance in the implementation of culturally and linguistically appropriate health care services, including organizational assessment and C&L program development, a Cultural Competency Initiative, and a Linguistic Competency Initiative, as well as ongoing C&L services. The Cultural and Linguistic Competency Initiatives are programs designed to assess and train skill-based competencies among providers, and to evaluate the

effectiveness of such training on the acquisition of new skills, as well as the quality of health care. Ongoing C&L activities include translation of all member materials, payment for qualified medical interpreter services, payment to providers for the use of qualified medical interpreters, training for providers and Alliance staff, and internal consulting services to integrate and support C&L efforts across departments.

As a result of the study conducted over the past 18 months, the following conclusions were reached:

- **The Alliance has developed an infrastructure, operational principles (philosophy), policies and procedures for addressing each of the 14 CLAS standards.** Analysis of Alliance documentation and direct observation of the Alliance's implementation of the 14 CLAS Standards revealed that specific policies and procedures exist that address each of the CLAS Standards as well as programs and activities designed to achieve specific CLAS goals and objectives. Additionally, the strength of the Alliance's efforts to implement the CLAS Standards rests with the fact that the C&L program coordinates the Alliance's CLAS efforts, and that the organization takes seriously the responsibility to provide culturally and linguistically appropriate, high quality health care services for the residents of Alameda County.

- **Analysis of the Alliance case yielded five strategies and an overall system for implementing CLAS.** The overall systems model presented in Figure 2 on Page 23 is not only generally applicable to the Alliance case, but for all health care organizations as well. The model is designed to describe organizational inputs, processes, and outcomes associated with implementing CLAS Standards, as well as the relationships that exist among those systems inputs, processes, and outcomes. Further, the general systems model specifies each of its components as relating to the health care organization level, provider level, or member/patient level—important distinctions that assist in understanding how the health care organization achieves CLAS Standards.

- **The Alliance strategy for data collection and quality monitoring (i.e., the collection of race, ethnicity, and language information) has resulted in important new program efforts (interventions) that improve the quality of health care for Alliance members.**

  One of the cornerstones of successful CLAS implementation is the capability to create, adapt, and improve programs and activities serving members and providers. The Alliance has developed a sophisticated data collection, management, and analysis system that permits a better understanding of members—provider relationship and ways to improve service delivery. Language concordance studies (where the language of the member and provider are compared), analysis of cultural or language group health care needs and services, and monitoring of health indicators for each cultural and language group in the Alliance service area are but a few examples of the work conducted by the Alliance to carefully examine the various needs, expectations, and delivery of services to their members. These analyses and studies can be conducted only because the Alliance values the collection of race, ethnicity, and language data and have designed specific uses for that information as it pertains to improving the quality of health care services for their members.

- **Interpreter and translation services have experienced much success with**

Spanish-speaking members, yet less success with Chinese-speaking and other Asian-language members. Careful review of Alliance documents and analysis of available data show that the Alliance has had increasing effectiveness providing interpreter services for Spanish-speaking members since the C&L program has been in existence, yet less success with Asian-language-speaking members. As discussed previously, all materials distributed to members (and those distributed to providers for members) are translated into the Alliance's predominant languages. Available data consistently suggested that persons of Asian culture and language had more difficulty understanding their doctors, required interpreters more frequently, and were not as satisfied with the care they received as compared to English- or Spanish-speaking members.

In addition to these conclusions, the following recommendations are suggested:

- Further Develop and Disseminate the CLAS Implementation Self-Assessment Tool. The CLAS Implementation Self-Assessment Tool (based on the CLAS Criterion Rating Scales) is potentially useful as a self assessment of an organization's implementation of the CLAS Standards. In fact, CLAS Standard 9 calls for "initial and on-going organizational self-assessments of CLAS-related activities…." Based on an extensive review of the literature, review and feedback from a national panel of experts in health care, and testing in the field, the CLAS Implementation Assessment Tool is comprised of 32 items (and an overall score) designed to provide a snapshot of a health care organization's level of implementation associated with each of the 14 CLAS Standards (as well as the proposed new Standard 15: Provider Network Management).

Operationally, eight of the CLAS Standards are assessed by two or more criterion rating items (for Standards 2, 3, 6, 7, 8, 9, 10, and 15), whereas seven of the CLAS Standards are assessed by a single criterion rating item (for Standards 1, 4, 5, 11, 12, 13, and 14). The coding and scoring instructions have been developed and tested and are presented in Appendixes C and D. In order to

most effectively utilize this tool, health care organizations would need to carefully review the instructions for using the CLAS Self-Assessment Tool and identify all of the necessary materials and individuals required for a complete review. This relatively short and simple tool is presented below.

CLAS Implementation Self-Assessment Tool

CLAS CRITERION RATING

	Poor	Fair	Good	Excellent	
148. CLAS definition statement	1	2	3	4	
149. MCO diversity recruitment	1	2	3	4	
150. MCO diversity retention	1	2	3	4	
151. MCO CLAS training	1	2	3	4	
152. MCO CLAS training objectives	1	2	3	4	
153. MCO CLAS training evaluation	1	2	3	4	
154. Interpreter service P & P	1	2	3	4	
155. Notice of right to interpreters	1	2	3	4	
156. Interpreter competency training objectives	1	2	3	4	
157. Interpreter competency skill assessment tool	1	2	3	4	
158. Member materials	1	2	3	4	
159. Bilingual signage	1	2	3	4	
160. Translation P & P	1	2	3	4	
161. CLAS management strategy	1	2	3	4	
162. Operational plans for service functions	1	2	3	4	
163. Workgroup mechanisms	1	2	3	4	
164. Organizational self-audit	1	2	3	4	
165. Targeted CC-QIP	1	2	3	4	
166. Patient satisfaction	1	2	3	4	
167. Data collection by REL	1	2	3	4	
168. Data analysis by REL	1	2	3	4	
169. Demographic data	1	2	3	4	
170. Epidemiology data	1	2	3	4	
171. Community-based partnerships	1	2	3	4	
172. Grievance P & P	1	2	3	4	
173. CLAS reporting	1	2	3	4	
174. Provider network diversity recruitment	1	2	3	4	
175. Provider network CLAS training	**1**	**2**	**3**	**4**	
176. Provider training objectives		**1**	**2**	**3**	**4**
177. Provider training evaluation		**1**	**2**	**3**	**4**
178. Provider CLAS contract specs	**1**	**2**	**3**	**4**	
179. Provider manual	**1**	**2**	**3**	**4**	

Subscores:
180. OVERALL CLAS Implementation Score: _____

- Add to the CLAS Standards "Standard 15: Health care organizations should provide leadership and support for their networks of providers regarding knowledge and skill development, translated materials and interpreter services, patient education, and data collection." Health care organizations

rely on their providers to administer high quality health care in culturally and linguistically diverse settings. In order for health care providers to deliver those services efficiently and effectively, health care organizations need to recruit and manage contracts with providers, offer training, conduct provider site assessments, and give support to providers whose language and cultural competence is substandard, among other services. While several of the CLAS Standards address, in some manner, aspects of provider network management (e.g., Standards 2, 3, 4, 6, 9, and 10), there is currently no standard that addresses these and other important and specific aspects of provider network management.

- The present study represents a single case with potential application to a wider audience of health care organizations. It is recommended that additional studies of health care organizations (e.g., managed care organizations) be conducted, with particular attention paid to services and outcomes related to improved quality of health care.
- This case study has provided information on the structures and processes necessary for successful implementation of CLAS. What this study does not provide is the various implementation strategies that may be employed by different health systems to meet local demands (as well as associated costs). It is highly recommended that a national survey be conducted to fully garner the scope of implementation strategies and the costs associated with these efforts. Such a survey would provide a nationally representative sample of what health systems are doing to address cultural and linguistic barriers and what broad national policies might be needed to address pervasive problems in implementation.

Bibliography

Andrulis, D., Del Banco, T., Avakian, L. and Shaw-Taylor, Y. (1999). *The cultural competence self-assessment protocol for health care organizations and systems.* A publication of the National Public Health and Hospitals Institute. New York Academy of Medicine.

Arredondo, P. and Woy, J.R. (2002). Issues in planning organizational diversity assessment. Workshop presented at the Relevance of Cultural Assessment in Evaluation Conference. Arizona State University, Tempe, AZ.

Berwick, D.M. and Nolan, T.W. (1998). Physicians as leaders in improving health care: A new series in the *Annals of Internal Medicine*. *Annals of Internal Medicine*, 128, 289-292.

Boyatzis, R.E. (1998). *Transforming qualitative information: Thematic analysis and code development*. Thousand Oaks, CA: Sage Publishing, Ltd.

Chambers, E. and McCombs, H. (1998). *Cultural competence performance measures for managed behavioral healthcare programs.* New York State Office of Mental Health.

Coye, M. and Alvarez, D. (1999). *Medicaid managed care and cultural diversity in California*. Report prepared by the Lewin Group.

Crabtree, B.F. and Miller, W.L. (eds.). (1992). *Doing qualitative research*. Newbury Park, CA: Sage Publications, Ltd.

Cross, T. (1993). *Organizational self-study on cultural competence for agencies addressing child abuse and neglect.* Northwest Indian Child Welfare Assoc., Inc.

CWLA. (1993). *Cultural competence self-assessment instrument.* Child Welfare League of America, Washington, D.C.

Donabedian, A. (1995). The quality of care: How can it be assessed? In Graham, N. (Ed). *Quality in health care. Theory, application, and evolution.* Aspen Publications, Maryland.

Forster, N. (1994). The Analysis of Company Documentation. In C. Cassell and G. Symon (eds.). *Qualitative methods in organizational research*. London: Sage Publications, Ltd. 147-166.

Garcia-Caban, I. (2001). *Improving systems of care for racial and ethnic minority consumers: Measuring cultural competence in Massachusetts acute care hospital settings.* Unpublished doctoral dissertation, Brandeis University, Waltham, MA.

Harrison, M. and Shirom, A. (1999). *Organizational diagnosis and assessment. Bridging theory and practice*. Thousand Oaks, CA., Sage Publications.

Harrison, M. (1994). Diagnosing organizations. Methods, models and processes. Second Edition. *Applied Social Research Methods Series.* Volume 8. Thousand Oaks, CA., Sage Publications.
Henderson, G. (1994). *Cultural diversity in the workplace. Issues and strategies.* Quorom Books, CT.

Hernandez-Gallegos, G., Capitman, J., Yee, D., and Madzimoyo, W. (1991). *Diversity and the aging network: An assessment handbook.* Brandeis University Heller School. Waltham, MA.

Hodder, I. (1994). The Interpretation of Documents and Material Culture. In: N.K. Denzin and Y.S. Lincoln (eds.). *Handbook of Qualitative Research*. London: Sage Publications, Ltd. 393-402.

HRSA. (2001). *Cultural competence works: Using cultural competence to improve the quality of health care for diverse populations and add value to managed care arrangements*. U.S. Department of Health and Human Services.

Institute of Medicine. *Crossing the quality chasm. A new health system for the 21st Century*. Committee on Health Care Quality. National Academy Press, Washington, D.C.

Lewin Group, Inc. (2002). Indicators of cultural competence in health care delivery organizations: An organizational cultural competence assessment profile. Monograph publication in progress. Funded by HRSA.

Mason, J. (1995). *Cultural competence self-assessment questionnaire. A manual for users.* Research and Training Center on Family Support and Children's Mental Health. Portland State University.

Medicaid Managed Care New Provisions. (2002). Centers for Medicare and Medicaid Services Final rule for 42 CFR. Volume 67, no. 115, June 14. **Rules and Regulations. *CMS 2104F.***

Mendez-Russell, A. Wilderson, F. and Tolbert, A. (1994). **Diversity profile instrument. Exploring differences in the workplace. *Carlson Learning Company.***

NCQA. (2001). *Surveyor guidelines for the accreditation of MCOs.* National Committee on Quality Assurance, Washington, D.C.

Nolan, T. (1998). Understanding medical systems. *Annals of Internal Medicine.* Volume 128, no. 4, February 15, pp. 293-298.

Perkins, J. (1999). *Language access questionnaire for managed care contractors that receive federal funding.* National Health Law Program, Los Angeles, CA.

Rosenbaum, S. and Shin, P. (1998). *Medicaid managed care: Opportunities and challenges for minority Americans.* Prepared for the Joint Center for Political and Economic Studies by George Washington University.

Strauss, A. and Corbin, J. (1990). *Basics of qualitative research: Grounded theory procedures and techniques*. London: Sage Publications, Ltd.
Tirado, M. (1998). *Monitoring managed care of culturally and linguistically diverse populations.* A Publication of Health Resources and Services Administration Center for Managed Care. National Clearinghouse for Primary Care Information, Vienna, CA.

TRD, Training & Research Development, Inc. (1997). *An assessment of the climate for cultural diversity in North Carolina public health.* North Carolina Office of Minority Health: Raleigh, NC, 42-43.

U.S. Department of Health and Human Services, Office of Minority Health. (2001). *National standards on culturally and linguistically appropriate services (CLAS) in health care*. United States Government Printing Office.

Wagner, C., De Bakker, H., Groenewegen. (1999). A measuring instrument for evaluation of quality systems. *International Society for Quality in Healthcare.* Volume 11, no. 2, pp. 119-130.

Ware, A. (2000). CLAS in managed care organizations study project overview. COSMOS Corporation. Presented at APHA Annual Meeting, Boston, MA.

JUSTIFICATION FOR SELECTION

OF CLAS PILOT STUDY SITE

Contract Number 282-98-0013

March 28, 2002

Submitted by:

ORC Macro
11785 Beltsville Drive
Calverton, MD 20705

Submitted to:

Office of Minority Health
Office of Public Health and Science
U.S. Department of Health and Human Services
Rockwall II, Suite 1000
5515 Security Lane
Rockville, MD 20852

Table of Contents

Appendices

I. Background

As the U.S. population becomes more diverse, medical providers and other people involved in health care delivery are interacting more often with patients/consumers from many different cultural and linguistic backgrounds. At the same time that health care organizations are struggling to improve their service to these diverse populations, they are being held more accountable for their patient outcomes. Because culture and language are vital factors in how health care services are delivered and received, it is important that health care organizations and their staff understand and respond with sensitivity to the needs and preferences that culturally and linguistically diverse patients/consumers bring to the health encounter. Providing culturally and linguistically appropriate services (CLAS) to these patients has the potential to improve access to care, quality of care, health outcomes and, ultimately, to reduce racial and ethnic health disparities.

OMH published the CLAS standards in December, 2000. OMH will conduct pilot tests to examine different approaches to implementing the CLAS standards by different types of health care organizations and to document an experience base that can be used in various settings. The initial study will examine implementation in a large managed care organization (MCO) that provides care to diverse populations through a network of affiliated providers. Such a setting was chosen as the first pilot site because a growing proportion of minority and low- income populations are being served by MCOs. Additionally, most state medicaid programs have contracts with MCOs.

The purpose of this initial project is to implement a pilot study that will report on guidelines and processes for implementing the CLAS standards among health care organizations. The project will document both enabling factors and potential barriers to the implementation of the CLAS standards. Additionally, the pilot project will measure the impact of implementation of the CLAS standards by a major managed care organization (MCO) on both its provider and patient population. The project will also measure the financial and procedural impact of the implementation of the CLAS standards on a major MCO.

II. Methodology

In the fall of 2001, the CLAS Pilot Project Team began the process of choosing a pilot site. In order to make an objective choice, the project team developed a set of criteria for the ideal site that would drive the site selection process. The potential sites were assessed in order to determine the extent to which each met the selection criteria. This report outlines the methodology of the site selection process, the findings, an analysis of the site assessments and recommendations for next steps.

In order to have a solid basis for comparison, two well-known managed care organizations were identified as potential CLAS Pilot Project Sites. The first, L.A. Care, is the largest managed care organization in Los Angeles, serving more than 700,000 members. L.A. Care has a Culture & Linguistics Services (C&L) Department which was created in January 2000, and actively participates in all cultural and linguistic initiatives undertaken for its membership. For example, the Department conducts a cultural and linguistic group needs assessment (GNA) among its members as part of L.A. Care's contractual agreements with the Managed Risk Medical Insurance Board (MRMIB) of California. More generally, the C&L Department participates at county, state, and national levels to help define culturally competent health care standards and policies in multiple arenas.

Beatriz M. Solis, MPH, serves as Director of L.A. Care's Culture & Linguistics Services Department. She was hired in July 2000 to spearhead L.A. Care's efforts and guide the organization toward fulfilling its mission of providing culturally and linguistically appropriate care. Her efforts have resulted in a number of new initiatives at L.A. Care, including a Medical Interpreters Cost/Benefit study.

The second organization identified was the Alameda Alliance for Health (the "Alliance"), which has a membership of 79,000 in Alameda County, California. The Alliance is a non-profit managed care organization that is well known and highly respected for its activities in the field of culturally and linguistically appropriate services in health care. The Alliance has had a Cultural and Linguistic program in place since the organization was formed in 1996. That program has been responsible for undertaking a range of initiatives that have resulted in the production of a large quantity of printed educational materials for both its providers and membership.

Juanita Dimas, Ph.D., serves as the Cultural and Linguistic Program Manager at the Alliance. Dr. Dimas joined the Alliance in September 2000, and is responsible for the development and management of its C&L Program, which develops strategies and provides guidance in the implementation of culturally and linguistically appropriate health care services.

The project team developed a set of site criteria—based on the previously developed CLAS Standards—that would be used in selecting a site for implementing the CLAS pilot project. Key members of the project team, including the OMH project officer, provided input into the development of the site selection criteria. (See Appendix A for a complete list of site selection criteria.) The criteria formed the basis of a phone interview guide and questionnaire; the project team and project officer provided valuable insights from various perspectives to improve the phone guide and questionnaire that was administered to each pilot site. (Appendix B)

The interviewer made an appointment with the previously identified contact at each organization: Beatriz Solis at L. A. Care and Juanita Dimas at the Alameda Alliance for Health. Each interview took about one and a half to two hours to completeby phone. The interviewer took notes on the conversations on a template. (Appendix C) The interviewer conducted a preliminary analysis by reviewing the responses to determine to what extent each potential site met the selection criteria. (Appendix C) Following this preliminary analysis, the interviewer solicited, by e-mail, supplemental information from both sites to clarify the earlier discussions. Both Ms. Solis and Dr. Dimas provided responses by e-mail. (Appendices D, E, and F)

The interviewer conducted a secondary analysis in conjunction with other project team members. This secondary analysis consisted of reviewing preliminary findings and discussing the supplemental information provided by both sites. Data from the supplemental information were included in the analysis table (Appendix C) only if the data were solicited to clarify the initial question(s) administered in the first interview. All other data were discussed during the secondary analysis discussions and can be found in Appendices D, E, and F.

Recommendations were based on the extent to which the sites met the selection criteria according to the information provided during the telephone interview or in the subsequent email responses. All data on which the recommendations were based can be found in the appendices at the end of this report.

After discussing the project team's findings and recommendations with the OMH project officer, the project director advised the potential sites of the final site selection for implementation of the CLAS pilot study.

III. Findings

The following findings are categorized by the site selection criteria that were established at the beginning of this process. The findings were determined by the analysis of information and materials provided by each potential site in response to the administration of the questionnaire that was developed to learn about the site selection criteria at each potential site. A list of the site selection criteria can be found in Appendix A; a detailed record of each site's responses to the questionnaire can be found in Appendix C; supplemental materials can be found in Appendices D, E, and F.

Managed Care Organization (MCO)

Both L. A. Care and the Alameda Alliance for Health are managed care organizations with similar organizational structures, call centers / member services, comprehensive care, health program participation, and diverse clientele.

Diversity of languages spoken in the service area

Both L. A. Care and the Alameda Alliance for Health serve primarily urban clientele who speak a variety of languages, including all seven of the threshold languages and up to 30 other languages. While the demographics for the populations served by the respective organizations are not the same, the data submitted for each reflects a diverse racial/ethnic population as well as a diversity of languages spoken in the service area. L. A. Care's data indicate that it serves a larger Hispanic population than the Alameda Alliance for Health; the Alameda Alliance for Health's data reflect a slightly larger African-American population and Asian/Pacific Islander population than that of L. A. Care.

Extent of support for the CLAS standards by senior management

The senior management of both L. A. Care and the Alameda Alliance for Health strongly support the CLAS standards as demonstrated in their interest and attendance at briefings and seminars that included discussion of the CLAS standards. Both organizations have demonstrated—to some extent—the existence of internal audits and/or grievance resolution procedures as they relate to culture and language. However, based on materials submitted, the senior management at the Alameda Alliance for Health appears to have demonstrated a more extensive commitment than L. A. Care as described in the internal assessment and cultural and linguistic program development (See Appendix E). The Alameda Alliance for Health has provided information about the integration of cultural and linguistic

competency-related measures into existing internal audits and quality improvement activities in an effort to institutionalize a focus on cultural and linguistic competencies within the organization.

Extent of Board support for CLAS standards

The Boards of both L. A. Care and the Alameda Alliance for Health strongly support the CLAS standards as demonstrated by the establishment of a Culture and Linguistics Services Department at L.A. Care; and a Cultural and Linguistics Program at the Alliance. Both boards have also been fully supportive of their respective organization's C&L initiatives.

In-kind contributions of staff and materials

Both organizations were willing to supply some staff and materials to the extent possible based on the information available at the time regarding the intervention. The Alameda Alliance for Health has already embarked on a cultural competency initiative—with its providers—with a focus on knowledge and skills about CLAS and the Alameda Alliance for Health standards. The Alameda Alliance for Health has already established an incentive program for the continuing education/training of providers in linguistic and culture issues. The Alameda Alliance for Health appears to have already demonstrated their commitment to in-kind contributions as the organization has committed to providing incentives to providers to attend training. Examples of current incentives: pay for providers' time, provide lunch, provide continuing education units, supply certificates, and explore other creative means. The Alameda Alliance for Health stated that the organization is exploring something similar to their medical interpreter program in the area of cultural competency.

On-site coordinator/contact person with requisite authority

Both organizations were willing to commit the appropriate staff to assist in coordinating activities. Both organizations stated that they would need more information about the pilot study in order to provide more specific details and stipulate to what extent they could provide assistance.

Size of organization

Both organizations employ a similar number of staff, maintain the same number of Board members, and maintain a similar level of membership and providers. Based on the information submitted, both organizations demonstrated a satisfactory size for the pilot study.

Number of clinic-based locations

Both organizations provide a similar number of clinic-based locations to their clients for medical care.

Degree of similarity of services in all locations

Both organizations provide comprehensive care and participate in the same government health programs.

Racial/ethnic composition of Board

Each of the Boards is composed of eight males and four females. Based on the information submitted, the racial/ethnic composition of both Boards is fairly diverse among the Board members. However, the data provided by each organization does not indicate a direct correlation between the racial/ethnic backgrounds of the Board members and the population served by the respective organizations.

Extent to which 14 standards are being implemented (scale 1-10)

Both organizations have been laying the groundwork and are creating an environment that would facilitate the implementation of the CLAS standards. The Alameda Alliance for Health's interview responses and supplemental information appear to indicate that its staff and providers are further along on the continuum of implementing CLAS standards as they relate to language access services, in particular.

Integration of CLAS standards in daily operations

While both organizations are making strides in several of the CLAS standards, there are a few that stand out among the rest of the standards:

- Standard 3—The Alameda Alliance for Health has formalized an initial culture and language training program for providers with incentives that include CEUs.
- Standard 4—both organizations provide, at a minimum, telephonic interpreting for clients at no additional cost during all hours of operation. The Alameda Alliance for Health appears to rely on such telephonic interpreting as a supplemental system to its primary in-person interpreter service. In its responses to the questionnaire and in additional information submitted to the project team, the Alameda Alliance for Health has provided more detailed data on the language capabilities of providers and a more extensive system of medical interpreters who provide services in-person.
- Standards 10 and 11—Because the state of California does not appear to collect or require collection of some types of linguistic data (e.g., level of proficiency in English, if any), neither organization had extensive data on their clients' language capabilities. However, the Alameda Alliance for Health has done its own study to gather such information. Both organizations mentioned the upcoming Medical study that will provide more linguistic data.
- Standards 9 and 13—Both organizations provided some information about systems for resolving grievances and participating in internal audits. The Alameda Alliance for Health's responses seem to indicate that their systems and procedures were further developed and more extensively integrated into organizational assessments from a larger perspective.

Diversity of workforce

Both organizations provided data on the diversity of their workforces. Because each organization presented its data differently, it would not be an accurate interpretation to compare the data directly. However, both organizations report that their member services/call center staff are skilled in providing customer service in at least all seven of the threshold languages.

Cultural backgrounds of clientele

Both organizations described communities where clients lived with others of similar backgrounds, and providers that have language and cultural capabilities who tend to practice in the corresponding communities. The data provided by each organization cannot be compared directly; a similar trend that exists in both organizations is that the largest groups of people who prefer to speak a language other than English are Spanish, followed by Cantonese. (Cantonese and Vietnamese were equal in the data from the Alameda Alliance for Health.)

Effectiveness in addressing needs of LEP individuals

Both organizations have similar call center / member services structure with staff who speak the seven threshold languages. Both use telephonic interpreting for other languages. Both make an effort to provide language ability information about providers to clients. Based on the information submitted, the Alameda Alliance for Health seems to go one step further as it provides qualified medical interpreters (in-person) free of charge to clients at providers' offices, if necessary. The data provided by the Alameda Alliance for Health indicates that their organization has more extensive data on the language skills of their providers; therefore, it seems that the Alameda Alliance for Health is able to provide more linguistic information to clients about the providers available to them.

IV. Recommendations

The Alameda Alliance for Health and L. A. Care are both highly qualified to be the pilot site for the CLAS pilot project. Both organizations have demonstrated a strong commitment to culturally and linguistically appropriate health care services in their responses to the questionnaire, in solicited supplemental information, and in their overall accomplishments and progress as they move toward a larger scale implementation of the CLAS standards.

Based on the overall findings, it is our recommendation that the Alameda Alliance for Health participate as the pilot site for the CLAS pilot project. As discussed in detail above, the Alameda Alliance for Health appears to have progressed further in implementing the CLAS standards relating to access to language services. The Alameda Alliance for Health has demonstrated commitment to linguistically appropriate services by 1) conducting its own study to supplement linguistic data on patients collected by the state, 2) recognizing the importance of provider language skills—including a need for standards and means for assessment of provider language proficiency—by providing training and significant incentives to providers, and 3) conducting studies on cultural and linguistic competency of health practitioners as a part of the Alameda Alliance for Health's organizational-wide and program-specific cultural and linguistic infrastructures designed to meet the needs of its community.

The leadership of both organizations strongly endorse the C& L initiatives of their respective organizations. From the information collected through our questionnaire, however, it appears that the CEO and other top management at the Alliance have demonstrated their unswerving commitment to these efforts over a longer period of time and with sustained stability in their management structure.

Because of the strengths demonstrated by L. A. Care and their enthusiastic cooperation with the selection process, it is our further recommendation that L. A. Care participate in the CLAS pilot project as a comparison site, if feasible, and that they be the early recipients of findings emanating from this study.

Appendix A: Site Selection

CLAS Pilot Project Site Selection Criteria

The criteria that follow will be used in selecting a site for implementation of the CLAS pilot project. These criteria will form the basis of a questionnaire that will be administered to each potential site. An analysis of answers to the questionnaire will help determine the extent to which each potential site meets the selection criteria which are as follows:

- Managed care organization (MCO)
- Diversity of languages spoken in the service area
- Extent of support for the CLAS standards by senior management
- Extent of Board support for CLAS standards
- In-kind contributions of staff and materials
- On-site coordinator/contact person with requisite authority
- Size of organization
- Number of clinic-based locations
- Degree of similarity of services in all locations
- Racial/ethnic composition of Board
- Extent to which 14 standards are being implemented (scale 1-10)
- Integration of CLAS standards in daily operations
- Diversity of workforce
- Cultural backgrounds of clientele
- Effectiveness in dealing with LEP individuals

Version Date: November 28, 2001

PHONE INTERVIEW GUIDE
FOR POTENTIAL CLAS PILOT SITES
(FINAL DRAFT)

Good morning/afternoon, _____. My name is Molly Delaney, and I work with ORC Macro, a research and evaluation firm working on a project for the Office of Minority Health at the Department of Health and Human Services. I am calling you because your organization is being considered as a pilot-testing site for our current CLAS project. I would like to set up a phone appointment with you so that I can learn more about your organization. I will need about an hour and a half of your time. I can fax questions to you in advance, if you would prefer. Your answers don't have to be exact—proximities are fine. When would be a good time for you?

Questions:

- Could you please tell me about your organization?

- How many doctors are enrolled? Are they in private practice or clinic settings? If the organization has clinics, how many? What types (e.g., pediatric, family practice, ambulatory, OB/GYN)?

- Do they serve a mostly urban or rural clientele? Number of each type?

- Compared to other Managed Care Organizations (MCOs) in your community, how would yours rank in terms of language diversity among patients? Among staff? In terms of commitment to serving language minority patients in their primary language?

- I'd like to learn about the make up of the board members of your organization. Could you describe their ethnic backgrounds? Number of male? Female?

- How diverse is your workforce—culturally and linguistically?

- How does your organization communicate with Limited English Proficiency (LEP) individuals?

- What challenges do you face working with LEP individuals and how do you deal with them?

- What are the demographic characteristics of the community you service?

- Could you please describe the ethnic backgrounds and native languages, if other than English, of the clients you serve?
    - Do they have the ability to speak English?
    - If so, which ones? Ages? To what degree can they converse in English?
    - If not, do you have staff who speak languages other than English? Which languages? How many staff? What type of staff (e.g., administrative, medical)? What is the percent of time that someone is available at all times [who can speak this/these language(s)]?

- I'd like to learn some more details about your various locations. How would you describe the clients' ethnic backgrounds at the various locations?
    - To what extent are all clients at all locations of similar/same ethnic background—on a scale from 1 to 10 with 1 being not very similar and 10 being very similar?
        - If similar—which locations are similar and how are they similar?
        - If varied—describe the differences in more detail.

    - To what extent are most clients at all locations able to speak English well—on a scale from 1 to 10 where 1 is not very well and 10 is very well?
        - If similar—which locations are similar and how are they similar?
        - If varied—describe the differences in more detail.

    - To what extent do most staff [e.g. administrative staff, technicians, nurses, doctors] at all locations have the ability to speak to the clients in the clients' native language(s)?
        - If similar—which locations are similar and how are they similar?
        - If varied—describe the differences in more detail.

- Have you ever heard of the CLAS standards? Has your Board heard of them, adopted them, considered them?

- Has your staff been trained on how to deliver linguistically and culturally appropriate services?

- To what extent are CLAS standards being implemented in your organization—on a scale from 1-10 where 1 is to a small extent and 10 is to a large extent?

- To what extent has your organization integrated CLAS standards into their daily operations?

- How does top management view the CLAS standards?

- To what extent do you think the CEO/Board/Sr. Management does/would support training in CLAS—on a scale from 1-10 where 1 is to a small extent and 10 is to a large extent?

- Do you think staff would be interested in attending training on CLAS? What types of staff?

- To what extent could you ensure that your staff would attend training (Timeframe—3 full day sessions between Jan. 1 and March 1, 2002) on a scale from 1-10 where 1 is to a small extent and 10 is to a large extent?

- Can you require that your staff attend training? If not, what would motivate them to attend training?

- Has your MCO sponsored training on CLAS standards (please itemize them)? If yes, how interested has the top management of the MCO been in these activities? How have they demonstrated their support (e.g., through earmarking resources)?

- Could you please describe the type of staff that your organization would need—on your end—to facilitate this pilot project at your site? Could you provide this staff? Or, how many of this necessary staff could you provide?

- Do you have someone on the staff who has been involved with thinking about training staff on CLAS standards? Who has expressed interest?

- How much time do you think this person could commit? (timeframe: over next 18 months @25%)

Thank you so much for your time; I have enjoyed talking with you. We'll be in touch—shortly (a few weeks).

CLAS Potential Pilot Site Analysis

*The Data incorporated following further clarification from sites is included in **italics** and can be found in Appendices D, E, and F.*

Questions	LA Care— Beatriz Solis 213-694-1250 ext 4278 bsolis@lacare.org	Alameda Alliance for Health— Juanita Dimas Jdimas@alamedaalliance.com	Analysis
1. Could you please tell me about your organization?	• Different product lines with different providers linked to them, such as: MEDICAL/AID—10000 PCPs and 8000 specialists; SCHIP Program—Generally same providers, but less than 8000 members. Because of population shifts, there are 41 PPGS. CAL KIDS- is free for undocumented children ages 0-18 with the same providers. • The organizational structure is multi-fold: traditional, state, and group health plans. All are full service, but mental health and children's special services have been carved out because of the county. • PCPs for Medical and Healthy Family/CalKids: 4,284 • Specialists for Medical and Healthy Families/CalKids: 5,689	• Alliance has over 1300 physicians, 160 pharmacists in all major hospitals in the county, including the community level. They offer primary care and specialists for comprehensive coverage. • *Medical: 67,295* • *Healthy Families: 6,089* • *Alliance Family Care: 4,406* • *Alliance FirstCare: 162* • *Alliance Group Care: 1,748*	Similar organizational structures with call centers/member services, types of physicians (comprehensive care), both participate in almost the same govt health programs, serve diverse populations.
2. How many doctors are enrolled? Are they in private practice or clinic settings?	See #1	• *1,300 physicians in solo and group practices and in 16 community clinics* • *over 100 ancillary providers* • *160 pharmacists* • *all major hospitals in county (12 public and private)* • *county health care clinics and providers* • *array of ancillary providers*	Both provide a substantial number of doctors and practices/clinics for members.

3. If the organization has clinics, how many? What types (e.g., pediatric, family practice, ambulatory, OB/GYN)?	Comprehensive care. *Several hundred clinics. See Appendix F for more details.*	Comprehensive care See #2 for more details.	Both provide comprehensive care.
4. Do they serve a mostly urban or rural clientele? Number of each type?	Serve LA County (geographic region, not govt), which is mostly urban with some rural parts.	Serve Alameda County (geographic region, not govt) which is urban.	Both serve primarily urban clientele.
5. Compared to other Managed Care Organizations (MCOs) in your community, how would yours rank in terms of language diversity among patients? Among staff? In terms of commitment to serving language minority patients in their primary language?	• Highest in terms of language diversity among patients. (based on MEDICAID eligibility). • Among staff: compared to look alikes, doing very well, but still need to do more. • In terms of commitment to serving language minority patients in their primary language: High priority—in mission statement—Equal access, and established a department to address these issues (dept is one year old).	• Highest in terms of language diversity among patients. • Highest among staff • Highest in terms of commitment to serving language minority patients in their primary language	Both rate their MCO high in all categories while recognizing room for improvement. Both demonstrate strong organizational commitment to serving language minority patients. See questions # 10 and 14 for more details.
6. Could you describe your board members' ethnic backgrounds? Number of male? Female?	8 male, 4 female 6 white males 3 white females 2 Latino males 1 African-American woman	4 female, 8 men African-American-5 Asian-American-1 Middle Eastern- 1 White - 5	Both have 8 male and 4 female. Both boards are *fairly* diverse and *fairly* representative of the diversity of the region they represent.
7. How diverse is your workforce—culturally and linguistically?	Appendix F shows the high level of diversity among the workforce.	See #13 *Diversity exists at all levels of seniority: 27% of color, 19% multilingual. Member Services Dept has staff that speak all threshold languages.*	*Both organizations demonstrate a culturally and linguistically diverse workforce.*
8. How does your organization communicate with Limited English Proficiency (LEP) individuals?	• *MCO has customer call center with multilingual staff for 7 threshold languages or use telephonic interpreting.* • *Rely on telephonic interpreting at provider level if provider or provider staff do not speak patient's language.* • *LA Care has conducted a survey of its providers to determine how*	• MCO has customer call center with multilingual staff for 7 threshold languages or use telephonic interpreting. • At provider level: if provider /provider staff does not speak client's language, AA will provide a medical interpreter at no additional charge to the client. • *Use telephonic*	• Similar customer service call center to serve 7 threshold languages. • *AAH provides a medical interpreter and relies on telephonic interpreting as a supplemental method only; while, LA Care relies on telephonic interpreting if provider and staff do not speak language of patient.*

	providers communicate with LEP individuals. See Appendix F for findings.	*interpreting as a supplemental method only.*	
9. What challenges do you face working with LEP individuals and how do you deal with them?	*LA Care has done a study to learn of providers' perceptions of problems. The general sense was that 75% of providers do not perceive a problem, but later indicated that there were cultural and language problems as to why patients did not adhere to medical treatments prescribed.* *43% of physicians rely on their staff to provide language assistance if they themselves are not able to speak with the patient directly.*	*When providers are not able to directly meet the language needs of our members, they are contractually required to use interpreter services. The Alliance translates written materials, has a complaint and grievance procedure in place, does member surveys, member focus groups, etc to assess their members' needs.*	*Both organizations actively assess the needs of their communities/health disparities among enrollees. The Alliance has moved further along the continuum to put more procedures into place in response to the information found.*
10. What are the demographic characteristics of the community you service?	• MEDICAL—730,000 members, and of those members with 7 threshold languages—English *43.2%*, Spanish *36.9%*, Armenian *3.1%*, Cambodian *0.5%*, Vietnamese *1.0%*, Cantonese *1.0%*. 52% are limited English proficient. • HEALTHY FAMILIES—50% LEP with primary languages: English *21%*, Spanish *71%*, and Cantonese *3%*. • CAL KIDS—Primarily Spanish.	• 40% primary language is one other than English—Spanish16%, Vietnamese 7%, Cantonese 7%. Remaining is wide and varied. (Includes Medical Threshold languages.) • ETHNICITY—87% of color or immigrant of which largest (35%) is African American, 23% Latino, 9% Vietnamese, 5% Chinese, 2% Cambodian, 2% Laotian, 6% other Pacific Islander.	See #14 for more detailed breakdown
11. Do they [clients] have the ability to speak English?	• Because of State reports/requirements, there isn't much data. • It seems that Cantonese speakers are mostly monolingual while Spanish speakers know some English (although more comfortable in Spanish) • MEDICAL's study is not complete, yet.	• Somewhat unknown. Language codes reported by State, which reports only primary language. • AAH has some data from their own survey of the Healthy Families Group and Medical survey. The results vary by language—Of the Spanish speakers in the Healthy Families Group, 71% are monolingual. Among the Cantonese Speakers, 68% are monolingual.	Both organizations report lack of detailed information. State reports primary language only of clients. AAH has some data from their own study.

		• Medical's study has not been completed, yet. Medical is, however, the largest segment of their business. AAH has 5 lines of business with Medical with a total of 78, 000 members—MEDICAL: 67,000, HEALTH FAMILY: 5,700. There are also 3 private lines—including 1.) FAMILY CARE which is subsidized for the parents of the kids in the Health Families group and favors immigrants with over 3000 members. 2.) Individual Care with 156 members, 3.) GROUP CARE—a recently created group for workers of county and home support services with 1500 members.	
12. If so, which ones? Ages? To what degree can they converse in English?	Information is not available.	Info is not available. MEDICAL is not organized by age. HEALTHY FAMILIES—is for children only. GROUPCARE—Adults only.	Due to lack of data in previous question, this is difficult for both organizations to answer. Both organizations "guesstimated" that children have better English abilities than their parents do.
13. If not, do you have staff who speak languages other than English? Which languages? How many staff? What type of staff (e.g., administrative, medical)? What is the percent of time that someone is available at all times [who can speak this/these language(s)]?	• Call center/member services/front line has staff who speak Spanish, English, Chinese, Vietnamese, Cambodian. MCO uses telephonic interpreting for non-threshold languages (@ 30!) • Provider directory lists languages spoken in each office, but does not separate physician from staff. MCO looks at language, geographical preference, preference for specialty before assigning to a PCP. • MEDICAL-members have rights—can change physicians every month if want to.	• Some provider and/or staff speak languages other than English—some by virtue of their backgrounds and for others it was specific to their job descriptions. • 19% are multilingual and 27% are of color Staff speak: Cantonese, French, Japanese, Mandarin, Vietnamese, etc. • Mostly it is the member services staff who speak languages other than English. Language skills are included in their job descriptions. Providers (doctors) speak over 20 different languages. • MCO provides multilingual (threshold languages) staff at all	Both have similar call center/member services structure with people who speak the 7 threshold languages. Both use telephonic interpreting for other languages. Both make an effort to provide language ability information about providers to clients. AAH seems to go one step further as it offers interpreter services free of charge to clients at providers' offices, if necessary.

		hours of operation (8-6). MCO uses phone interpreter service if staff not available. • At provider sites—depending on site, would have own multilingual staff if specialize, and some have own interpreter services—Alliance also pays for qualified medical interpreters. So, if there is any provider who doesn't speak the language of an Alliance member, Alliance will arrange and pay for an interpreter—with advance notice. If advance notice is not possible, provider can use telephone language line. • Hospitals—have interpreter services on staff.	
14. How would you describe the clients' ethnic backgrounds at the various locations?	Armenian—majority in Glendale and North Hollywood (so most providers who speak Armenian or providers who are trusted by the Armenian community are in that area. Blacks and Latinos are spread out over LA County. Cambodian more in Long Beach.	Pattern of membership is best seen at community clinics. Alliance started in 1996. Community clinics were instrumental for enrolling members into Medical and Healthy Families, which helped form the pattern of their membership. The majority of Latinos go to Clinica de la Raza; Asians to Asian Health Services. Other smaller clinics serve Native American and African-Americans. Other locations have a wide variety of different ethnicities. Language abilities would have heavier load or those providers who have been in the community longer.	Both described communities where clients lived with others of similar backgrounds, and providers with language and cultural capabilities tend to practice in the corresponding communities.
15. To what extent are all clients at all locations of similar/same ethnic background—on a scale from 1 to 10 with 1 being not very similar and 10 being very similar?	See #13	See #13	Both said that people of similar/same background tend to congregate in the same community/provider location.

If similar—which locations are similar and how are they similar? If varied—describe the differences in more detail.			
16. To what extent are most clients at all locations able to speak English well-on a scale from 1 to 10 where 1 is not very well and 10 is very well? If similar—which locations are similar and how are they similar? If varied—describe the differences in more detail.	At some sites, members can speak better English than others. It is varied across the board. Look at disenrollment by language.	English proficiency only available through survey just conducted by Alliance—not done by State. There is not an obvious or clear pattern.	See #11-12; there is a lack of data.
17. To what extent do most staff [e.g. administrative staff, technicians, nurses, doctors] at all locations have the ability to speak to the clients in the clients' native language(s)? If similar—which locations are similar and how are they similar? If varied—describe the differences in more detail.	Many patients don't use telephonic interpreting; they use a family member to interpret. To whatever extent possible, MCO indicates in provider directory which language is spoken at which office.	See #13	Both have made some effort to provide this info to members. Alameda Alliance has more data, although still very few data. Alliance also provides an interpreter service.
18. Have you ever heard of the CLAS standards? Has your Board heard of them, adopted them, considered them?	See #23	The Board doesn't deal with the day to day on any subjects at that level, but Board knows about the CLAS standards because Juanita presented them and they know the standards are being enacted. The CEO has endorsed enacting the standards.	Both Juanita and Beatriz are aware /knowledgeable on CLAS standards. The boards of both organizations are aware and support CLAS. Both Beatriz and Juanita have personally discussed /presented to the Board on CLAS.
19. Has your staff been trained on how to deliver linguistically and culturally appropriate services?	Not at the level of implementing the CLAS standards. Beatriz has been trying to educate the network on state and federal regulations, such as small groups and large seminars so that network folks would understand contractual obligations. Beatriz found that there was a lack of understanding on the network side. She was able to get their attention by researching and understanding contracts—so that providers would be doing what they "have" to do rather than adding tasks. Beatriz has found	See #27	Neither organization has trained all staff. Both have taken some initial steps to educate and/or put systems in place to facilitate training. (Note: Both Juanita and Beatriz are extremely knowledgeable.) See #27 for more details on staffs' exposure to CLAS.

	that add-ons do not seem to be taken seriously. Beatriz educates in multiple modalities: Quarterly quality improvement groups—in physician provider groups/admin wing for individual providers. Has also educated Medical directors within network—e.g. Aug 2001—to address standards from state and federal perspective with folks who administer Healthy Families–providers to low-income kids. She brought in outside authorities with positive feedback. She did a providers survey which indicated low knowledge and that providers are not following standards.		
20. To what extent are CLAS standards being implemented in your organization—on a scale from 1-10 where 1 is to a small extent and 10 is to a large extent?	There is potential to implement CLAS because already have systems in place, such as the handling of grievances received from front line folks from customers /patients. Beatriz looks at the root of the grievance e.g. is it a linguistic or cultural issue? How to document. She makes sure that staff are coding issues especially because providers are saying it isn't a problem.	To the fastest extent that they can. In Sept. 2000 Alliance created full time dedicated staff at 2 at organizational level at management level with dedicated budget with responsibilities for policies and procedures and other departments to integrate into their activities, own mission statement, initiatives, activities, with federal policies, and regulations/states highest of those standards are their minimum. 75% of providers report provide services in at least language other English.	Both are eager to implement and are moving in that direction. Both have staff/department dedicated to that end. Both have laid a good foundation.
21. To what extent has your organization integrated CLAS standards into their daily operations?			N/A See #20
22. How does top management view the CLAS standards?	In mission statement—will ensure access to culturally/linguistic appropriate services. Beatriz recognizes that although much improvement needs to be done, there are some champions. LA CARE did establish a separate	• *Expanded services beyond Medical and Healthy Families* • *Designed an organization-wide and program specific cultural and linguistic infrastructures*	Both have separate departments dedicated to cultural and linguistic issues.

	department to work with cultural and linguistic issues—the department isn't a part of other departments.		
23. To what extent do you think the CEO/Board/Sr. Management does/would support training in CLAS--on a scale from 1-10 where 1 is to a small extent and 10 is to a large extent?	Beatriz is an auditor for one of the Board's subcommittees on cultural and linguistic issues. She has done 2 audits, and has found that scoring is extremely low, such as quality improvement board asked Beatriz to explain why the scoring was so low. She stated that this demonstrated their desire to know what they need to do to address these problems; linguistic and cultural issues are on their radar screen and they see them as a problem to be addressed. The Board fully supports training in CLAS.	110% support See #22	Both project that top management would support training in CLAS—based on support for their departments, etc.
24. Do you think staff would be interested in attending training on CLAS? What types of staff?	Staff would be interested; found that staff was interested during small group meetings of in-house staff providers. Beatriz found that some want to know about CLAS from a business side to maintain membership, while others negate CLAS' importance. Others are slowing coming up on the radar screen. Time is a problem with providers. *LA Care would refer to findings from their needs assessment among providers to determine the level of interest/availability for provider training.*	• AAH Staff would be interested in an overview of standards at management and other staff levels. In depth1-11/2 day trainings targeting toward departmental activities and how to implement them would be helpful. The situation might be different with the provider network. AAH is already embarking on a cultural competency initiative with a focus on knowledge and skills about CLAS and Alliance standards. They are at the beginning phases, and will begin training in April and assessment in February. Time has proven to be a barrier, and AAH increases incentives where they can. They have already dedicated: pay time, provide lunch, CEUs, certificate, and are exploring other creative means—maybe list in directory, or financial payment for that clinical skill. They already pay the	Both think staff would be interested in attending training with focus on how applicable to their jobs. Both see challenges in training providers.

		provider for the use of the interpreter. They are exploring something similar for cultural competency.	
25. To what extent could you ensure that your staff would attend training (Timeframe—3 full day sessions between Jan. 1 and March 1, 2002) on a scale from 1-10 where 1 is to a small extent and 10 is to a large extent?	Already have buy in from VP and managers, so will attend if required. An example of training attendance includes training on financial issues within the organization.	Attendance would not be a problem, such as part of a departmental or group meeting. Juanita would coordinate with support of CEO. MCO has already committed to ongoing education for internal staff. AAH can't guarantee provider attendance, but would throw all incentives at them and hope they would attend. AAH has no authority to make them attend. Current provider cultural competency—8 hours for provider and 4 hours for their staff.	Both could ensure staff attendance, and are willing to provide incentives to providers to attend training.
26. Can you require that your staff attend training? If not, what would motivate them to attend training?	If coined as professional development/ improvement/ enhance skills as well as VP requirement.	See #25	Yes, can require staff to attend training.
27. Has your MCO sponsored training on CLAS standards (please itemize them)?	Beatriz has participated in seminars, written departmental newsletter articles, and participated in the Speakers Bureau-- where the MCO invites community based organizations in their membership to discuss key health topics—what the topic is and what services are available. MCO expects them to know at least who to go to about cultural and linguistic issues.	Juanita has taken a broad approach—started with management, then all staff, then board, a couple of clinical departmental meetings, and provider relations departments—where the focus was on the services and what is happening at the national level, including CLAS. She then reviewed state contracts, internal policies, and then some details of how things could work in their departments (i.e. what is most relevant to that department/provider She has introduced the language of this issue and provided a handout to help work with providers. She has participated in the health plan policy meeting and gone over the policies in detail.	Both have provided information/included CLAS standards in other seminars/briefings within a larger context of MCO services.
28. If yes, how interested has the top management of the MCO been in these activities?			Both very interested

29. How have they demonstrated their support (e.g., through earmarking resources)?			Separate departments and requested briefings.
30. Could you please describe the type of staff that your organization would need—on your end—to facilitate this pilot project at your site?	Might need to hire some more staff. Current staff—interpreters/translators, cultural/linguistic specialist. Would need trainer, curriculum development. MCO could facilitate and would actively bring on additional staff if necessary—Beatriz would lobby board for funds or get from CA Endowment.	If just to coordinate, don't need more staff. If need help with data collection, or follow-up, would need more details about SOW.	Unfair question based on lack of SOW. However, both willing to provide some staff support.
31. Could you provide this staff? Or, how many of this necessary staff could you provide?			Both need more information
32. Do you have someone on the staff who has been involved with thinking about training staff on CLAS standards?	Yes	Yes	Juanita and Beatriz (depts..)
33. Who has expressed interest?			See #32 and 24 and Board
34. How much time do you think this person could commit? (timeframe: over next 18 months @25%)			Need SOW in order to answer this question.
Other comments from MCO		Alliance has made a top priority to integrate in all departments and interested in moving field forward including CEO and Director.	

Alameda Alliance for Health

Responses to Solicited Information
Regarding Consideration of Serving as an OMH Pilot Site for Implementation of CLAS Standards

History and Mission of the Alameda Alliance for Health

Alameda Alliance for Health (Alliance) is a public health plan that offers locally based health care services to low-income residents of Alameda County, California. Since its inception in 1996, the Alliance has been strongly committed to providing comprehensive, high quality, accessible health care to our culturally and linguistically diverse membership, comprised of traditionally underserved children and adults throughout Alameda County. Nearly three-quarters (73%) of the county's Medi-Cal managed care-eligible patients are Alliance enrollees, as are 57% of the county's Healthy Families (CHIP) enrollees. Alliance demographics indicate that 87% of our members are people of color (of over 79,000 current plan members, 35% are African-American, 23% Latino/a, 13% White, 9% Vietnamese, 5% Chinese, 2% Cambodian, 2% Laotian, and 6% other Asian/Pacific Islander), with over 40% who have a primary language other than English (the largest groups being 16% Spanish, 7% Vietnamese, and 7% Cantonese).

The geographic area served by the Alliance is Alameda County, California. The Alliance's license with the Department of Managed Health Care is to provide services in Alameda County. Alameda County is an area of 820 square miles (land and water area), over 50 miles across, containing 16 cities, with an estimated 1,375,850 residents. The largest city is Oakland, with an estimated total population of close to 390,000. The following is a list of the cities in the Alliance's service area: Alameda, Albany, Berkeley, Castro Valley, Dublin, Emeryville, Fremont, Hayward, Livermore, Newark, Oakland, Pleasanton, San Leandro, San Lorenzo, Sunol, and Union City.

Lines of Business

The Alliance recently initiated an expansion of our services beyond those covered by Medi-Cal Managed Care and Healthy Families. In line with our mission to serve uninsured children and adults, the Alliance launched two new programs for working families: Family Care and First Care. The Alliance Family Care program offers comprehensive medical and dental benefits similar to Healthy Families to working, uninsured, and immigrant families whose household income is under 300% of federal poverty guidelines with no US citizenship or legal residency requirements.

- **MediCal (67,295 members)**
  California's Medicaid program. State and federally funded comprehensive health coverage for families and individuals that provides health, dental and vision coverage.

- **Healthy Families Program (6,089 members)**

California's SCHIP Program. State and federally funded low cost health care program that provides health, dental and vision coverage to children with family incomes above the level eligible for no cost Medi-Cal and below 250% of the federal income guidelines ($34,704 for a family of three).

- **Alliance Family Care (4,406 members)**
  Alliance Family Care is designed to fill in the void for low-income families (250% to 300% above the federal poverty guidelines) who do not qualify for the Medi-Cal or Healthy Families Program, and who want choice in a health care plan. As part of the Alliance's commitment to the community, the Alliance underwrites part of the cost for Alliance Family Care, to keep the monthly premium as low as $10 per month; and a family of three (parents age between 19-39 years old) would be $50 per month for the entire family. Alliance Family Care also includes dental coverage. The Alliance will subsidize Alliance Family Care with $8 million dollars to cover the anticipated 2000 enrollees for the next five years.

- **Alliance First Care (162 members)**
  Alliance First Care provides comprehensive health and dental coverage to working families and individuals that want affordable health care without high deductibles. There are no income restrictions for the Alliance First Care and the target population for this plan are consultants, small business merchants, the self-employed and college students who now are required to have health insurance coverage prior to enrollment. The premium for a single person (under 30 years of age) is $118 per month. Alliance First Care is an affordable plan that also includes dental coverage.

- **Alliance Group Care (1,748 members)**
  In-Home Supportive Services (IHSS) home care workers in Alameda County may qualify for Alliance Group Care health care coverage. An Alliance Group Care member would pay just $8 a month, plus the applicable copays, to receive comprehensive benefits ranging from routine physical exams to emergency care.

Number of Providers by Type of Practice Setting (eg. private, clinic)

The Alliance serves our membership, regardless of type of health plan, through a provider network of more than 1,300 physicians practicing in solo and group practices and in 16 community clinics, over 100 ancillary providers, 160 pharmacists, all major hospitals in the county (12 public and private), county healthcare clinics and providers, and an array of ancillary providers.

I. Language Capability of Providers

Seventy-five percent of providers report having the capacity to provide services in a least one other language than English, with capabilities in over 20 different languages. All reported languages are listed in the Provider Directory distributed to the Alliance membership. In addition, the community clinics that are part of the Community Health Center Network have made providing health care to the major cultural and linguistic groups in the county a priority.

Staff Diversity and Cultural Competence

The commitment to CLAS is shared throughout the Alliance and is viewed as a high priority. The Alliance staff at al levels of seniority is very culturally and linguistically diverse, with 27% of color, and 19% multilingual. Member Services Department has a staff that speaks all threshold languages (English, Spanish, Cantonese, Vietnamese). Qualifications, experience, ethnicity and cultural competence of staff taking a lead in implementing CLAS standards are summarized below, and bios are attached.

Irene Ibarra, J.D., Chief Executive Officer, and a bilingual Mexican-American, has long time and dedicated commitments to health care delivery for minority and underserved populations (see bio for details). Ms. Ibarra holds a JD, Masters in Public Administration, and Masters of Social Work. Arthur Chen, M.D., Medical Director, and Chinese-American, has a long history of serving culturally diverse populations. He is a multilingual practicing physician at Asian Health Services, a Community Based Clinic serving seven different Asian sub-populations. Prior to joining the Alliance Dr. Chen was the Health Officer for Alameda County Public Health Department. Kelvin Quan, J.D., MPH, Chief

Financial Officer and General Counsel, and Chinese- American, has great experience in culturally and linguistically appropriate health care services in a wide variety of health care settings. His community service includes services as the President of the Board of Directors of the Asian Pacific Islander American Health Forum. Mr. Quan holds a JD and Masters in Public Health. He was responsible for creating the Alliance's Cultural and Linguistic Program, and as such, is the direct supervisor of the C&L Program Manager. Juanita Dimas, Ph.D., Cultural and Linguistic Program Manager, and a bilingual Chicana, is responsible for the program development and management of the C&L Program. Dr. Dimas has a Ph.D. in Clinical Psychology, and has experience in providing cultural competency training to clinicians, as well as research experience examining cultural factors in health disparities. Michele Prestowitz, MPH, MPP, Cultural and Linguistic Program Coordinator, and Pilipina American, is responsible for the day-to-day coordination of the C&L Program, and reports directly to the C&L Program Manager. A recent graduate of UC-Berkeley with Masters in Public Policy and Public Health, Ms. Prestowitz has specialized in culturally and linguistically appropriate services in managed care.

Challenges in Serving LEP, and How We Address Those Challenges

Please see attached responses to the Department of Managed Health Care, dated March 26, 2001.

The Alliance's Cultural Commitment

The Alliance has the solid commitment of our senior management to sustaining the subsequent institutionalization of CLAS standards and training across all Alliance operations.

The Alliance is unique among health plans in its commitment to providing culturally and linguistically appropriate health care services. For example, the Alliance initiated an expansion of our services beyond those covered by Medi-Cal Managed Care and Healthy Families. In line with our mission to serve uninsured children and adults, we have launched two new programs for working families: Family Care and First Care. The Alliance has committed $14.8 million, along with a generous grant from The California Endowment, to subsidize premiums for the Family Care program, which offers comprehensive medical and dental benefits similar to Healthy Families to working, uninsured, and immigrant families whose household income is under 300% of federal poverty guidelines with no US citizenship or legal residency requirements. The First Care program has similar benefits and is open to people in any income range, with enrollees paying their own premiums. These initiatives extend our services to formerly uninsured people who historically have had little or no access to routine or preventive care.

In addition, as part of our commitment to serve a diverse community, the Alliance has taken active steps designing organizational-wide and program specific cultural and linguistic infrastructures to best meet the needs of our diverse community. Towards this end, the Alliance created a Cultural and Linguistic (C&L) Program with full-time dedicated staff. The C&L Program develops strategies and provides guidance in the implementation of culturally and linguistically appropriate health care services, including organizational assessment and C&L program development, a Cultural Competency Initiative, and a Linguistic Competency Initiative, as well as ongoing C&L operations. The Cultural and Linguistic Competency Initiatives are programs designed to assess and train skill-based competencies among providers, and to evaluate the effectiveness of such training on the acquisition of

new skills, as well as quality of health care. Ongoing operations include translation of all member materials, payment for qualified medical interpreter services, payment to providers for the use of qualified medical interpreters, training for providers and Alliance staff, and an internal consulting services in order to integrate C&L efforts across all departments.

The Cultural Competency Initiative is a two-year feasibility study to establish the business case for cultural competency training and assessment of health practitioners in an operational managed care setting. This study has two goals. The first goal is to identify and address implementation challenges facing health plan administrators concerned with addressing the distinct needs of culturally and linguistically diverse members in their health plans. This would include examining effectiveness of using tools and processes to implement such a program across managed health care settings, as well as institutional and individual level resistances. The second goal is to examine the implications of these cultural competency tools for enhancing quality of health care, with a focus on processes of care, as well as selected health outcomes. Results of this two-year project will inform the Alliance and other health plans of how to institutionalize cultural competency training and evaluation at the operational level.

The Language Proficiency Initiative is an eighteen-month study to identify and address gaps in quality health care services for limited English proficient (LEP) populations, with a focus on standards and assessment of language proficiency of providers in managed care organizations. This would address two major gaps in the current literature – 1) a focus on provider language skills. To date, the focus has been on patients and interpreters; and 2) a need for standards and means of assessment of provider language proficiency. Provider language proficiency has been the forgotten variable of the language access equation. Limited English proficiency does not necessarily result in a patient not being able to communicate directly with the provider. Many providers rely on their own bilingual skills. The need to establish standards and measures for assessment of professional medical interpreters has recently been recognized. However, as the gold standard is direct patient-provider communication, is critical to be able to assess providers' language abilities before the field can move forward in examining provider's role in the delivery of quality health care services for LEP populations. Results of this project will help to inform the field of the importance and nature of the current gaps of provider language proficiency, to provide a report on beginning steps in managed care organizations to address these gaps, to make recommendations for future activities and research, and to discuss policy implications.

Irene M. Ibarra
Chief Executive Officer
Alameda Alliance for Health
1850 Fairway Drive, San Leandro, CA 94577-0187
510.895.4532

Irene Ibarra serves as the Chief Executive Officer of the Alameda Alliance for Health (the "Alliance"). The Alliance is a local, not-for-profit health plan that provides comprehensive health care services to children and families in the Medi-Cal and Healthy Families Programs. The Alliance also offers Family Care and First Care for uninsured, working and immigrant families. In June, 2001 the Alliance began providing health care for Alameda County In-Home Supportive Services Workers. Primary, specialty and hospital services are provided through a network of over 1,000 public and private physicians, the major hospitals in Alameda County, the Alameda County Medical Center and sixteen community clinics.

Ms. Ibarra joined the Alliance in July, 1996 as Chief Operating Officer and was appointed Chief Executive Officer in January, 1998. She is responsible for the leadership and overall management of the Alliance. Ms. Ibarra relocated to the bay area from Seattle, Washington where she practiced corporate and business law at Hillis, Clark, Martin and Peterson, a private Seattle law firm.

Ms. Ibarra served in Colorado Governor Roy Romer's cabinet for over four years as Executive Director of the state department of health and human services. In this capacity she was responsible for statewide health and human services programs, including Medicaid, managed care programs and long term care. She initiated health care and human services policy reform, managed a large state department, and maintained effective working relationships with elected officials, community groups, health care providers throughout the state and various federal agencies. Ms. Ibarra was appointed Chair by the Governor to lead statewide policy commissions including the Governor's Policy Council on Families and Children, the Governor's Policy Board on Homelessness and the Governor's Commission on Family Economic Self-Sufficiency.

Ms. Ibarra has served in a range of health and human services management positions, including Deputy Manager for the Denver Department of Social Services as an appointee of Mayor Federico Pena. Throughout her career, she has served on community boards and national and state commissions, including the Insure the Uninsured Project Advisory Board and the California Foster Children's Health Task Force. Ms. Ibarra serves on the Board of Directors of the Lucile Packard Foundation for Children's Health, the California Association of Health Plans Board of Directors, Children Now Board of Directors, and the Local Health Plans of California. She also serves on the Advisory Committee on Managed Health Care.

Ms. Ibarra holds a Juris Doctor from the University of Washington, Master of Public Administration and Master of Social Work in Community Services and Social Planning from the University of Denver. She completed the Program for Senior Executives in State and Local Government at Harvard University John F. Kennedy School of Government.

Arthur M. Chen, M.D.
Medical Director
Alameda Alliance for Health
1850 Fairway Drive, San Leandro, CA 94577-0187
510.895.4503

Dr. Arthur Chen currently serves as the Medical Director of the Alameda Alliance for Health, a Local Initiative, Medi-Cal Managed Care public organization serving Alameda County. From 1996-2001 he was the Health Officer for Alameda County. Since 1983 he has practiced clinical medicine as a family physician at Asian Health Services (a community health center) in Oakland, California where he also served as Medical Director and Special Programs Director. Prior to that he served as an emergency room physician/instructor and the Associate Medical Director of the Institute of Emergency Medicine at the Albert Einstein College of Medicine, Bronx,NY. He was also the Executive Director of the Chinatown Health Clinic in New York City.

He completed his postgraduate training at the Residency Program in Social Medicine (Family Practice) at the Montefiore Hospital and Medical Center of the Albert Einstein College of Medicine, Bronx, New York. He received his B.S. and medical degrees from the University of California at Davis.

He currently serves on the National Association of County and City Health Officials MAPP (Mobilization for Action through Planning and Parnterships) planning committee (formerly APEXCPH: Assessment and Planning Excellence through Community Partners for Health. He is Chairperson on the Board of Directors of the Asian and Pacific Islander American Health Forum, a national policy and advocacy organization serving Asian American and Pacific Islanders. On March 8, 2001 he was appointed to the Task Force on Culturally and Linguistically Competent Physicians and Dentists for the CA Dept of Consumer Affairs. He is an Executive Council member of the Alameda Contra Costa County Medical Association. In 1999 he served on the CDC/ATSDR Task Force on Public Health Workforce Development. From 1997-2001 he served as a Board Member and later an Executive Committee member of the California Conference of Local Health Officers. He was selected as a fellow to the 1996-7 Public Health Leadership Institute sponsored by the Centers for Disease Control and the University of California. During l989-l992 he was a member of the Kellogg National Fellowship Program and has since served as a consultant to the W.K. Kellogg Foundation. He has also served on advisory and planning committees to the Bureau of Primary Health Care of the U.S. Public Health Service, the Office of Minority Health, the National Institutes of Health and the American Lung Association. He has also testified before Congress and President Clinton's Health Task Force.

Among his publications are: "Health is strength": a research collaboration involving Korean Americans in Alameda County; “A behavioral risk factor survey on Korean Americans; Community-Sensitive Research,Information Management For the 90's; "Special Health Problems of Asians and Pacific Islanders," "Behavioral Risk Factor Survey of Chinese in California," "Cigarette Smoking Among Chinese, Vietnamese and Hispanics in California," and "Conducting a Culturally-sensitive Health Survey in the Chinese Community."

Kelvin P. Quan, JD, MPH
Chief Financial Officer & General Counsel
Alameda Alliance for Health
1850 Fairway Drive, San Leandro, CA 94577-0187
510.895.4501
Email: KQuan@AlamedaAlliance.com

Kelvin P. Quan, JD, MPH is the Chief Financial Office & General Counsel of the Alameda Alliance for Health, the managed care health plan serving Medi-Cal and other low-income, vulnerable populations throughout Alameda County in Northern California, where he has administrative responsibility for their Cultural & Linguistics program. Since 1996, Mr. Quan has been the Board President of the Asian & Pacific Islander American Health Forum, a national health advocacy and policy organization that promotes policy, program & research for APIA communities. He is a co-founder of the Bay Area Asian Health Alliance, an early health advocacy group formed in 1980, and a co-founder of Self-Help HomeCare, a home health agency serving the monolingual Chinese elderly since 1981.

Mr. Quan is the Co-Investigator and Quality Assurance Specialist for the study "Exploring Ethnic/Language Match and Cervical Cancer Screening," which is funded by the California Cancer Research Program. He serves as a member of the Project Advisory Group for the U.S. Office of Minority Health/National Health Law Program "Assessment of State Laws affecting Racial & Ethnic Data by Health Plans," the Research Advisory Committee of the Resources for Cross Cultural Health Care, OMH and AHRQ, and the National Advisory Committee of the National Center for Cultural Competence's Children with Special Health Needs Project.

As an attorney at the law firm of Cooley Godward, Mr. Quan's law practice focused on transactional health care law. Prior to that, Mr. Quan was the Chief Financial Officer of Chinese Hospital in San Francisco. He has held senior financial and administrative positions at Mills-Peninsula Hospitals and French Hospital Medical Center. He earned his Juris Doctorate from the University of California, Hastings College of the Law; his Masters in Public Health with a concentration in Corporate Healthcare Management from the University of California, Berkeley; and his undergraduate degree from Northwestern University. Mr. Quan is a Board member of the American Heart Association (East Bay affiliate) and Operation Access, a non-profit organization that provides outpatient surgeries to the uninsured through the voluntary efforts of surgeons, nurses and hospitals, and volunteers as the Legal Counsel for the Federation of Chinese American and Chinese Canadian Medical Societies. His past board affiliations include Self-Help for the Elderly, St. Mary's Chinese Foundation, and the Oakland Chinese Community Council. He has been a member of the California State Bar since 1993.

Juanita M. Dimas, Ph.D.
Cultural and Linguistic Program Manager
Alameda Alliance for Health
1850 Fairway Drive, San Leandro, CA 94577-0187
510.895.4530
jdimas@alameda-alliance.com

Juanita Dimas serves as the Cultural and Linguistic Program Manager of the Alameda Alliance for Health (the "Alliance"). The Alliance is a local health plan that provides comprehensive health care services to children and families in the Medi-Cal and Healthy Families Programs. The Alliance also offers Family Care and First Care for uninsured, working and immigrant families. In June, 2001 the Alliance began providing health care for Alameda County In-Home Supportive Services Workers. Primary, specialty and hospital services are provided through a network of over 1,000 public and private physicians, the major hospitals in Alameda County, the Alameda County Medical Center and sixteen community clinics.

Dr. Dimas joined the Alliance in September, 2000, and is responsible for the development and management of the Cultural and Linguistic (C&L) Program at the Alliance. As part of the Alliance's commitment to serve a diverse community, the Alliance has taken active steps to design organizational-wide and program specific C&L infrastructures to best meet the needs of the communities of Alameda County. The C&L Program develops strategies and provides guidance in the implementation of culturally and linguistically appropriate health care services, including organizational assessment and C&L program development, the Culturally Competency Initiative, the Language Proficiency Initiative, as well as ongoing C&L operations.

Dr. Dimas is a licensed clinical/community psychologist, with a specialization in working with diverse, poor and underserved populations, and in researching cultural factors related to health disparities. As a professor of psychology, she taught a variety of graduate level courses, including cultural competency. Dr. Dimas' numerous presentations have been made to national and state health institutes, professional organizations, as well as colleges and universities; her publications focus on cultural factors and health and include book chapters, professional journal articles, and policy reports.

Dr. Dimas earned her Ph.D. in Clinical Psychology from the University of California, Berkeley, and served her clinical internship and postdoctoral fellowship at the University of California, San Francisco, Public Service and Minority Cluster, based at San Francisco General Hospital.

Michele Ott Prestowitz
833 Stannage Avenue, Albany, CA 94706
510.558.9935
michele@prestowitz.com

Experience

Alameda Alliance for Health, San Leandro, CA **7/01 to present**
Cultural and Linguistic Program Coordinator
- Assist with development and implementation of cultural competency programs, initiatives, and internal consulting services.
- Coordinate translations, interpreter services, and Community Advisory Committee meetings.
- Produce reports, correspondences, and

Asian & Pacific Islander American Health Forum, San Francisco, CA **5/00 to 5/01**
Policy Intern
- Conducted analysis of cultural competency training programs for health care providers
- Produced action alerts, policy updates, and fact sheets
- Convened health care leaders to discuss cultural competency and quality of care
- Conducted training for community based organizations on effective policy advocacy
- Managed and maintained division website

Medi-Cal Policy Institute, Oakland, CA **5/99 to 8/99**
Intern
- Researched, wrote and published a report on the history of Medi-Cal physician reimbursement to be distributed to policy-makers and opinion-leaders in California

North American Medical Management, Emeryville, CA **6/97 to 7/98**
Business Analyst
- Analyzed enrollment, utilization and financial data of commercial and Medicare managed care populations for executive board and physician panels
- Produced Medical Director's Handbooks, surplus reports, and specialty studies

Market Strategies, Inc., Southfield, MI **11/94 to 4/97**
Associate Project Manager, Health Care Division (8/96 to 4/97)
- Managed quantitative and qualitative health care marketing research projects
- Created reports, presentations and project proposals for clients
- Responsible for data analysis, questionnaire development, and sample definition

Systems Engineer, Research Operations Center (4/95 to 4/97)
- Programmed and operated Perception Analyzer™ to provide data collection for quantitative analysis of focus groups
- Responsible for training of staff and project management

Data Analyst, Research Operations *Center* (11/94 to 8/96)

- Developed statistical and tabulation programs for research projects in health care, policy, politics, and energy utilities

Asian Pacific American Youth Task Force, Boston, MA **5/93 to 9/93**

Project Intern

- Organized *Conference for Asian Pacific American Youth*. Established statewide networks, outreach and educational programs for APA students

Institute for Asian American Studies, Boston, MA **1/93 to 5/93**

Legislative Intern

- Successfully lobbied state legislature for fiscal support to establish the first Asian Pacific American public policy institute on the East Coast

Education

- **University of California, Berkeley**
  - **Goldman School of Public Policy**
    Masters of Public Policy, May 2001
  - **School of Public Health**
    Masters of Public Health, May 2001

- **Cultural Competency Training Programs for Health Care Providers: Recommendations for California's Department of Health Services**, Policy Analysis
  Reviewed training programs from health plans, teaching hospitals, community service organizations, and guidelines from government agencies for common and divergent themes based on program structure, implementation, and curriculum. Recommended state action and steps for implementation.

- **Bates College**, Lewiston, ME
  Bachelor of Arts in Political Science and Sociology, High Honors, May 1994
  - **The Incidence of Anti-Asian Violence in High Schools**, Honors Thesis
    Analyzed hate crime experiences of students, and studied policy options in response to hate crimes in the classroom. Defended project before a panel of experts.

Skills

- MS Office, SPSS, programming knowledge of ANSI C, familiar with STATA
- Familiar with finance, grant development, planning and policy analysis techniques
- Perform traditional and contemporary Filipino *Rondalla* music in U.S., Europe, and Asia

March 26, 2001

Angela Mora
Patient Advocate
Office of the Patient Advocate
Department of Managed Health Care
320 – 4th Street; Suite 880
Los Angeles, CA 90013-1105

Dear Ms. Mora:

In response to your letter dated February 22, 2001 requesting information regarding our cultural and linguistic services, please find attached our response to each of your questions.

The Alameda Alliance for Health (the "Alliance") is a local health plan dedicated to providing continuous, comprehensive, high quality care to the traditionally under-served children, families and individuals in Alameda County, California. As part of our commitment to serve a diverse community, the Alliance has taken active steps designing organizational-wide and program specific C&L infrastructures to best meet the needs of our diverse community. Towards this end, the Alliance has recently created a Cultural and Linguistic Program, and hired a full-time, dedicated C&L Program Manager. The C&L Program develops strategies and provides guidance in the implementation of culturally and linguistically appropriate health care services, including organizational assessment and C&L program development, the Cultural Competency Initiative, the Linguistic Competency Initiative, as well as ongoing C&L operations.

The Cultural and Linguistic Competency Initiatives are programs designed to assess and train skill-based competencies among providers, and to evaluate the effectiveness of such training on the acquisition of new skills, and on health care utilization and outcomes. Ongoing operations include translation of materials, training for providers and Alliance staff, and an internal consulting services in order to integrate C&L efforts across all departments.

Also as part of ongoing operations, the Alliance provides and pays for interpreter services through a local community language bank that trains and certifies interpreters. When interpreters are not available, the Alliance pays for the use of a telephone language line as back-up. The plan uses provider contracts, the provider manual, Provider Representatives, and articles in the provider newsletters to promote the use of interpreters. The Alliance is exploring creative means to provide resources and incentives to providers in order to improve the use of interpreters by the provider network. The Alliance is committed to providing culturally competent health care services to plan members in the various programs.

Please contact me if you require any further information, or if I can be of any further assistance.

Thank you,

Juanita M. Dimas, Ph.D.
Cultural and Linguistic Program Manager
phone (510) 895-4530
fax (510)483-0566
jdimas@alameda-alliance.com

Responses to the Department of Managed Health Care's Questions Regarding Culturally and Linguistically Appropriate Services At the Alameda Alliance for Health

March 26, 2001

The Alliance serves our membership's cultural and linguistic (C&L) needs in a myriad of ways and across relevant operations. Please also see related responses to subsequent questions, and the attached "Language Access and Health Care Services at the Alliance".

Internal Assessment and C&L Program Development

The C&L Program is 1) conducting initial and ongoing organization-wide assessments of cultural and linguistic related activities, and 2) integrating cultural and linguistic competence-related measures into internal audits, performance improvement programs, patient satisfaction assessments, and outcomes-based evaluations. An initial organizational assessment, including an inventory of organizational policies, practices, and procedures, is necessary to implement our strategic plan. Ongoing organizational assessment is necessary to determine the degree to which the Alliance has made progress in achieving C&L competencies. Integrating cultural and linguistic competency-related measures into existing internal audits and quality improvement activities will help institutionalize a focus on cultural and linguistic competencies within the Alliance. By linking the organizational assessment processes to quality and outcome efforts, this integration may have the additional benefit of helping to build the evidence base regarding the impact of cultural and linguistic interventions on access, patient satisfaction, quality, and clinical outcomes (US DHHS, OMH, October 2000).

In keeping with the Office of Minority Health guidance, major domains for assessment will include the following:

1. Governance or organization
2. Plans and policies in support of cultural and linguistic programming
3. Patient care
4. Quality monitoring and improvement
5. Management Information Systems
6. Staffing patterns
7. Staff and provider training and development
8. Communication and linguistic support

Given the Alliance's strategy for cultural competency, an estimation of costs of different cultural competency interventions will inform the Alliance as it makes decisions about which interventions to pursue. The information generated from such an analysis will not only inform the Alliance as to which interventions may be the most effective, but also which may yield the most benefits given the financial investment at hand and the resources within the Alliance. Such an analysis can also provide insight into the spectrum of possible interventions available to fulfill each standard and meet the needs of the plan, patient, and provider. A beginning cost analysis of needs and utilization of interpreter services is currently being conducted.

In order to implement the C&L strategic plan, and to accomplish the stated goals and objectives, an infrastructure has been created to provide the necessary resources. These resources include organizational commitment, programmatic and agency-wide policies and procedures, program budget, dedicated staff, and in-house and contracted expertise.

1. **How do you determine what the cultural and linguistic needs are of the population that is enrolled in your plan? How do you know which languages your enrollees speak or communicate in, and how do you deal with enrollees who are Limited English Proficient (LEP)?**

Threshold Languages

Our threshold languages by product line are:

- MediCal: English, Spanish, Chinese, and Vietnamese (determined by DHS, based on number of eligible beneficiaries in the county)
- Healthy Families: English, Spanish, and Chinese (formula set by MRMIB, based on enrollment).
- Family Care: English, Spanish, Chinese (determined by the Alliance, based on enrollment)
- First Care: English (determined by the Alliance, based on enrollment)
- IHSS: English, Spanish, Chinese, Vietnamese, Farsi (determined by contract, based on eligible beneficiaries)

Data on Ethnicity and Language of Members

At time of enrollment, members indicate their preferred language and their ethnicity. For MediCal and Healthy Families, DHS and MRMIB forward this information electronically to the Alliance, where we store that data in our mainframe data bank. The Alliances collects this data directly for all other lines of business. This data is then used in reporting, including monthly membership reports, membership rosters to providers, language on membership cards.

Providers

We offer a diverse network of primary and specialty providers. At time of enrollment with the Alliance, members choose a Primary Care Provider (PCP). If the member does not choose a PCP, the Alliance assigns the member a PCP, taking into consideration the member's primary language, among other factors. Our Provider Directories indicate language capabilities of each provider office. When providers are not able to directly meet the language needs of our members, they are contractually required to use interpreter services as detailed below.

Member Services

Our Member Services Department is staffed with representatives who speak the primary languages of our membership. When we are unable to directly meet the language needs of our LEP members, we use a telephone language line as detailed below. Our voice mail system is delivered in threshold languages and directs calls to specific Member Representatives based on language of the caller.

Written Materials

The Alliance translates written materials directed to members in threshold languages as detailed below, and considering our populations' literacy levels.

Complaint and Grievance

Complaint and grievance procedures include a separate code for C&L related complaints, and complaint and grievance reports filed by members are analyzed by ethnicity and language. Communication with members who have filed a complaint or grievance is conducted in the member's primary language, regardless of whether it is a threshold language.

Health Education, Utilization Management, and Internal Quality Improvement Programs

The Clinical Department conducts needs assessment examining ethnicity and language of members, and designs programming accordingly, such as identifying areas of disparity, offering health education classes in a variety of languages, and involving the community in designing interventions for specific populations.

Community Advisory Committee (CAC)

Although part of our contract with DHS, we also enlist the input from our communities for all our populations and lines of business. We convene on a quarterly basis a committee composed of consumers, community advocates, and traditional and safety-net providers to gather C&L information from our stakeholders and the communities that we serve, to advise on C&L competency issues, and on educational and operations issues affecting LEP populations.

Group Needs Assessments (GNA)

As part of our contracts with DHS and MRMIB, we conduct regular groups needs assessments that inform the development of our C&L work plan. As indicated by DHS the goals of the GNA are to identify C&L needs of our members, and to identify community resources in order to inform the development and implementation of appropriate C&L programs and services. While conducted as part of contractual obligation for two lines of business, we apply the highest levels of C&L activities equally across all lines of business.

Member Surveys

Data gathered directly from the Alliance's members provide information about their experiences, satisfaction, perceptions and priorities that is equally important as the Alliance's other quantitative measures. Surveys are conducted in our threshold languages and by ethnicity. We usually conduct these surveys to coincide with our formal Group Needs Assessments, so that we can use this important source of information in the analysis of need by ethnic and language group, and for development of appropriate C&L services.

Member Focus Groups

Five focus groups were conducted in September/October 1999. These included specific focus groups for members who spoke English (African-Americans), English (All others), Spanish, Vietnamese, and Chinese. There also was a group of English speaking pregnant members. We inquired about perceptions of quality of health care, access to health care and medications, health beliefs and needs.

County of Alameda Uninsured Survey (CAUS)

The Alliance has funded ($50,000) the UCLA Center for Health Policy Research to conduct CAUS, which will, for the first time, create a population-based surveillance system of the County's uninsured population. It will be capable of describing characteristics of the uninsured by race/ethnicity, nativity and age at local levels, and is being conducted in all our threshold languages.

The goals are to:

- Understand who are the uninsured, why they are uninsured, and for how long;
- Understand the financial, health and social impact of being uninsured;
- Understand the factors affecting enrollment and disenrollment in safety net programs, specifically the transition in and out of Medi-Cal and Health Families;
- Gain information for the design and implementation of insurance products including marketing, enrollment, disenrollment and access and network issues which affect participation;
- Determine access to and utilization of health services.

2. If it's applicable to your plan, how do you comply with the August, 2000 guidance of the Federal Office of Civil Rights regarding Title VI of the Civil Rights Act?

OCR Title VI is applicable to our plan. Details of how we implement each of these activities can also be found in responses to subsequent questions. In brief:

- The Alliance offers and provides language assistance services, including bilingual staff and interpreter service, at no cost to provider or member, at all points of medical and non-medical contact, in a timely manner, 24 hours a day, 7 days a week.
- The Alliance regularly provides to our members in our membership's threshold languages both verbal offers and written notices informing them of their right to receive language assistance services.

- The Alliance requires that providers offer services in the member's primary language, either through multilingual staff or with the aid of an interpreter.
- The Alliance is currently survey the language capabilities of providers and their medical and office staff, and is developing means of assessing and training language proficiency of interpreters, providers and their medical and office staff. The Alliance does not rely on members' family and friends to provide interpretation services (except on request by the member) and instructs providers to adhere to these same standards.
- The Alliance makes available easily understood patient-related materials in our membership's threshold languages, and in other languages upon request.
- The Alliance requires that providers post way-finding signage in the languages of the commonly encountered groups and/or groups represented in the service area.

3. Do you have a written policy providing oral language assistance and translation of written materials into non-English languages? What is your policy on providing interpreters?

Below is a list of specific written policies regarding linguistically appropriate services at the Alliance:

- Title VI Compliance (CUL-29)
- 24-Hour Access to Interpreter Services (HPD-1524)
- Requesting Interpreter Services (HPD-16)
- Linguistic Capabilities of Provider Network (PRO-15)
- Ensure Appropriate Bilingual Proficiency (PRO-16)
- Facility Site Review (PRO-07)
- Assessing the Linguistic Capabilities of Employees (HR-01)
- Inform Members of Availability of Linguistic Services and Translated Materials (MSD-32)
- Development of Culturally and Linguistically Appropriate Member Materials (HPD-17)

Our policy on providing interpreters is as follows (excerpted from above P&P):

The Alliance will provide 24-hour access to interpreter services to improve access to quality health care services at medical and non-medical points of delivery. The Alliance provides an interpreter service that includes either in-person or telephonic interpretation when a provider cannot meet the language needs of an Alliance member. These interpreter services are provided to the patient at no cost and are used during discussions of medical and non-medical information. The Alliance will use in-person interpreters whenever possible. The Alliance shall inform members of the availability of linguistic services and translated materials. Information provided to members shall include but not be limited to: the availability of interpreter services at no charge; the right to request an interpreter; the right to have access to translated member materials; and the right to file a complaint or grievance if either translated materials or linguistic services' needs are not met. The Alliance will also inform members that it will not require or encourage members to use family members or friends as interpreters.

4. Do you provide notice to LEP enrollees in their language of their right to free language assistance? If so, how is this accomplished?

Yes, using our threshold languages, we inform our membership of their right to receive services in their primary language. (Please see above related responses.)

We inform our membership in the following ways:

- During orientation
- In the Evidence of Coverage
- In the quarterly newsletters to members
- On our web site
- When they call Member Services
- On the Complaint and Grievance instructions
- Through our providers

5. Do you provide training to your staff and providers to ensure that they understand the plan's LEP policy and procedure?

Yes, we currently provide instruction to our staff and providers regarding our C&L related policies in the following ways:

- The C&L Program directly communicates and collaborates with each Alliance department, through management meetings, departmental staff meetings, special work groups, and individual meetings.

- Providers are informed:
  — In their contracts
  — In the Provider Manuals
  — In the Provider Newsletters
  — Through Provider Representatives
  — Individually if and when a problem is identified
  — Individually upon request

6. How do you evaluate the capacity of your provider network to meet the cultural and linguistic needs of your enrollees?

- We offer a diverse network of primary and specialty providers.
- We survey the language capabilities of provider offices.
- We monitor providers' documentation in patient medical records of patients' cultural and linguistic needs, and request or refusal of interpreter services.
- We conduct site reviews, which include the following relevant areas:
  — Medical Record Review
  — Administration
    - Staff knowledge of procedures
    - Cultural and Linguistic Services, including signage on the availability of interpreter

    - Services
- We examine patient -provider language match.
- We examine utilization of interpreter services.
- We are developing a Cultural Competency Initiative. This project will implement and evaluate a program to assess levels of cultural competency among providers, and to provide training in cultural competency to providers to improve health outcomes, and thereby reduce health disparities. This project is intended to lead to the development of an ongoing, institutionalized cultural competency assessment and training program with related ongoing assessment of health outcomes. Providers will be offered financial and other incentives, as well as CME units.
- We are developing a Linguistic Competency Initiative. We propose to identify objective measures and testing tools to ensure the language proficiency of interpreters, physicians and their medical and office staff. This will involve collaboration with the California Health Interpreters Association and other health advocates. We recognize that in spite of the emphasis placed on health interpreters, many times communication continues between providers and LEP patients without the use of health interpreters. While the Alliance will undertake efforts to ensure the linguistic proficiency of physicians and their office staff, we recognize the potential reluctance of this group to be tested for a variety of reasons. The Alliance will *explore* creative means to encourage cooperation.
- We have funded ($50,000) the City of Berkeley Substance Abuse Services and Provider Training Program. This is a program for pregnant and parenting African-American women with substance abuse problems. The program will provide individual counseling, referrals for treatment, and provider training.

7. How do you monitor the effectiveness of your programs in these areas, and how often do you examine these programs?

- Language capabilities of providers, and their medical and non-medial staff are assessed either in our initial survey of providers, or during the initial provider credentialing process. Information regarding these language capabilities are then updated semi-annually. Provider directories are edited accordingly
- Site reviews are conducted for all PCP's during the initial provider credentialing process, and every two years as part of the ongoing re-credentialing process. Provider Relations Department will submit an annual report to the C&L Program Manager regarding provider compliance with cultural and linguistic requirements.
- Both the Cultural Competency and Linguistic Competency Initiatives are designed to evaluate through rigorous design and statistical methodology the effectiveness of the interventions on provider skills acquisition, and on member access, satisfaction, trust, services utilization, and health outcomes. Data will be gathered though provider self-report, patient report of provider, survey of office operations, and claims data. Both Initiatives are intended to lead to the development and institutionalization of regular assessment, training, and evaluation in these areas.
- The City of Berkeley Substance Abuse Services and Provider Training Program will provide the Alliance with aggregate outcome data on rates of postpartum care, well-baby care, substance free deliveries, substance free breast feeding, and babies enrolled in MediCal.

8. How does the health care service plan assess health disparities of different populations among its enrollee populations?

- We rely on community wide data from the Public Health Department to inform our processes.
- We evaluate HEDIS results by ethnicity and language.
- The above mentioned Cultural Competency Initiative will examine patient satisfaction, trust and health outcomes by ethnicity and language as related to their provider's level of cultural competency.
- Clinical Initiatives assess disparities in outcomes for specific conditions/diseases, such as diabetes, asthma, and prenatal care.

- We are conducting two clinical studies examining specific health disparities:
  — *Assessment of Enhanced Prenatal Care for Ethnically Diverse Women*. In collaboration with researchers from UCSF, this is an Internal Quality Improvement Program (IQIP) examining the relationship of cultural competency in prenatal care to ethnic group disparities in patient satisfaction and in health behaviors. Results from this project are intended to inform design and implementation of relevant interventions.
    - *Exploring Ethnic/Language Match and Cervical Cancer.* In collaboration with researchers from UCLA, this study investigates whether language and ethnic match between patient and provider is related to ethnic group disparities in cervical cancer screening. Results from this project are intended to inform design and implementation of relevant interventions.

9. How do you determine what the needs are of persons with disabilities who are enrolled in your plan?

- American Sign Language (ASL) is included as primary language option provided at time of enrollment.
- Members are identified through our Utilization Management Program by our RN Case Managers.
- Members self-identify their needs when necessary, to the Alliance and/or to their providers.
- The Alliance has a memo of understanding with the California Children Services (CCS) program that allows us monthly access to a listing of our pediatric members with active cases and the list of diagnoses which qualify them. These conditions are chronic, disabling, or would benefit from rehabilitation.
- The Clinical Department has instituted a pediatric special needs risk assessment program to systematically identify children with chronic physical, mental, developmental, social, or other risk factors not routinely reported with standard diagnosis and procedure codes, by PCPs, using a unique Risk Assessment scale. The Alliance pays a monthly capitation supplement to PCP's who identify moderate- and high-risk children using the risk assessment tool, meeting the traditional definition of special needs and also those with significant psychosocial risk factors. We also compensate PCPs for non-billable services (e.g., telephone consultation, "case management" documentation, inter-agency coordination and referral) necessary for special needs children.
- The Alliance membership also includes SSI recipients in the Blind, Aged, and Disabled aid categories. These members have chosen voluntarily to enroll in the Alliance, often by word of mouth, because of the benefits the Alliance offers. Their care is reimbursed on a fee for service, rather than capitated basis, to encourage providers to accept them in the panels. If they are under age 21, they can also be assessed with the risk assessment form and their providers will receive a

one time payment of $25 for completing the form, which allows the plan to obtain information about the disability and, if appropriate, make referrals or establish that a case has been opened with CCS or the Regional Center of the East Bay.

10. How do you evaluate the capacity of your provider network to meet the needs of enrollees with disabilities?

We conduct site reviews, which include a review of the following accommodations:

- Wheelchair ramp
- Water fountain
- Elevator
- Designated parking
- Bathroom accessibility
- Handrails in bathroom
- Provision of sign language interpretation
- Ability for TTY communication

11. Do you assure that your providers comply with the Americans Disabilities Act?

Yes, through the above mentioned site reviews, and through our provider contracts.

12. Do you monitor the effectiveness of any programs dealing with persons who have disabilities?

- We are evaluating the pediatric special needs program through an Internal Quality Improvement Program, which examines the rate of preventive care visits for children in special needs populations (CCS, SSI and/or risk assessment groups). Initial findings indicate a need to improve the rate of preventive care visits which may be due to children primarily seeing specialists. We are currently monitoring the effectiveness of the program against five goals:
  - — Identify children with clinical, psychosocial and other risk factors not routinely reported with standard diagnosis and procedure codes, by PCPs, using a unique Risk Assessment scale developed by the Committee.
  - — Accumulate and analyze utilization and cost of primary and specialty care by children with special needs.
  - — Compensate PCPs for non-billable services (e.g., telephone consultation, “case management,” documentation, inter-agency coordination and referral) necessary for special needs children.
  - — Encourage new providers to become the “medical home” for special needs children.
  - — Provide PCPs with the resource of the Public Health Clearinghouse to link them and special needs families with Public Health and other community services and resources.

Language Access and Health Care Services at the Alliance

The following are highlights of the current activities, future plans and long-term issues of the Alameda Alliance for Health in the area of language access and health care services.

1. The Alliance pays for the cost of qualified health interpreters and makes such payment directly to the interpreters. The Alliance makes the arrangements for the attendance of such interpreters at medical and non-medical points of contact upon notification from the provider's (physician's) office or Health Promotions Department of the upcoming need.
2. In the event that a face to face interpretation cannot be arranged due to late notice or the unavailability of a qualified health interpreter, the Alliance pays for the cost of the use of the AT&T Language Line.
3. The Alliance regularly notices its providers of the availability of both qualified face to face and telephonic interpreters at no cost to the member patient. The Alliance specifically encourages its providers to use these resources while discouraging the use of family or friends and particularly minors, except in extraordinary circumstances.
4. The Alliance translates written materials directed to members in threshold languages. This is an ongoing effort to (a) ensure accuracy, completeness and cultural sensitivity and (b) coordinate the translated materials with the goals and external approvals of their English counter-parts.
5. The Alliance is currently developing measures and testing tools to ensure the language proficiency of both health interpreters and providers. We view this as a short and long term process. Within the coming year, we intend to require the successful completion of a test as a contractual pre-requisite for our contracted health interpreters. Notwithstanding our efforts in this development, we actively support such efforts by external parties to create a uniform industry standard.
6. The Alliance is specifically interested in developing measures and testing tools to ensure the language proficiency physicians and their office staff. We recognize that in spite of the emphasis placed on health interpreters, many times communication continues between providers and limited English proficient patients without the use of health interpreters. While the Alliance will undertake efforts to ensure the linguistic proficiency of physicians and their office staff, we recognize the potential reluctance of this group to be tested for a variety of reasons. The Alliance will explore creative means to encourage cooperation by physicians that might include the following:
   - Annual stipend for those who pass the test;
   - After the initial taking of the test, a short series of classes could be offered to raise their language skills to a level that might allow them to successfully pass the test;
   - Continuing Medical Education (CME) credits for physicians who participate in the classes described above; and
   - Consideration of demonstrated language proficiency as a criteria for the allocation of year end risk sharing in recognition of an additional medical skill available to a physician's member patients.
7. The Alliance intends to conduct a series of analyses that will measure the relationship of language and medical utilization as part of its ongoing quality improvement program. All of the efforts described in this memorandum are but part of a larger organization-wide program to address cultural and linguistic needs.

8. Whenever practical, the Alliance will engage community based organizations in the furtherance of the above stated programs and goals. For example, the Alliance utilizes the Language Cooperative of Asian Health Services as its (a) primary vendor for health interpreters and (b) external consultant in the development of measures and testing tools to ensure the language proficiency. We have also established communications with the California Health Interpreters Association and other health advocates in the area of language access.
9. The Alliance recognizes that addressing the problems of language barriers to health services must be shared by all interested parties in our field. The benefits and linguistic skills derived by any physician carry over to all of their patients. The Alliance envisions the adoption of programs such as those described here (particularly the development of uniform measures and testing tools) for the health care industry.

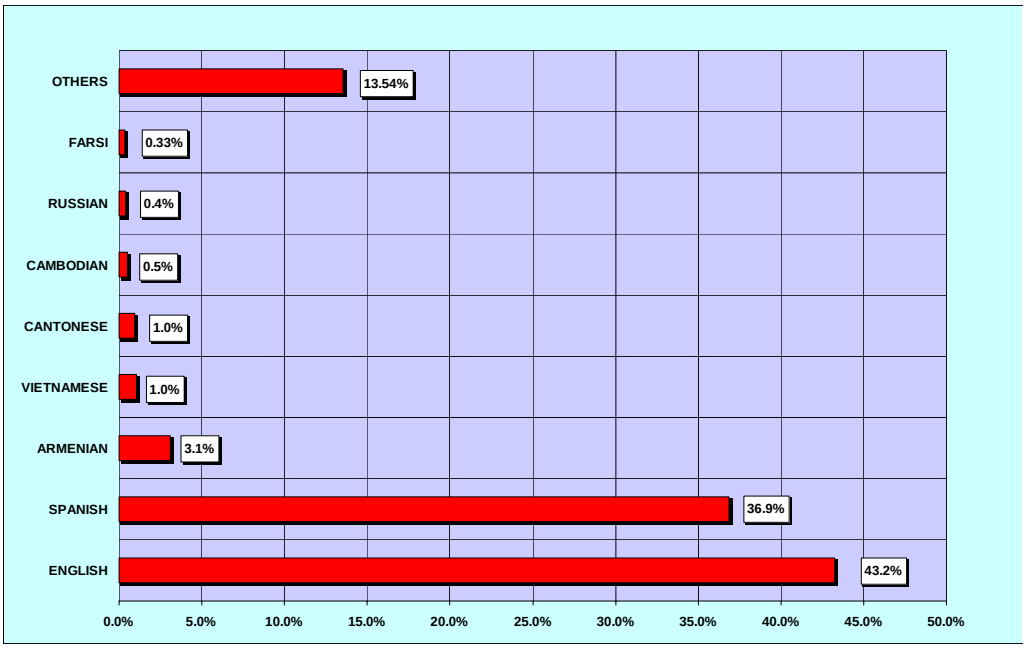
Dear Molly,

Here are my responses.

1. **We discussed the programs that you support, such as Medical and Medicaid, Cal Kids, etc. Could you please list the programs with the number of providers available in each one and the number of members (i.e. patients) in each program.**

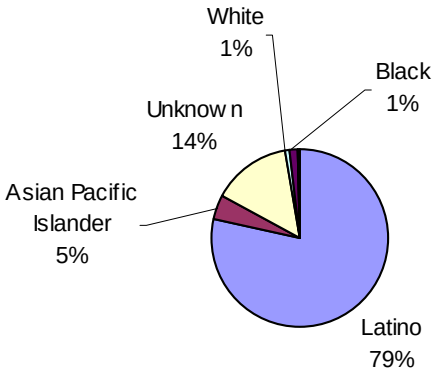
	Medi-Cal Only	Healthy Families/CalKids Only	In Both Product Lines	**Total**
PCPs	2355	359	1570	**4284**
Specialists	3441	716	1532	**5689**
Total	**5796**	**1075**	**3102**	**9973**

Medi-Cal Members (730,000 members)



Ethnicity of L.A. Care Healthy Families Program Members

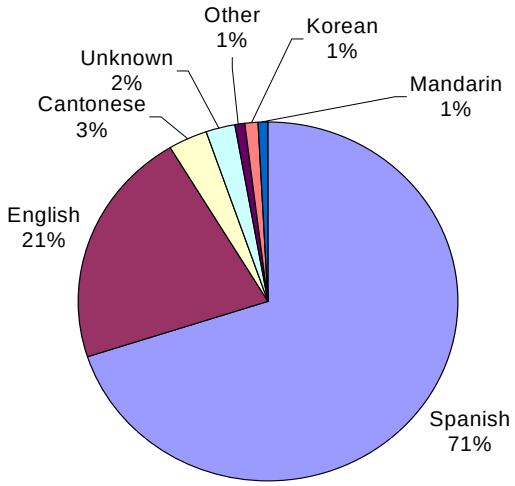
(N=6,012)



Provides a breakdown of the self-reported language preferences among Healthy Families Program members' parents, guardians, or others completing the application. Spanish is the preferred language of the majority, followed by English and Cantonese.

Preferred Languages Of L.A. Care Healthy Families Program Members

(N=6,012)



2. Are the providers in private practice or clinic settings? (An approximate breakdown is fine.)

I will need some time to do research on this question. I am not sure if we collect information on whether providers are contracted with different entities, for example, we do know that many providers are contracted with more than one MCO in order to ensure member enrollment. Can you ask the question in another way? Or provide information on the intent of the question.

3. How many clinics are available to your members (i.e. patients)?

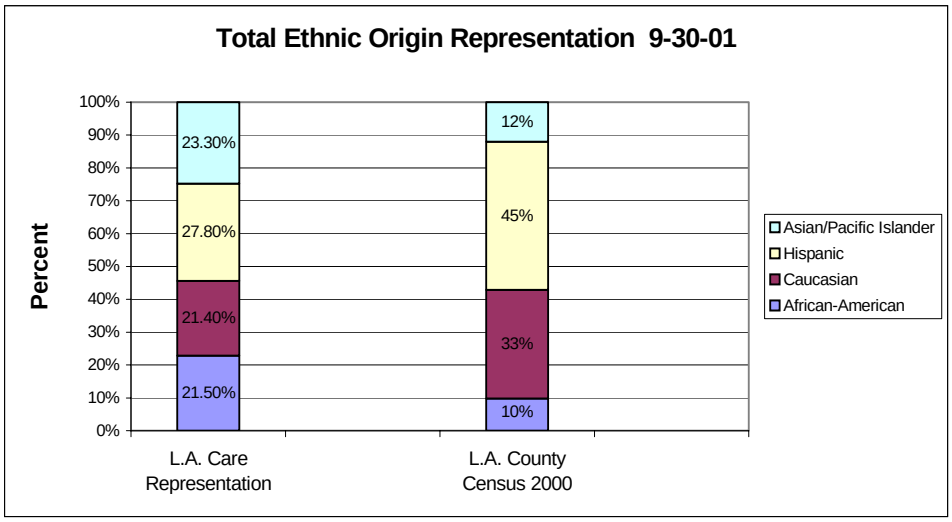
Several hundred throughout L.A. County. Again are you asking about safety net provider clinics or providers that have contracts with clinics?

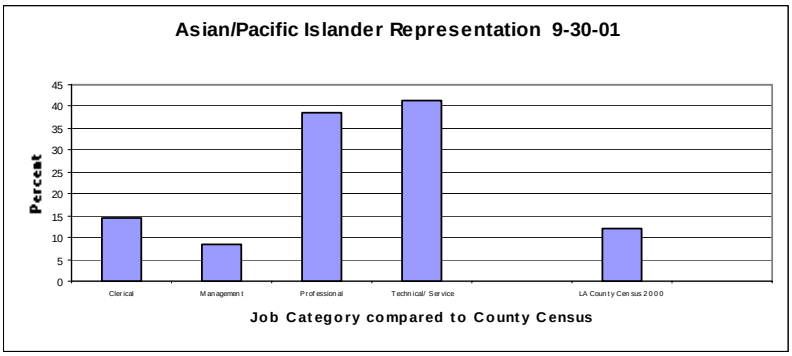
4. I received the information you sent on your Board, but could you please describe the ethnic backgrounds of your Board members.

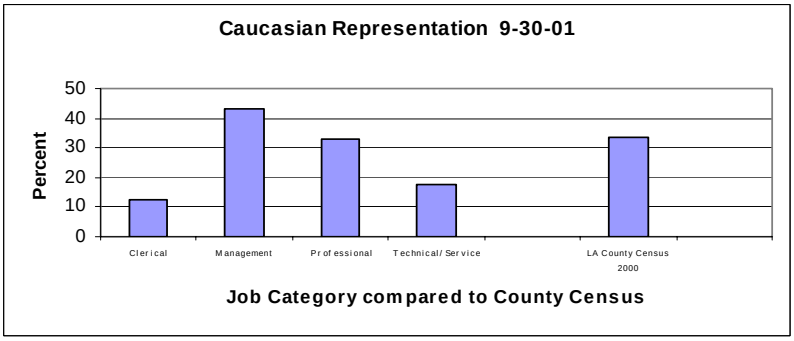
There are twelve members of the Board at present, with one vacancy, the CAHP slot. The breakdown is as follows:

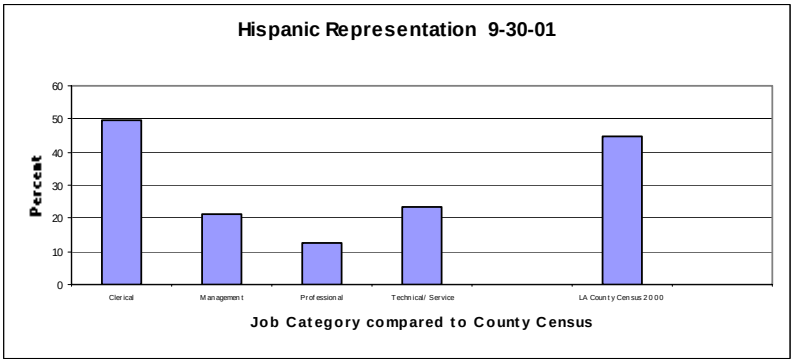
- 6 white males (Abbate, Coan, Edwards, Knabe, Leaf, Tranquada)
- 3 white females (Fesler, Nicholas, Wyard)
- 2 Latino males (Bautista, Rivera)
- 1 African-American female (Broadus)
- The Regional Community Advisory Committees, are composed of over 90% people of color, primarily African American and Latinos. Three RCAC's are held in Spanish, one is in Cambodian and English and all the others are in English.

5. How would you describe the cultural and linguistic diversity of your workforce at LA CARE?









Among the providers?
Based on the data we collect, we see the following:

Of those providers, PCP's and Specialist, here is the language breakdown: (note: I indicates not fluent and F is fluent in the language. A caveat of the data is that it is self-report).

LANG_DESC	*Count of CA_LIC*	LANG_PROF	%
American Sign Language	2		0.05%
American Sign Language	2	F	0.05%
Arabic	64		1.63%
Arabic	114	F	2.90%
Arabic	32	I	0.82%
Armenian	181		4.61%
Armenian	87	F	2.22%
Armenian	23	I	0.59%
Cambodian	15		0.38%
Cambodian	18	F	0.46%
Cambodian	5	I	0.13%
Cantonese	66		1.68%
Cantonese	77	F	1.96%
Cantonese	13	I	0.33%
English	1149		29.27%
English	3552	F	90.50%
English	80	I	2.04%
Farsi	109		2.78%
Farsi	124	F	3.16%
Farsi	49	I	1.25%
French	71		1.81%
French	111	F	2.83%
French	36	I	0.92%
Hebrew	23		0.59%
Hebrew	24	F	0.61%
Hebrew	8	I	0.20%
Hmong	1		0.03%
Hmong	3	F	0.08%
Hmong	3	I	0.08%
Ilacano	11		0.28%
Ilacano	6	F	0.15%
Ilacano	1	I	0.03%
Italian	19		0.48%
Italian	24	F	0.61%
Italian	3	I	0.08%
Japanese	13		0.33%
Japanese	12	F	0.31%
Japanese	5	I	0.13%
Korean	44		1.12%
Korean	86	F	2.19%
Korean	32	I	0.82%
Laotian	1		0.03%

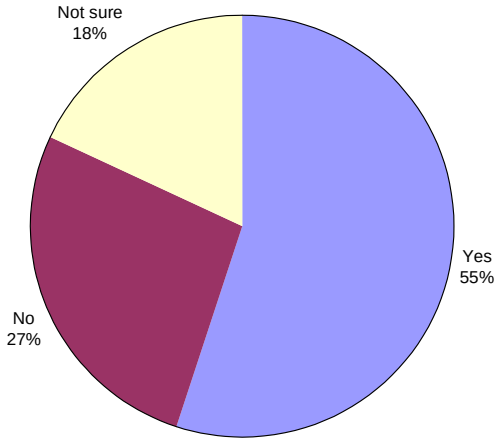
Laotian	3	F	0.08%
Mandarin	131		3.34%
Mandarin	137	F	3.49%
Mandarin	27	I	0.69%
Not Valid	1		0.03%
Not Valid	3	I	0.08%
Other	11		0.28%
Other Chinese	33		0.84%
Other Chinese	153	F	3.90%
Other Chinese	36	I	0.92%
Other Non English	168		4.28%
Other Non English	171	F	4.36%
Other Non English	55	I	1.40%
Other Sign Language	9		0.23%
Other Sign Language	3	F	0.08%
Other Sign Language	1	I	0.03%
Polish	6		0.15%
Polish	5	F	0.13%
Portuguese	9		0.23%
Portuguese	11	F	0.28%
Portuguese	4	I	0.10%
Russian	59		1.50%
Russian	74	F	1.89%
Russian	27	I	0.69%
Samoan	35		0.89%
Samoan	1	F	0.03%
Spanish	1024		26.09%
Spanish	1378	F	35.11%
Spanish	437	I	11.13%
Tagalog	154		3.92%
Tagalog	267	F	6.80%
Tagalog	60	I	1.53%
Thai	5		0.13%
Thai	13	F	0.33%
Thai	5	I	0.13%
Turkish	28		0.71%
Turkish	14	F	0.36%
Turkish	12	I	0.31%
Vietnamese	51		1.30%
Vietnamese	127	F	3.24%
Vietnamese	29	I	0.74%
Total Unique Medical PCPs	**3925**		**100%**

6. We discussed LA CARE's system of working with LEP individuals when they call the member services department at LA CARE (e.g. the language capabilities of your call center staff at LA CARE and telephonic interpreting). Could you please clarify how the providers communicate with LEP individuals?

We conducted a survey among providers within our network that provide services to Medi-Cal/Medicaid and Healthy Families members. And this is what we found:

Providers were asked about the language capability assessment process for staff serving as interpreters. Sixty percent of the physicians responded that they assessed the bilingual capability of their staff members by conducting an oral interview with them. Only 6% said that they formally tested staff members' language capability. Figure 8-2 displays the percentage of physicians who, while not currently testing the language capability of their staff members, would use a language test if one was made available to them.

Figure 8-2: Language Test Usage By Physicians

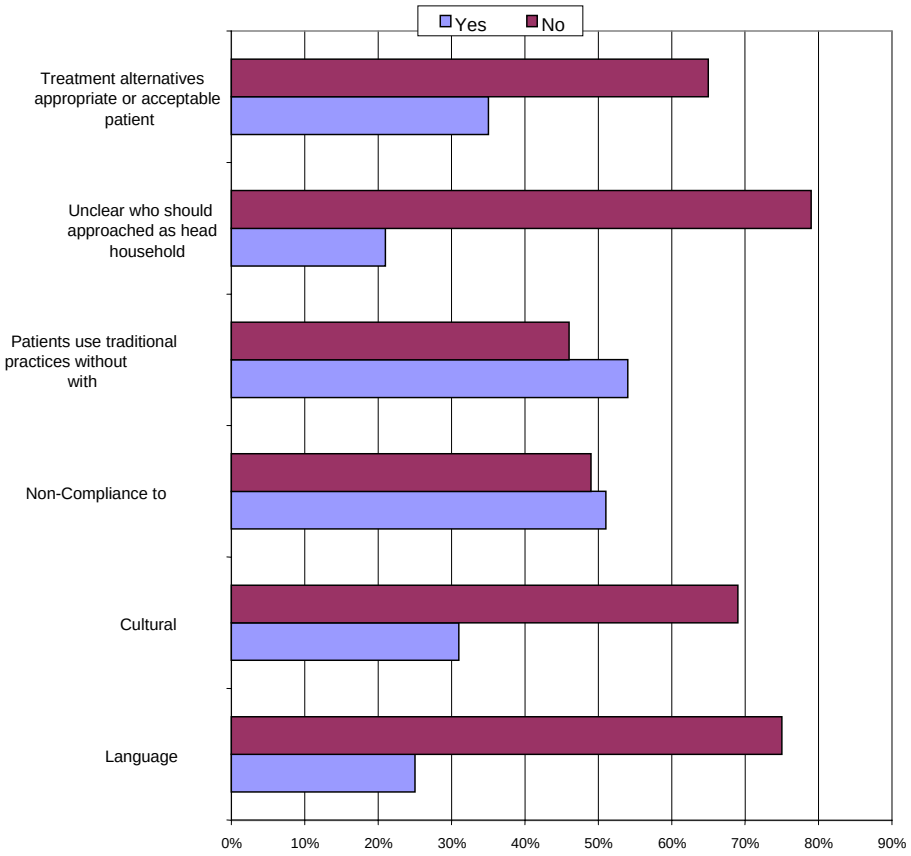


When asked about the effectiveness of staff language capability, 76% of physicians said they felt their staff function very effectively as interpreters. Sixteen percent responded that their staff is effective, and 8% responded that their staff is somewhat effective to ineffective.

G. Perceived Communication Barriers

Providers were asked whether they felt a language barrier exists between them and their patients. Three out of four respondents (N=47) stated that they felt no barrier to communication with their patients. Table 8-3 details physicians' perceived barriers in communicating with LEP and culturally diverse patients.

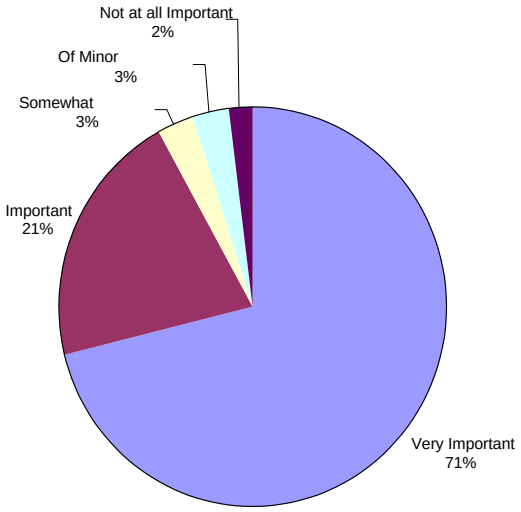
Table 8-3: Perceived Barriers in Communicating With LEP and Culturally Diverse Patients



Judging from the responses to this series of questions, it is clear that physicians generally perceive no language or cultural barrier. However, when these responses are juxtaposed with response regarding the specific behaviors of patients, a slightly different image appears. For instance, a little over one-half (51%) of the physicians said that their patients do not adhere to medical treatments because of culture and language barriers. A similar percentage (54%) said that their patients use traditional healing practices but do not communicate about their use.

Respondents were asked to rate the degree to which they consider language and cultural issues important in the delivery of care to patients. Figure 8-3 shows that 71% of responding physicians consider language and cultural issues to be very important in the delivery of patient care.

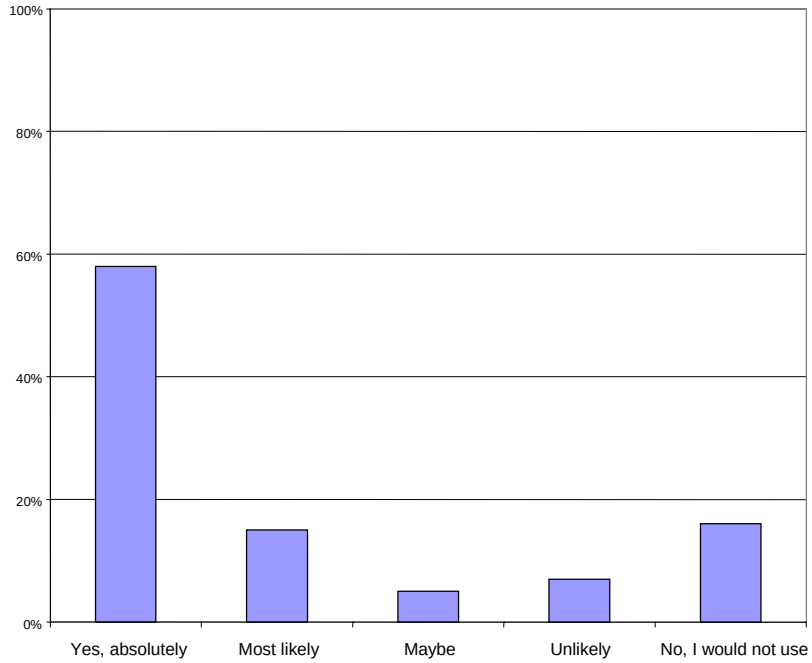
Figure 8-3: Physician's Ratings on the Importance of Language and Culture Issues



H. 8.5.4 Medical Interpreters

When asked whether or not they would use interpreters if available to them, 58% of physicians said they would "absolutely" use them, as shown in Table 8-4.

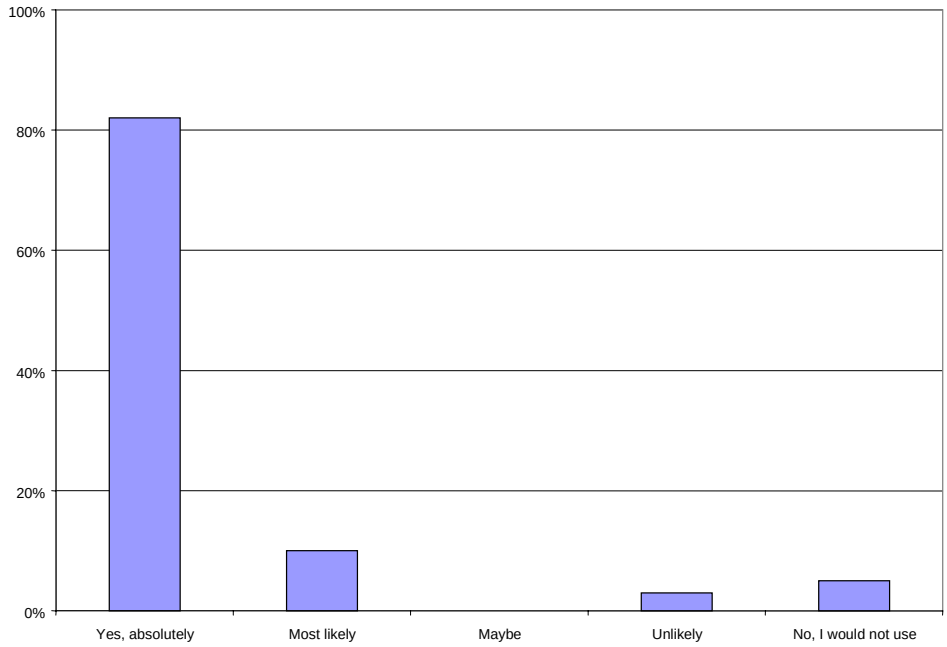
Table 8-4: Percent of Physicians Indicating They Would Use Interpreters



Physicians were asked to rate their interest level in having staff trained as professional interpreters. Close to one-half (49%) said they would be interested in such training; one-quarter (25%) said they would not be interested and 8% were not sure.

Respondents were asked if they would use translated materials should they be made available. The majority of respondents (82%) said they would make use of translated materials, as seen in Table 8-5.

Table 8-5: Percent of Physicians Who Would Use Translated Materials

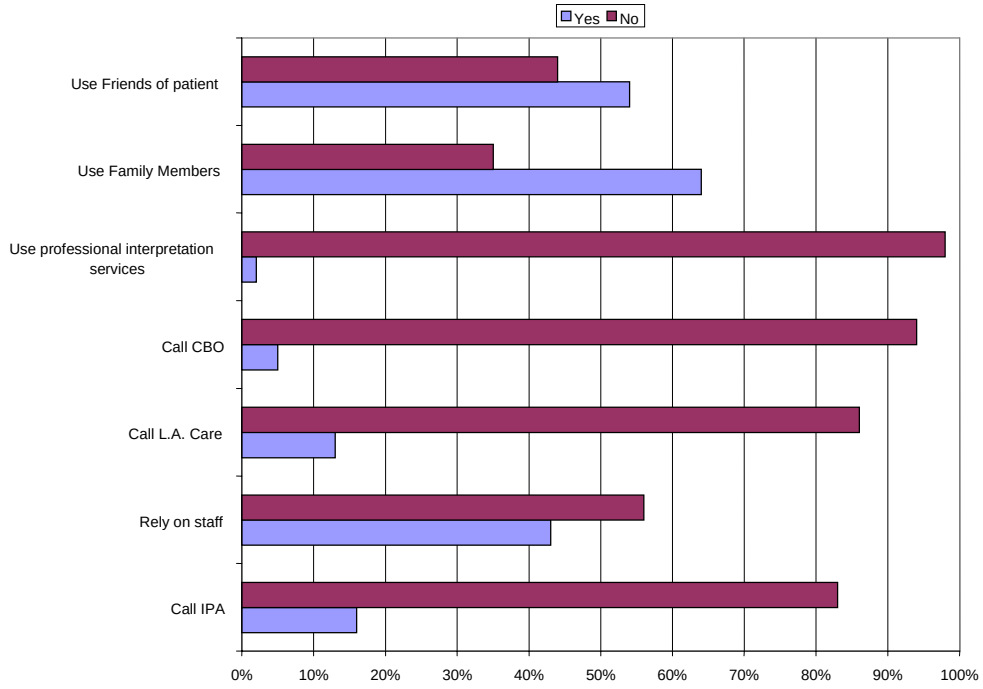


I. 8.5.6 What Providers Do When Their Staff Do Not Speak the Language of Their Patients

Physicians were asked what they do when confronted with a Limited English Proficient patient and the office does not have the necessary language capability. When asked whether or not they call a PPG for assistance, 83% responded that they do not.

Forty-three percent of physicians responded that they rely on their staff to provide language assistance if they themselves are not able to speak with the patient directly, as shown in Table 8-6.

Table 8-6: Modalities Used to Communicate With LEP Patients



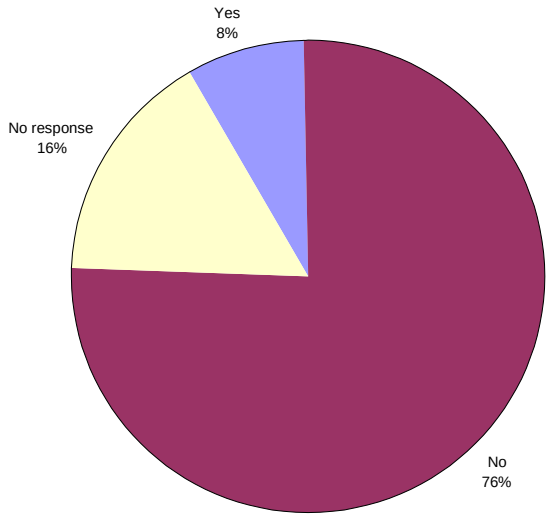
Interestingly, 13% of the physicians said they called on L.A. Care's Member Services Department for language assistance.

Physicians were also asked if they use community based organizations and private translation services. Fewer than 5% said they did, while the majority do not.

Asked if they used family members to interpret, 64% said they have used family members to interpret for patients. Fifty-four percent of the respondents mentioned that they use patients' friends for interpretation services.

Providers were also asked if they have used a 24-hour telephone interpretation service. Only 8% said they have used such a service, as shown in Figure 8-4.

Figure 8-4: Providers Usage Of The 24-Hour Language Line Service



J. 8.5.7 Culture and Linguistics Regulations

Physicians were asked about their familiarity with access laws for patients. Less than one-quarter (24%) said they were familiar with such laws, 5% said they were not, 51% said they were not sure, and 21% did not respond to the question.

K. 8.5.8 Challenges for Providers

A series of questions was asked on the challenges faced by providers who see Limited English Proficient (LEP) patients. Fifty-one percent of providers indicated that not having written materials in languages other than English is a challenge for them. Other challenges included having a large number of patients (32%) and lack of access to professional interpreters (22%).

7. What challenges do you face working with LEP individuals, and how do you deal with the challenges?

I am not sure if I understand your question. But, I think you may be asking how we handle the needs of diverse members. We find that among some of our Asian members, they are reluctant to file a compliant. However, I have to add that this is probably a situation that impacts all of our membership and it is more pronounced with LEP's. We have a lot of work to do to inform members of their health care rights. Complaints about a health plan are taken seriously by health care organizations and attention is given to find solutions when complaints are reported by members. I suspect that many members are not aware of this right and that for cultural reasons folks (many immigrants communities

are fearful of making complaints because they fear they may lose their health benefits, for instance) are not complaining.

In terms of education the "health care system" we have a number of challenges as indicated from our provider and member surveys to date. Because our network is extensive, there is much to do. Additionally, just providing information on C&L is one aspect but incentives also need to be added.

8. To what extent do you think your providers would be interested and/or available to attend training on the CLAS standards?

Again, I will defer to our findings from our needs assessment among providers.

L. Cultural Competency Training

Physicians were asked if they had ever received any kind of cross-cultural training in health care delivery. Over one-half (56%) said that they had not had such training. Thirty-eight percent responded that they had received such training and 6% were not sure.

When asked if their staff had ever received cultural competency training in health care delivery, close to six out of 10 (59%) physicians said that they had not received such training. Fourteen percent responded that their staff had received cultural competency training in health care and 10% were not sure.

Additionally, we held a seminar on cultural and linguisitic state and federal regulations. And we received this feedback.

Over 90% of our attendees stated that they would recommend this seminar to other providers and health care works and that they have a better understanding of C&L regulations. Moreover, the majority responded that as a result of the seminar they are able to identify barriers that diverse populations experience when accessing health care services.

Open-ended comments indicated a desire to "we hear a lot of the "what" and the "why" but we really need conferences on "how" to implement these new regulations. Examples of successes and failures, discussions on practical implementation of C&L issues." Another attendee stated "How do we make all of this happen? Especially on provider level with small medical offices with limited resources."

9. To what extent would your organization be willing/able to provide or contribute toward incentives for provider attendance?

I think incentives work well with providers. I am certain that the organization would be willing to contribute to this effort to stimulate participation and attendance.

Appendix B: Code Tool

Appendix B: Code Tool

1.1. GOVERNANCE DIRECTIVES

	Yes	No	Missing
1. Mission statement articulates cultural diversity as core principal	1	2	9
2. Corporate strategy outlines Diversity Business Plan	1	2	9
3. Corporate strategy outlines CLAS management strategy	1	2	9
4. Board racial/ethnic mix reflects customer profile (below)	1	2	9

Race/Ethnic Groups	Members RY02 (n)	(%)	Board of Directors (n)	(%)	Ratio
African American/Black	26,882	32			
Asian (Chinese, Cambodian, Vietnamese, Laotian)	22,647	27			
Hispanic/Latino	21,649	26			
White/Caucasian	11,000	13			
Other (Am. Indian, Nat. Hawaiian, Pacific Isldr)	2,050	2			
Unknown/not reported	0	0			
TOTALS	84,228				

1.2. HUMAN RESOURCES

5. MCO staff mix reflects customer profile served as follows:

Race/Ethnic Groups	Members RY02 (n)	(%)	Alliance Staff (n)	(%)	Ratio
African American/Black	26,882	32			
Asian (Chinese, Cambodian, Vietnamese, Laotian)	22,647	27			
Hispanic/Latino	21,649	26			
White/Caucasian	11,000	13			
Other (Am. Indian, Nat. Hawaiian, Pacific Isldr)	2,050	2			
Unknown/not reported	0	0			
TOTALS	84,228				

6. Ethnic minority staff occupy the following positions:

M. Staffing Positions	Total Staff (n)	Minority Staff (n)
Senior Management (Executives/Division Dir.)		
Administrators (Unit Dir.)		
Middle Management		
Clinical staff (Drs., nurses, etc.)		
Support (admin asst, clerical)		
Other professionals (technology, policy researchers, interpreters, health educators, etc.)		
TOTALS		

1.3 Funding Sources & Allocation

7. Types of revenue sources for MCO
    1. Federal funds (list): _____
    2. State funds (list): _____
    3. Employers (list): _____
    4. Grants (list): _____
    5. Other (list): _____
    6. Combo above (list): _____
    9. Missing
8. Types of Programs Funded to address Ethnic Minority Initiatives
    1. Equal Employment Opportunity/Affirmative Action
    2. Diversity Business Initiatives
    3. Cultural & Linguistic (C & L) Programs
    4. Language Service Programs
    5. Other (describe): _____
    6. Combo of above (list): _____
    9. Missing

9. Budget line items allocate funds to implement CLAS management strategy:
    1. Human Resources/Staffing (FTE) Resources
    2. Training programs
    3. Educational Resources
    4. Consultants
    5. Diversity management initiatives
    6. Other (describe): _____
    7. Combo of above(list): _____
    9. Missing

1.4 Technology

Information Systems Collects Data by:	R	E	L	R/E	R/L	E/L	REL	Tot	Missing
10. Member Enrollment data	1	2	3	4	5	6	7	8	9
11. Member Enrollment by payer	1	2	3	4	5	6	7	8	9
12. Medicaid membership	1	2	3	4	5	6	7	8	9
13. Primary Care Provider profiles	1	2	3	4	5	6	7	8	9
14. Provider turnover	1	2	3	4	5	6	7	8	9
15. Grievance data	1	2	3	4	5	6	7	8	9
16. Availability of Interpreter Services	1	2	3	4	5	6	7	8	9
17. Outpatient visits	1	2	3	4	5	6	7	8	9

18. Data Collection Policy & Procedures for REL:
    1. Uses Observation Methods (staff using visual assessment)
    2. Uses Voluntary Reporting Methods (option for member to disclose)
    3. Combination of 1 & 2 above
    4. Other (describe): _____
    5. Does not indicate a limitation
    9. Missing

19. Website technology used to access/disseminate information on CLAS projects/products for:
    1. Members
    2. Provider network
    3. MCO staff
    4. Vendors
    5. Other (list): _____
    6. Combo of above (list): _____
    9. Missing

1.5. EQUIPMENT

Telecommunication systems used to access/disseminate information to members via:

	Yes	No	Missing
20. ATT Language Line Systems	1	2	9
21. Bilingual voicemail system	1	2	9
22. TTDY	1	2	9
23. Beeper system	1	2	9

1.6 PROGRAM DIRECTIVES

C & L Program Structure includes:	Yes	No	Missing
24. CLAS definition statement	1	2	9
25. Dedicated FTE staff	1	2	9
26. Workplan Goal & Deliverables	1	2	9
27. Policies & procedures	1	2	9
28. Budget allocated	1	2	9
29. CLAS Reporting	1	2	9

30. C & L Program Directives address policy and mandates:
1. Federal mandates/policy (Title 6, OMB #15, CLAS, BBA regs, etc.)
2. National accreditation (NCQA, JCAHO, etc.)
3. State mandates (Medicaid, Medicare + choice,)
4. Other (describe): _____
5. Combo of above (list): _____

9. Missing

31. CLAS Reporting is aimed at:
1. Consumer/members
2. Provider network
3. Community based organizations
4. Regulatory agencies (federal & state): _____
5. Funding sources
6. other not listed: _____
7. combo of above (list): _____

9. Missing/ not done

32. Public Reporting on CLAS activity is done via the following mechanisms:
1. Member newsletters
2. Provider newsletters
3. Existing organizational reports & documents
4. Stand alone documents/reports
5. Media (newspaper, TV, radio)
6. Conference presentations
7. Website information
8. combo of above (list): _____
9. Missing/ not done

2.1. WORKFORCE DEVELOPMENT

33. Diversity recruitment strategies include partnership with:
1. academic settings (universities, colleges, medical & allied health schools)

2. community based agencies
3. job fairs or employment programs
4. health care settings
5. Other (describe): _____
6. Combination of above (list): _____

9. Missing

34. Diversity retention strategies include:
    1. financial incentives
    2. career advancement programs
    3. minority mentoring programs
    4. reward& recognition events
    5. other (describe): _____
    6. combo of above (list): _____
    9. Missing

35. MCO Cultural Competence/Diversity Staff training is aimed at:
    1. Senior Mgt. staff (Executive &/or Board of directors)
    2. Middle managers & Administrators
    3. Clinical Staff (Drs., nurses, medical care staff)
    4. Other Professional Staff (technicians, educators, interpreters, etc.)
    5. Support Staff (clerical, etc.)
    6. Combo of above (list): _____
    9. Missing

36. MCO Staff training curriculum emphasizes improving:
    1. Basic diversity &/or or cultural awareness
    2. Knowledge of cultural health beliefs/practices among varying subgroups
    3. Strategies & techniques for cross-cultural & language communication
    4. Skills development pertinent to job roles (Planning, evaluation, QIP design, etc.)
    5. clinical mgt of chronic disease among various subgroups
    6. other topics not listed: _____
    7. combo of above (list): _____
    9. Missing/not done

37. MCO Staff training evaluation forms assess:
    1. curriculum objectives addressed above (list): _____
    2. pre & post test
    3. generic or logistics (topic/speakers interesting, food, speakers, space, etc.)
    3. other not listed: _____
    4. combo of above: _____
    9. Missing/not done

38. Frequency of Staff training is offered:
    1. Monthly
    2. 4x/yr (quarterly)
    3. 3x/yr
    4. 2x/yr (biannual)
    5. Annual
    6. Other: _____
    9. Missing

2.2 WORKGROUP MECHANISMS

39. Types of C & L specific workgroups/committees
    1. Diversity Taskforce/Council
    2. Cultural Competence Advisory Group
    3. CC-QIP committee/workgroup
    4. Task specific workgroups (ex: translations, brochure development, etc.)
    5. Other (describe): _____
    6. Combo of above (list): _____

9. Missing

40. C & L workgroup structure occurs as:
    1. Ad-hoc or when needed
    2. Formal ongoing activity (weekly, monthly, etc.)
    3. Other (list): _____
    4. Combo of above (list): _____
    9. Missing

41. Intra-workgroup communication on C & L efforts occurs through:
    1. meetings
    2. memos
    3. presentations
    4. other (list): _____
    5. combo of above (list): _____
    9. missing

2.3 COMMUNITY ASSESSMENT PROFILES

	R	E	L	R/E	R/L	E/L	REL	Tot	Missing
42. Demographic data profiles are done by	1	2	3	4	5	6	7	8	9
43. Public health data profiles are reviewed by	1	2	3	4	5	6	7	8	9
44. Ethnic subgroup health status profiles are done by	1	2	3	4	5	6	7	8	9

2.4 COMMUNITY COLLABORATION

45. Community Advisory Board/Committee includes:
    1. consumer representation
    2. physicians from practices that serve high percentage REL groups
    3. community based organization leaders
    4. clergy or church leaders
    5. other (list): _____
    6. combo of above (list): _____
    9. Missing

Marketing & Outreach is aimed at the following racial/ethnic sub-groups:

	Yes	No	Missing
46. Black/African Americans	1	2	9
47. Hispanic/Latino	1	2	9
48. Chinese	1	2	9
49. Vietnamese	1	2	9
50. Cambodian	1	2	9
51. Other subgroups (list): _____	1	2	9

52. Input on CLAS delivery policy, marketing & staff training from REL groups are obtained via:
    1. targeted focus groups with race/ethnic populations
    2. community advisory groups/committee
    3. community forums
    4. coalition groups
    5. Other (list): _____
    6. combo of above: _____
    9. Missing/ not done

2.5 MEMBER MATERIALS & SERVICES

Place X in box that reflects materials currently translated by the MCO:

TYPES OF MATERIALS	1 English	2 Spanish	3 Chinese	4 Vietnamese	5 Cambodian	6 Cantonese	7 Other (write in)	8 Combo	9 Missing
53. Enrollment application									
54. Member Handbook & coverage info.									
55. Member Newsletter									
56. Grievance materials									
57. Asthma									
58. Prenatal Care									
59. Emergency room use									
60. Diabetes									
61. Other health materials: (vital documents) _____ _____ _____ _____									

62. Translation policy & procedures utilize:
    1. one-way translation (bilingual staff translates into target language)
    2. double or back translation (translate into target language & back to English)
    3. translation by committee/group (>2 people)
    4. de-centering methods (developed for conceptual cultural equivalence)
    5. Other not listed: _____
    6. Combo of above : _____
    9. Missing

63. Notices to members of right to interpreters is provided via:
    1. "I speak" cards
    2. member handbook
    3. grievance materials
    4. member newsletter
    5. oral methods
    6. other (list): _____
    7. combo of above (list): _____
    9. Missing

64. Interpreter Services Management Accountability:
    1. Human Resources Dept.
    2. Cultural & Linguistic Program Dept.
    3. Community Outreach Dept.
    4. Legal Dept.
    5. Other (specify): _____
    6. External Supplier: _____
    9. Missing

65. Interpreter Service Staffing Mechanism(s):
    1. Paid staff (FTE)
    2. Volunteer Base (Internal &/or External)
    3. AT&T language line
    4. Subcontracted vendor (per diem, language banks, etc)
    5. Combo of above (list): _____
    9. Missing

66. Interpreter Service Hours of Operation:
    1. Normal Business hours (8-6 pm)
    2. 24 hours/day
    3. Varies with Volunteer Base
    4. As needed
    5. Combo of above (list): _____
    9. Missing

Interpreter Service Policy & Procedure Outlines:	Yes	No	Missing
67. Service Mission/Goals	1	2	9
68. Procedures for face-to face vs. phone service	1	2	9
69. Interpreter Competency Training	1	2	9
70. Interpreter Competency Skill Assessment	1	2	9
71. Training Competency Objectives	1	2	9
72. Staff Training Requirements	1	2	9
73. Frequency of Training	1	2	9
74. Language Data Collection	1	2	9
75. Language Data Analysis	1	2	9

Interpreter Training Curriculum objectives incorporates:	Yes	No	Missing
76. Proficiency in target language	1	2	9
77. Professional Code of Ethics competencies	1	2	9
78. Medical terminology translation	1	2	9
79. Cross-Cultural Communication skills	1	2	9

I. S. Skill Assessment Tools evaluates:	Yes	No	Missing
80. Proficiency in target language	1	2	9
81. Professional Code of Ethics	1	2	9
82. Medical Terminology translation	1	2	9
83. Cross-Cultural communication	1	2	9

84. I.S. Data Analysis reports on Language access/utilization are generated on:
1. Member enrollment by type of plan
2. Encounter data (claims, ,etc.)
3. Enrollee utilization
4. Cost Analysis by language
5. Other (list): _____
6. Combo of above (list): _____
9. Missing

2.6 QUALITY MONITORING

85. Patient Satisfaction Survey Tool(s) used:
1. Developed In-house survey
2. CAHPS
3. Other (describe): _____
5. Combo of above: _____
9. Missing

86. Patient Satisfaction Surveys are translated into:
1. English only
2. Spanish
3. Chinese
4. Vietnamese
5. Cambodian
6. Cantonese
7. Other
8. Combo of above (list): _____
9. Missing

	R	E	L	R/E	R/L	E/L	REL	Tot	Missing
87. Patient Satisfaction Data Collection is stratified by:	1	2	3	4	5	6	7	8	9
88. Patient Satisfaction Data Analysis is stratified by:	1	2	3	4	5	6	7	8	9

89. Grievance policy includes provisions for:
1. oral interpreters to be available to consumers
2. translated notices for NESP of right to file complaints
3. complaints/grievances from racial/ethnic subgroup
4. complaints/grievances from linguistic subgroups
5. other (list): _____
6. combo of above (list): _____

9. Missing [not done]

90. Grievance procedures provide:
1. staff-peer observation
2. medical record review
3. focus groups with consumer subgroups
4. other not listed _____
5. combo of above: _____
9. Missing

Clinical Process/Outcomes are Collected by:	R	E	L	R/E	R/L	E/L	REL	Tot	Missing
91. Asthma (admissions, mgt, meds)	1	2	3	4	5	6	7	8	9
92. Diabetic Care (eye exams, HbA1c, etc.)	1	2	3	4	5	6	7	8	9
93. Prenatal Care (1st trimester)	1	2	3	4	5	6	7	8	9
94. C-Section/VBAC rates	1	2	3	4	5	6	7	8	9
95. Well Child visits (1st 15 mos.)	1	2	3	4	5	6	7	8	9
96. Immunizations (child, adolescent)	1	2	3	4	5	6	7	8	9
97. Low Birth weight	1	2	3	4	5	6	7	8	9
98. Breast cancer screening (mammography)	1	2	3	4	5	6	7	8	9
99. Cervical cancer screening (pap test)	1	2	3	4	5	6	7	8	9
100. Cardiac Care	1	2	3	4	5	6	7	8	9
101. Emergency Room Visits	1	2	3	4	5	6	7	8	9
102. Inpatient utilization (general, acute, LOS)	1	2	3	4	5	6	7	8	9

103. Targeted CC-QIP activity focuses on improving:
1. MCO staff core competencies
2. MCO information system (data quality, documentation)
3. Provider Network core competencies
4. Provider network care coordination
5. Member Access (scheduling, wait time, interpreters, etc.)
6. Member Clinical Process/Outcome Indicators (HEDIS, etc)
7. Other (describe): _____
8. Combo of above (list): _____
9. Missing

104. CC-QIP Intervention is focused on:
1. MCO Staff Competency Training (knowledge, awareness, skills)
2. Mgt. Info. System Changes (add/change computer fields/field staff trg)
3. Provider Network competency training
4. Provider Care Coordination QIPs (PCC linkage, patient education, etc.)
5. Expand Language Access/Resources (add AT&T, hire staff, interpreters)
6. Monitoring select outcomes (describe): _____
7. Other (describe): _____
8. Combo of above (list):_____
9. Missing

105. CC-QIP efforts is Managed by:
1. Quality Mgt. Dept./Director, staff
2. Medical Director
3. C & L Program Director
4. Cross-disciplinary Team/Group (describe): _____
5. Other not listed (describe): _____
9. Missing

2.7 CLAS Purchasing Strategy

106. Types of CLAS specs in contract:
1. Requires CLAS standards 1-3

2. Requires CLAS standards 4-7
3. Requires CLAS standards 8-14
4. Other (describe): _____
5. Combo of above: (list): _____
9. Missing/none

107. C & L contracting Incentives:
1. financial
2. technical assistance
3. training programs
4. other: _____
5. combo of above: (list): _____
9. Missing

2.8 PROVIDER OPERATIONS

108. Provider training programs are targeted to
1. Physicians (solo & group)
2. Community & County Clinics
3. Hospitals (public, private)
4. Behavioral Health providers
5. Ancillary providers
6. Other providers:_____
7. Combo of Above: (list): _____
9. Missing/not done

109. Provider training curriculum emphasizes:
1. Basic cultural awareness/sensitivity
2. Knowledge of cultural health beliefs/practices among varying subgroups
3. Strategies & techniques for cross-cultural & language communication
4. Skills development pertinent to job roles (cross-cultural assmt, QIP design, etc.)
5. clinical mgt of chronic disease among various subgroups
6. other topics not listed: _____
7. combo of above: _____
9. Missing/not done

110. Provider training evaluation assesses:
1. curriculum objectives addressed above (list): _____
2. pre & post test
3. logistics of training (food, speakers, space, etc.)
4. other not listed: _____
5. combo of above: (list): _____
9. Missing/not done

111. Provider CC Training's are offered:
1. Monthly
2. 4x/yr (quarterly)
3. 3x/yr
4. 2x/yr (biannual)
5. Annual
6. Other: _____
9. Missing

112. Provider Training Programs offers:
1. CME
2. CEU
3. combo of above

9. Missing/ not done

2.9 PROVIDER NETWORK

Types of Provider Network targeted for C & L efforts:	Yes	No	Missing
113. Physicians (solo & group)	1	2	9
114. Community & County Clinics	1	2	9
115. Hospitals	1	2	9
116. Ancillary Providers	1	2	9
117. Pharmacy Benefit Managers/PCN	1	2	9
118. Other (AMP, CFMG, unilab, etc.)	1	2	9

Provider Manual includes guidance/instructions on CLAS implementation for:

	Yes	No	Missing
119. CLAS standards 1-3	1	2	9
120. CLAS standards 4-7	1	2	9
121. CLAS standards 8-14	1	2	9

122. Provider Network Cultural Mix Profile

Provider Staffing	Black	Asian	Hispanic	White	Other R/E	Spanish spoken	Chinese spoken	Other languages
Physician (PCC)								
Nurses (RN, NP)								
OB -GYN /Prenatal								
Mental Health								
Specialists (oncology, heart, endocrine, etc.)								
Other Allied health professional:								

123. Provider Network CLAS Assessment is conducted via:

1. Cultural competence assessment tools
2. Surveys
3. Focus groups
4. Provider meeting/forums
5. Contract reporting requirements
6. Other (describe): _____
7. Combo of above: _____
9. Missing

124. Frequency of Provider Network CLAS Assessment

1. Monthly
2. Quarterly
3. 3x/yr
4. 2x/yr
5. Annual
6. Combo of above: (list): _____
9. Missing/none

125. The MCO does a Cultural competence organizational self-assessment (OSA):

1. 1x/year
2. Every other year
3. Every 2-3 years

4. Other (describe): _____
9. Missing

126. Bilingual way-finding signage is located:
1. select points in MCO facility
2. all public areas in MCO facility
9. Missing/ none in place

127. Community Needs assessment methodology includes:
1. surveys
2. focus groups
3. individual interviews
4. other (describe): _____
5. combo of above (list): _____
9. Missing

Data Analysis of Outcome/Process indicators:	R	E	L	R/E	R/L	E/L	REL	Tot	Missing
128. Member Enrollment data	1	2	3	4	5	6	7	8	9
129. Member Enrollment by payer	1	2	3	4	5	6	7	8	9
130. Medicaid membership	1	2	3	4	5	6	7	8	9
131. Primary Care Provider profiles	1	2	3	4	5	6	7	8	9
132. Provider turnover	1	2	3	4	5	6	7	8	9
133. Grievance data	1	2	3	4	5	6	7	8	9
134. Availability of Interpreter Services	1	2	3	4	5	6	7	8	9
135. Asthma (admissions, mgt, meds)	1	2	3	4	5	6	7	8	9
136. Diabetic Care (eye exams, HbA1c, etc.)	1	2	3	4	5	6	7	8	9
137. Prenatal Care (1st trimester)	1	2	3	4	5	6	7	8	9
138. Immunizations (child, adolescent)	1	2	3	4	5	6	7	8	9
139. Low Birth weight	1	2	3	4	5	6	7	8	9
140. Breast cancer screening (mammography)	1	2	3	4	5	6	7	8	9
141. Cervical cancer screening (pap test)	1	2	3	4	5	6	7	8	9
142. Cardiac Care	1	2	3	4	5	6	7	8	9
143. Emergency Room Visits	1	2	3	4	5	6	7	8	9
144. Inpatient utilization (general, acute, LOS)	1	2	3	4	5	6	7	8	9
145. Outpatient visits	1	2	3	4	5	6	7	8	9
146. C-Section/VBAC rates	1	2	3	4	5	6	7	8	9
147. Well Child visits (1st 15 mos.)	1	2	3	4	5	6	7	8	9

CLAS CRITERION RATING

	Poor	Fair	Good	Excellent	NOTES
148. CLAS Definition statement	1	2	3	4	_____
149. MCO Diversity recruitment	1	2	3	4	_____
150. MCO Diversity retention	1	2	3	4	_____
151. MCO CLAS training	1	2	3	4	_____
152. MCO CLAS Training objectives	1	2	3	4	_____
153. MCO CLAS training evaluation	1	2	3	4	_____
154. Interpreter Service P & P	1	2	3	4	_____
155. Notice of right to interpreters	1	2	3	4	_____
156. Interpreter Competency training objectives	1	2	3	4	_____
157. Interpreter competency skill assessment tool	1	2	3	4	_____
158. Member materials	1	2	3	4	_____
159. Bilingual signage	1	2	3	4	_____
160. Translation P & P	1	2	3	4	_____
161. CLAS management strategy	1	2	3	4	_____
162. Operational plans for service functions	1	2	3	4	_____
163. Workgroup mechanisms	1	2	3	4	_____
164. Organizational self-audit	1	2	3	4	_____
165. Targeted CC-QIP	1	2	3	4	_____
166. Patient Satisfaction	1	2	3	4	_____
167. Data Collection by REL	1	2	3	4	_____
168. Data Analysis by REL	1	2	3	4	_____
169. Demographic data	1	2	3	4	_____
170. Epidemiology data	1	2	3	4	_____
171. Community based partnerships	1	2	3	4	_____
172. Grievance P & P	1	2	3	4	_____
173. CLAS Reporting	1	2	3	4	_____
174. Provider Network Diversity recruitment	1	2	3	4	_____
175. Provider Network CLAS Training	1	2	3	4	_____
176. Provider Training Objectives	1	2	3	4	_____
177. Provider Training Evaluation	1	2	3	4	_____
178. Provider CLAS Contract Specs	1	2	3	4	_____
179. Provider Manual	1	2	3	4	_____
Subscores:					

180. OVERALL CLAS Implementation Score: _____

To calculate #167 & 168

Data identifier	Data Collection # items (wt.)	totals	Data Analysis # items (wt).	totals
R/E/L	(1.0)		(1.0)	
R/E	(.5)		(.5)	
E/L	(.5)		(.5)	
E	(.25)		(.25)	
L	(.25)		(.25)	
Total	(.10)		(.10)	
Missing	(0)		(0)	
Totals				

Appendix C: Criterion Rating Scale

Criterion Rating Indicator	1 = POOR (Absent or Not implementing)	2 = FAIR (Planning or Minimal implementation)	3 = GOOD (Implementation is Limited in Scope)	4 = EXCELLENT (Best Practice Implementation)
148. CLAS Definition statement (defined as respectful, understandable & effective care by OMH)	No CLAS mission or goal statement is in place	In planning stage or existing one uses vague terms (community, poor, diverse groups, etc.)	Clear reference to member values &/or organizational outcomes (not both)	Clear reference to member values/cultural needs and organizational outcomes
149.MCO Diversity recruitment	No recruitment strategy is evident or has generic provisions for EEO	In planning stage or addresses at least 1 area coded [but not grounded in strategy]	Recruitment addresses select strategies (in 2-3 areas coded)	Reports comprehensive strategy that addresses > 4 areas coded
150. MCO Diversity retention	No diversity retention plan in place	Planning stage, has generic provisions or addresses at least 1 area of coded items	Reports select retention strategies (in 2-3 areas coded items)	Reports comprehensive retention strategies (>4 areas in coded items)
151. MCO Staff Diversity/CC Training (skill based)	No CC or diversity training is evident or has occurred	In planning or pilot stage, does at employee orientation or on request	Reports occasional [1x/yr] training with Mgt, &/or non-mgt staff (not both)	Reports ongoing [2-4x/yr] training with both Mgt & non-mgt staff
152. MCO CLAS Training Objectives	No CLAS competency objectives are identified	In planning or pilot stage or targets at least 1 area coded related to job roles	Focus on basic competency objectives related to job roles (2-3 areas of coded items)	Focus on broad competency training (> 3 areas listed in coded items)
153. MCO CLAS Training Evaluation	No evaluation process in place	In planning stage, or uses generic evaluations not linked to training objectives	Evaluates competency objectives (but no post-test to determine skill attainment)	Uses pre & post evaluation to assure competency objectives are attained
154. Interpreter Service P & P (of MCO)	Has no P & P in place or in process of developing (Score = 0 – 1 pt..)	Has outlined minimal P & P from coded items (Score = 1 – 4 pts.)	Has adapted select P & P from coded items (Score 4.1 – 8 pts.)	Adapts most P & P based on code items (Score 8.1 – 13 pts.)
155. Notice of Right to Interpreters (verbal & written)	Does not provide notices to members	In Planning stage or provides notices in at least 1 format	Provides notices in select verbal or written formats (not both)	Implements notices in multiple formats & languages
156. Interpreter Competency Training Objectives	Does not identify competency objectives or states in planning stage	Minimal competency training objectives addressed in at least 1 of 4 areas coded	Partial competency training objectives addressed in 2-3 areas coded	Comprehensive competency training objectives addresses in > 3 areas coded
157. Interpreter Competency Skill Assessment tools	Does not use skill assmt tools or infers planning to	Identifies competency skill assessment in at least 1 of 4 objectives	Identifies competency skill assessment in 2-3 competency objectives coded	Identifies competency skill assmt in > 3 competency objectives coded
158. Translate Member Materials	No translation of materials are evident	In planning phase or translates materials for at least 1-3 topic areas coded	Translates materials for at least 4-6 topic areas coded	Translates materials for > 6 topic areas coded

159. Bilingual Signage	No bilingual way-finding signage is evident	In planning phase to have bilingual signage installed	Has bilingual signage at select points of entry in the facility	Has bilingual signage in all public areas of the facility
160. Translation Policy & Procedures	No translation P & P is evident	In planning stage or has limited policy or uses minimal procedures (one-way translation)	Uses back translation or multi-person methods for some materials	Uses cultural equivalence translation methods for all materials
161. CLAS Mgt Strategy	No CLAS Mgt. workplan evident	In planning phase or existing one uses vague terms (diversity, community, etc.)	Identifies consumer & system area goals but strategy not anchored in mission statement	Identifies clear consumer & system area goals and is anchored in mission statement.
162. CLAS Operational plans	No CLAS workplan is in place	In planning stage or has an ad-hoc workplan	Plan targets select ethnic groups, system or service improvements (not all)	Plan targets all ethnic groups, service and system function improvements
163. CLAS Workgroup Mechanisms	Reports no workgroups in place to implement CLAS workplans	Reports ad-hoc groups or at least 1 workgroups in place	Reports at least 2-3 CLAS workgroups in place	Reports > 4 CLAS workgroups in place
164. Organization Self-Assmt (OSA)	Does not do use OSA to inventory CLAS strategy, progress or P&P	In planning stage, existing process is vague or does informal OSA	Conducts occasional OSA to inform CLAS strategy or progress (every 1-2 yrs)	Conducts ongoing OSA to inform CLAS strategy & progress (quarter/biannual)
165. Targeted CC-QIP	No QIP activity evident	Reports in planning or piloting stage or QIP not relevant to quality domains	Reports some (1-2 areas coded) QIP activity relevant to REL consumer groups	Reports a variety (>3 areas coded) of QIP activity relevant to REL consumer groups
166. Patient Satisfaction Survey	Not translating or targeting surveys for REL subgroups	In planning stage, targets surveys to at least 1 REL sub-group or translates survey into at least 1 language	Targets surveys to select REL groups) &/or translates surveys in at least 2 – 3 languages	Targets surveys to all REL subgroups and translates survey in> 4 languages
167. Data Collection by REL (21 items]	Does not stratify measures or aggregates by Totals only (Scores = 0 – 3 pt.s.)	Collects minimal admin/clinical measures by R/E/L (Scores = 3.1 – 10.5 pts.)	Collects select admin/clinical measures by R/E/L (Scores = 10.6 – 16 pts.)	Collects all admin/clinical measures coded by REL (Scores = 16.1 – 21 pts.)
168. Data Analysis by REL [22 items]	Not analyzing any data by REL or does by totals only (Scores = 0 – 3 pt.s.)	Does minimal analysis of admin/clinical data by REL (Scores = 3.1 – 11 pts.)	Does some analysis of admin./clinical data by REL (Scores = 11.1 – 16 pts.)	Analyzes most admin/clinical data by REL (Scores = 16.1 – 22 pts.)
169. Demographic Data for CLAS Planning	Does not use census data for CLAS planning	In planning stage or collects data but no action taken	Uses census data for select aspects of CLAS planning or identifying community need profiles (not both)	Uses census data to inform all aspects of CLAS planning and to develop community need assessment profiles

170. Epidemiology data for CLAS Planning	Does not use public health data to develop Community health status profiles	In planning stage or has data but no action taken	Uses public health data for select aspects of CLAS planning or assmt profiles	Uses public health data for all aspects of CLAS planning & to develop community health status profiles
171. Community Based Partnerships	Does not report any activity	In planning stage or has limited CBO collaboration (ad-hoc groups)	Uses community advisory group &/or targets REL communities [not both]	Reports formal community advisory groups and ongoing collaboration with all REL consumer groups
172. Grievance Policy & Procedures	No P& P has been adapted to address processes for CLAS standards	In planning stage to adapt P&P or existing one is vague or unclear	Partial amendments for race discrimination &/or language based complaints (not both)	Clear P& P for language and race discrimination based complaints
173. CLAS Reporting	No CLAS reporting is done or communication plan is in place	In planning stage to develop CLAS public reports or does minimal reporting	Does cLAS reporting to select internal or external stakeholder groups (not both)	Does CLAS reporting to all internal & external stakeholder groups
174. Provider Network Diversity Recruitment	No strategy evident for diversity recruitment of REL PCC staff	In planning stage to develop plan or does informally [no clear strategy]	Reports focus to recruit racial & linguistic minority PCC staff (not both)	Reports focus to recruit both racial & linguistic minority PCC staff
175. Provider Network CLAS Training	No training in CLAS is evident	In planning or piloting stage or in process to secure CME, CEU	Targets occasional training to PCC staff &/or includes CME/CEU (not both)	Targets ongoing training to PCC and provides CEU/CME
176. Provider CLAS Training Objectives	No CLAS competency objectives are identified	In planning or pilot stage or targets at least 1 area coded related to job roles	Focus on basic competency objectives related to job roles (2-3 areas of coded items)	Focus on broad competency training (> 3 areas listed in coded items)
177. Provider CLAS Training Evaluation	No evaluation process in place	In planning or pilot stage, or uses generic evaluations not linked to training objectives	Evaluates competency objectives (but no post-test to determine skill attainment)	Uses pre & post evaluation to assure competency objectives are attained
178. Provider CLAS Contracting	No specs included for CLAS requirements, or existing ones too vague	Planning to include specs or includes at least 1-3 CLAS standard requirements	Includes select specs for at least 4-6 CLAS standard requirements	Includes comprehensive specs for > 6 CLAS standard requirements
179. Provider Manual	No provisions in manual to implement CLAS contract requirements.	Planning to include provisions or has vague guidelines for CLAS	Includes provisions to implement select CLAS specs required in contracts	Outlines provisions to implement all CLAS standards required.

Appendix D: Code Tool Instructions

Appendix D: Coding Instructions

var. 1	MCO Mission statement describes valuing diversity	1= Yes (submitted info) 2 = No (submitted info but text does not mention) 9 = Missing (no info submitted to code this item)
var. 2	Diversity Business Plan [*see also HR P&P*]	1= Yes (submitted info) 2 = No (submitted info but text does not mention) 9 = Missing (no info submitted to code this item)
var. 3	CLAS management strategy	1= Yes (submitted info) 2 = No (submitted info but text does not mention) 9 = Missing (no info submitted to code this item)
var. 4	Board racial/ethnic profile (Data to be calculated)	1= Yes (submitted info) 2 = No (submitted info but text does not mention) 9 = Missing (no info submitted to code this item)
var. 5	MCO ethnic minority staff mix	Data to be calculated
var. 6.	Ethnic minority staff positioning	Data to be calculated
var. 7	Organizational revenue sources	1 = federal (grants, contracts, etc.) 2 = state (Medicaid, state programs, etc) 5 = Other not listed (grants, etc.) 6 = Combo (write in #'s above) 9 = Missing (no info submitted to code this item)
var. 8	Types of Programs Funded	5 = Other (write in if not listed above) 6 = Combo (write in #'s above) 9 = Missing (no info submitted to code this item)
var. 9	Budget allocation	6 = Other (write in if not listed above) 7 = Combo (write in #'s above) 9 = Missing (no info submitted to code this item)

var. 10-17 These variables are to represent ***data collection*** activity that is defined as generating standardized reports using the organization's internal information systems [separate from *external data – census, county, public, etc*.].

Circle data identifiers used for standardized reporting as follows:

1- Race only (R)	4 - Race & Ethnicity only (R/E)	7 - Race, Ethnicity & Language (R/E/L)
2 - Ethnicity only (E)	5 - Race & Language only (R/L)	8 - Total numbers provided only (T)
3 - Language only (L)	6 - Ethnicity & Language only (E/L)	9 - Missing (Blank/No submission)

NOTE: *AH uses the word 'ethnicity' to mean race & ethnicity [which is inconsistent with OMB #15]. Ethnicity code 3 & 6 to be used when aim is to generate data for select subgroups within 1 racial group (ex: Asian – Vietnamese, Cambodian, Laotian, etc.) or Hispanic subgroups for the data indicator being coded.*

var. 18.	Data Collection P& P for REL	4 = Other (write in if not listed above) 9 = Missing (no info submitted to code this item)
var. 19	Website technology used	5 = Other (write in if not listed above) 6 = Combo (write in #'s above) 9 = Missing (no info submitted to code this item)

var. 20-23	Telecommunication systems used	1= Yes (submitted info) 2 = No (submitted info but text does not mention) 9 = Missing (no info submitted to code this item)
var. 24-29	C & L Program description includes	1= Yes (submitted info) 2 = No (submitted info but text does not mention) 9 = Missing (no info submitted to code this item)
var. 30.	C & L Program operationalized on	4 = Other (write in if not listed above) 5 = Combo (write in #'s above) 9 = Missing (no info submitted to code this item)
var. 31.	CLAS Reporting is aimed at:	6 = Other (write in if not listed above) 7 = Combo (write in #'s above) 9 = Missing (no info submitted to code this item)
var. 32	Public Reporting on CLAS activity	8 = Combo (write in #'s above) 9 = Missing (no info submitted to code this item)
var. 33	MCO Diversity recruitment activity	5 = Other (write in if not listed above) 6 = Combo (write in #'s above) 9 = Missing (no info submitted to code this item)
var. 34	MCO Diversity retention activity	5 = Other (write in if not listed above) 6 = Combo (write in #'s above) 9 = Missing (no info submitted to code this item)
var. 35	Diversity/Cultural Competence Training	6 = Combo (write in #'s above) 9 = Missing (no info submitted to code this item)
var. 36	MCO Staff Div/CC Training Curriculum	6 = Other (write in if not listed above) 7 = Combo (write in #'s above) 9 = Missing (no info t submitted to code this item)
var. 37	MCO Staff CC training evaluation forms	3 = Other (write in if not listed above) 4 = Combo (write in #'s above) 9 = Missing (no info submitted to code this item)
var. 38	Frequency of Staff CC/Div Training	6 = Other (write in if not listed above) 9 = Missing (no info submitted to code this item)
var. 39	Types of C & L Workgroups/Committees	5 = Other (write in if not listed above) 6 = Combo (write in #'s above) 9 = Missing (no info submitted to code this item)
var. 40	C & L workgroup structure	3 = Other (write in if not listed above) 4 = Combo (write in #'s above) 9 = Missing (no info submitted to code this item)
var. 41	C& L intra-workgroup communication	4 = Other (write in if not listed above) 5 = Combo (write in #'s above) 9 = Missing (no info submitted to code this item)

var. 42-44 These variables represent ***data collection & analysis*** activity to generate reports using data sources external to the organizations information system [ex: *census, county or public health data*]

Circle data identifiers used for profile reporting as follows:

1- Race only (R)	4 - Race & Ethnicity only (R/E)	7 - Race, Ethnicity & Language (R/E/L)
2 - Ethnicity only (E)	5 - Race & Language only (R/L)	8 - Total numbers provided only (T)
3 - Language only (L)	6 - Ethnicity & Language only (E/L)	9 - Missing (Blank/No submission)

NOTE*: Same note as in var. 10-17 applies here*

var. 45	Community Advisory Board/Committee makeup	5 = Other (write in if not listed above) 6 = Combo (write in #'s above) 9 = Missing (no info submitted to code this item)
var. 46-51	Marketing/Outreach is aimed at R/E sub-groups	1= Yes (submitted info) 2 = No (submitted info but text does not mention) 9 = Missing (no info submitted to code this item)
var. 52.	Consumer input in CLAS Mgt. strategy	5= Other (write in if not listed above) 6 = Combo (write in #'s above) 9 = Missing (no info submitted to code this item)
var. 53-61	Translated Member materials	7 = Other (write in language not listed) 8 = Combo (write in #'s of language scale) 9 = Missing (no info submitted to code this item)
var. 62	Translation policy & procedures	5 = Other (write in if not listed above) 6 = Combo (write in #'s above) 9 = Missing (no info submitted to code this item)
var. 63	Member notice of right to interpreters	6 = Other (write in if not listed above) 7 = Combo (write in #'s above) 9 = Missing (no info submitted to code this item)
var. 64	Interpreter Service Mgt. Oversight	5 = Other (write in if not listed above) 6 = Include name of vendors, subcontracts 9 = Missing (no info submitted to code this item)
var. 65	Interpreter Service Staffing Mechanism(s)	5 = Combo (write in #'s above) 9 = Missing (no info submitted to code this item)
var. 66	Interpreter Service Hours of Operation	5 = Combo (write in #'s above) 9 = Missing (no info submitted to code this item)
var. 67-75	Interpreter Service P & P Outlines	1= Yes (submitted info) 2 = No (submitted info but text does not mention) 9 = Missing (no info submitted to code this item)
var. 76-79	Interpreter Training Curriculum objectives	1= Yes (submitted info) 2 = No (submitted info but text does not mention) 9 = Missing (no info submitted to code this item)
var. 80-83	I. S. Skill Assessment Tools evaluates:	1= Yes (submitted info) 2 = No (submitted info but text does not mention) 9 = Missing (no info submitted to code this item)
var. 84	I.S. Data Analysis reports generated for (analysis differs from standardized report)	5 = Other (write in if not listed above) 6 = Combo (write in #'s above) 9 = Missing (no info submitted to code this item)
var. 85	Patient Satisfaction Survey Tool(s) used:	5 = Combo (write in #'s above) 9 = Missing (no info submitted to code this item)
var. 86	Patient Satisfaction Surveys are translated into:	7 = Other (write in if not listed above) 8 = Combo (write in #'s above) 9 = Missing (no info submitted to code this item)

var. 87-88 Patient Satisfaction Data Collection & Analysis [*See definitions for coding var. 10-17; 128-148]*

Circle data identifiers used for profile reporting as follows:

1- Race only (R)	4 - Race & Ethnicity only (R/E)	7 - Race, Ethnicity & Language (R/E/L)
2 - Ethnicity only (E)	5 - Race & Language only (R/L)	8 - Total numbers provided only (T)
3 - Language only (L)	6 - Ethnicity & Language only (E/L)	9 - Missing (Blank/No submission)

var. 89 Grievance policy includes provisions

5 = Other (write in if not listed above)
6 = Combo (write in #'s above)
9 = Missing (no info submitted to code this item)

var. 90 Grievance procedures describe

4 = Other (write in if not listed above)
5 = Combo (write in #'s above)
9 = Missing (no info submitted to code this item)

var. 91-102 These variables represent ***data collection*** activity that is defined as generating standardized reports for *Clinical Process/Outcome Indicators* using the organization's internal information systems [***not*** *external data – census, county or public health, etc*.].

Circle data identifiers used for standardized reporting as follows:

1- Race only (R)	4 - Race & Ethnicity only (R/E)	7 - Race, Ethnicity & Language (R/E/L)
2 - Ethnicity only (E)	5 - Race & Language only (R/L)	8 - Total numbers provided only (T)
3 - Language only (L)	6 - Ethnicity & Language only (E/L)	9 - Missing (Blank/No submission)

NOTE: *AH uses the word 'ethnicity' to mean race & ethnicity [which is inconsistent with OMB #15]. Ethnicity code 3 & 6 to be used when aim is to generate data for select subgroups within 1 racial group (ex: Asian – Vietnamese, Cambodian, Laotian, etc.) or Hispanic subgroups for the data indicator being coded.*

var. 103 Targeted CC-QIP activity focus

7 = Other (write in if not listed above)
8 = Combo (write in #'s above)
9 = Missing (no info submitted to code this item)

var. 104 Focus of CC-QIP Intervention

7 = Other (write in if not listed above)
8 = Combo (write in #'s above)
9 = Missing (no info submitted to code this item)

var. 105. Management of CC-QIP efforts

5 = Other (write in if not listed above)
9 = Missing (no info submitted to code this item)

var. 106 Types of CLAS specs in contract:

4 = Other (write in if not listed above)
5 = Combo (write in #'s above)
9 = Missing (no info submitted to code this item)

var. 107 C & L contracting Incentives

4 = Other (write in if not listed above)
5 = Combo (write in #'s above)
9 = Missing (no info submitted to code this item)

var. 108 Provider training programs

6 = Other (write in if not listed above)
7 = Combo (write in #'s above)
9 = Missing (no info submitted to code this item)

var. 109 Provider training curriculum

6 = Other (write in if not listed above)
7 = Combo (write in #'s above)
9 = Missing (no info submitted to code this item)

var. 110 Provider training evaluation

4 = Other (write in if not listed above)
5 = Combo (write in #'s above)
9 = Missing (no info submitted to code this item)

var. 111	Provider CC Training frequency	6 = Other (write in if not listed above) 9 = Missing (no info submitted to code this item)
var. 112	Provider Training CME/CEU	3 = Combo (write in #'s above) 9 = Missing (no info submitted to code this item)
var. 113-118	Types of Provider Network targeted	1= Yes (submitted info) 2 = No (submitted info but text does not mention) 9 = Missing (no info submitted to code this item)
var. 119-121	Provider Manual CLAS provisions	1= Yes (submitted info) 2 = No (submitted info but text does not mention) 9 = Missing (no info submitted to code this item)
var. 122	Provider Network Cultural Mix Profile	To be calculated
var. 123	Provider Network CLAS Assessment	6 = Other (write in if not listed above) 7 = Combo (write in #'s above) 9 = Missing (no info submitted to code this item)
var. 124	Frequency of Provider CLAS Assessment	6 = Other (write in if not listed above) 9 = Missing (no info submitted to code this item)
var. 125	MCO CC organizational self-assessment	4 = Other (write in if not listed above) 9 = Missing (no info submitted to code this item)
var. 126	MCO Bilingual signage	9 = Missing (no info submitted to code this item)
var. 127	Community Needs assessment methodology	4 = Other (write in if not listed above) 5= Combo (write in #'s above) 9 = Missing (no info submitted to code this item)

var. 128-157 These variables represent ***data analysis*** activity defined as examining data collected from the organization's internal information systems [***not*** *external data— census, etc*.] to identify & describe differences among consumer subgroups.

Circle data identifiers used for reporting as follows:

1- Race only (R)	4 - Race & Ethnicity only (R/E)	7 - Race, Ethnicity & Language (R/E/L)
2 - Ethnicity only (E)	5 - Race & Language only (R/L)	8 - Total numbers provided only (T)
3 - Language only (L)	6 - Ethnicity & Language only (E/L)	9 - Missing (Blank/No submission)

NOTE: *AH uses the word 'ethnicity' to mean race & ethnicity [which is inconsistent with OMB #15]. Ethnicity codes 3 & 6 to be used when documents mention targeted analysis aimed at subgroups within 1 racial group (ex: Asian – Vietnamese, Cambodian, Laotian, etc.) or Hispanic subgroups.*

var. 148-180 CRITERION RATING INSTRUCTIONS (see attached **Table 1** for descriptive rating scale)

When rating each CLAS standard refer to the responses (& documents) coded for items listed and Table 1. Rating should be entered by circling item in code tool.

		Refer to
Var.148	CLAS definition	item 24
Var.149	MCO Diversity recruitment	items 4 – 6 & 33
Var.150	MCO Diversity retention	item 34
Var.151	MCO CLAS training	items 35 & 38
Var. 152	MCO Training objectives	items 36 & 38
Var.153	MCO Training evaluation	item 37
Var.154	Interpreter P&P	items 62, 64 – 75 [see below]

Scoring for Var. 154 is calculated based on 13 items coded

- Assign a weighted score for items with Yes = 0.80 pts & No/Missing = 0 pts.
- Total the number of weighted scores (fractions) for the 13 items coded
- Refer to CLAS item & scoring assignment scale that matches your total score in Table 2 below.

Var.155	Notice of Rt to Interpreter	items 63 & 89
Var. 156	Interpreter training objectives	items 76 – 79
Var. 157	Interpreter skill assessment	items 80 – 83
Var. 158	Member materials	items 53 – 61
Var. 159	Bilingual signage	item 126
Var. 160	Translation P&P	item 62
Var. 161	CLAS Mgt strategy	items 3, 24 – 29
Var. 162	C&L operational workplan	items 3, 24 – 29
Var. 163	Workgroup mechanisms	items 39 – 41
Var. 164	Organizational self-audit	item 125
Var. 165	Targeted CC-QIP	items 103 – 105
Var. 166	Patient satisfaction	items 85 – 86 & CAHPS Reports
Var. 167	Data collection by REL	items 10 – 17; 87; 91 – 102

Scoring for Var. 167 is calculated based on 21 items coded

- Assign a weighted score (fraction) for each data elements coded based on scores in column 3 of Table 2 below
- Total the number of weighted scores (fraction) for the 21 items to get a total score
- Refer to CLAS item for DC by REL & scoring assignment scale that matches your total score in Table 2 below

Var. 168 Data analysis by REL items 84, 88, 128 – 148

Scoring for Var. 168 is calculated based on 22 items coded

- Assign a weighted score (fraction) for each data elements coded based on scores in column 3 of Table 2 below
- Total the number of weighted scores (fractions) for the 22 items to get a total score
- Refer to CLAS item for DA by REL & scoring assignment scale that matches your total score in Table 2 below

Var. 169	Demographic data for plg	items 42 & 44
Var. 170	Epidemiology data for plg	items 43 & 44
Var. 171	CBO Partnerships	items 45 – 52
Var. 172	Grievance P & P	items 89 – 90
Var. 173	CLAS reporting	items 19, 29, 31-32
Var. 174	Provider network recruitment	item 122
Var. 175	Provider Network CLAS Training	item 108 – 112
Var. 176	Provider Training Objectives	item 109
Var. 177	Provider Training Evaluation	item 110
Var. 178	Provider Contract Specs	item 106 & 107
Var. 179	Provider Manual	item 119 – 121

Var. 180 Overall CLAS Implementation Score: To calculate score assign a weight to each item rated (poor – excellent) based criterion rating weight scores column of table below. Total your number of weighted scores for the 32 items. Refer to overall rating score assignments that match your total score in table below

Table2: Scoring Instructions

DATA VARIABLES (Definitions for OMB)	CODE NAME	WTD SCORE	CRITERION RTG WT. SCORES	RATED CATEGORY	OVERALL RATING SCORE ASSIGNMENTS			
Race (Asian, Black, White, N.American, Hawaiian/ Pacific Islander)	R	0.25	1 = 0.25	CLAS item	*Poor*	*Fair*	*Good*	*Excellent*
Ethnicity (Hispanic only)	E	0.25	2 = 0.50	Interpreter P & P	<1 pt.	1 – 4	4.1 – 8	8.1 – 13
Language	L	0.25	3 = 0.75	DC by REL	0 –3 pts.	3.1-10.5	10.6-16	16.1- 21
Race/Ethnicity	R/E	0.75	4 = 1.00	DA by REL	0 – 3 pts	3.1-11	11.1-16	16.1-22
Race/Language	R/L	0.50						
Ethnicity/Language	E/L	0.50		**Overall CLAS Implementation**	**0 – 8 pts**	**8.1 - 16**	**16.1 - 24**	**24.1 - 32**
Race/Ethnicity/Language	R/E/L	1.00						
Totals only	Tot	0.10						
Missing [not available]	Missg	0						

Appendix E: Site Visit Reports

A. Background and Purpose

A site visit was conducted by ORC Macro staff at the Alameda Alliance for Health (the Alliance) in Oakland, CA, beginning on Wednesday, February 20, and ending on Friday, February 22, 2002. The Alliance was selected as the project site for the Office of Minority Health (OMH) CLAS Pilot Project, whose purpose is to implement a pilot study that will report on guidelines and processes for implementing the CLAS standards among health care organizations. The project will document both enabling factors and potential barriers to the implementation of the CLAS standards. Additionally, the pilot project will measure the impact of implementing the CLAS standards by a major managed care organization (MCO) on both its provider and patient population. The project will also measure the financial and procedural impact of the implementation of the CLAS standards on a major MCO.

The site visit served as a means for key staff members of the respective organizations to meet each other in person; for the ORC Macro contingent to understand better the range of services and activities offered by the Alliance; and for ORC Macro staff to begin data collection activities.

Four staff members from ORC Macro attended the site visit for varying periods of time. Molly Delaney, research assistant, and C. Godfrey Jacobs, project director, were present for the duration of the site visit. Ellen Marks, research coordinator, attended all but the last two sessions; while Adrienne Semidey, training coordinator, joined the group on Thursday through the Friday sessions. Guadalupe Pacheco, project officer, was present during the Thursday and Friday sessions.

The Alliance's key staff members who attended most of the sessions were Irene Ibarra, CEO; Kelvin Quan, CFO; Juanita Dimas, Cultural and Linguistic Program Manager; and Michele Prestowitz, Cultural and Linguistic Program Coordinator. Additionally, the site visitors met with each of the division heads and members of their staff. A copy of the site visit agenda appears at the end of this report.

This report presents, in section B, the key findings of the site visit. Section C presents summaries of each session conducted during the site visit. Subsequent sections of this report are based on ORC Macro staff debriefings following the site visit, and present major themes that were discerned; major questions that require further exploration; preliminary potential interventions; and needed additional information.

Much has transpired since the site visit. The issues addressed in this report have already resulted in a revised technical approach, which has been submitted to OMH as a separate document. In it, specific goals are outlined, tasks detailed, and time frames presented.

B. Key Findings

Based on the discussions conducted with The Alliance staff, ORC Macro site visitors found that the Alliance was much further along in their CLAS related activities than had been apparent prior to the site visit. Following are the six key findings to this effect.

- **Commitment to CLAS**
  The Alliance is fully committed to and engaged in the implementation of cultural and linguistic initiatives, including the CLAS standards. Among the most significant and visible of these are printed materials in several languages, radio spots, and interpretation services and the various culture and language initiatives. The Alliance is fully cognizant of the CLAS standards and has used them in designing its cultural and linguistic initiative.

- **Buy-in from key officials**
  The leadership of the Alliance is fully committed to the various cultural and linguistic initiatives currently being pursued. The CEO, CFO, and Medical Director enthusiastically endorse these initiatives and view them as good medical and business practice.

- **Alliance has concerns about reaching its audiences**
  Alliance staff expressed concerns that, so far, portions of the C&L initiatives are not producing the outcomes they had expected. For example, despite the provision of materials and incentives, few providers utilize the readily available interpreter services for their patients. Alliance staff are questioning whether there may be more effective ways to reach the provider community.

- **Physicians are inundated with information**
  Compounding the difficulty of effectively reaching providers is, according to Alliance staff, the complaint from physicians that they have too much to manage in terms of forms, paperwork, and other Alliance and other managed care-related requirements. The Alliance has acknowledged the need to streamline such requirements and to identify more effective channels for reaching physicians with messages.

- **Extent of and Relationship with Provider Network**
  The Alliance serves its membership through a contracted provider network of more than 1,300 physicians practicing in solo and group practices and in community clinics, over 100 ancillary providers, 160 pharmacists, and all major hospitals in the county. The Alliance provider network includes providers with capabilities in over 20 different languages. In addition, the community clinics that are part of the Community Health Center Network have made providing health care to the major cultural and linguistic groups in the county a priority. The Alliance reports having a good reputation and working relationships among its providers.

- **Diverse population**
  The Alliance serves a richly diverse population. Of the more than 81,000 current plan members, 35% are African-American, 23% Latino/a, 13% Caucasian, 9% Vietnamese, 5% Chinese, 2% Cambodian, 2% Laotian, and 6% other Asian/Pacific Islander. More than 40% of the plan members have a primary language other than English. The Alliance's membership composition strongly indicates the importance of providing culturally and linguistically appropriate services.

C. Session Summaries

Following are summaries of the twelve respective sessions that were conducted during the site visit.

Wednesday, February 20, 2002

Session: Welcome and General Orientation
Attendees: Molly Delaney, Ellen Marks, C. Godfrey Jacobs, Irene Ibarra, Kelvin Quan, Juanita Dimas, Michele Prestowitz

Irene Ibarra spoke on behalf of the Alliance and welcomed the ORC Macro site visit team. She indicated that she and her staff were excited to be part of this pilot study. She also mentioned that Art Chen, Medical Director, was the only key staff member who would not be available during the site visit. Godfrey Jacobs spoke on behalf of ORC Macro and indicated that he was pleased to have the Alliance as a partner in this important undertaking.

Alliance staff then provided a general orientation regarding how the Alliance functions. They pointed out that the provider network, consisting of 299 primary care physicians (PCP's) and 1300 specialists are the key individuals in the provision of care. The Alliance has contracts with them to provide care to their approximate 81,000 members or patients, in Alameda County.

The staff pointed out that the challenge with the providers was in getting them to change their behavior as it relates to the provision of culturally and linguistically appropriate services. The staff's goal is to move beyond "sensitivity" to behavioral change. The key issue is how to get the providers to utilize materials that are provided by the Alliance. The same applies to the membership group.

The main competitor for The Alliance is Blue Cross/Blue Shield. Since The Alliance was chartered by the State of California to be a not for profit organization, all profits are recycled to the providers. Administrative data is collected from providers that allows The Alliance to compare outcomes among the various providers. The Alliance provides incentives for this data.

Session: **Alliance Overview**
Attendees: **Molly Delaney, Ellen Marks, C. Godfrey Jacobs, Irene Ibarra, Kelvin Quan, Michele Prestowitz, Nina Maruyama**

Nina Maruyama, Director, Corporate Development & Government Relations, joined Irene Ibarra in presenting an overview of the Alliance. A summary of the information that was presented follows.

Membership and Background

- California Knox-Keene Licensed Local Health Plan.
- Current membership: 81, 482
  - Medi-Cal (began Jan. '96)—67,973
  - Healthy Families (began Jul. '98) —6,232.
  - Family Care (began Jul. '00) —5,166
  - First Care (began Jul. '00)—187
  - Alliance Group Care (began June '01)—1,924
- Public/private partnership represented by independent 12-member Board.
- Support for traditional and safety net providers.
- Dedicated to serve a culturally and linguistically diverse community.

Two-Plan Model

- State Department of Health Services (DHS) Two-Plan Model – Introduced in March '93
- DHS administers the Medi-Cal program
- 12 Counties were chosen to participate:
  - Alameda, Contra Costa, San Francisco, Santa Clara, San Joaquin, Tulare, Kern, Riverside, San Bernadino, Los Angeles, Stanislaus, and Fresno
- Two Plans:
  - Locally-developed, comprehensive HMO
  - Commercial plan
- Both must be Knox-Keene licensed

Who Can Join a 2-Plan Medi-Cal Managed Care Plan?

- Mandatory Eligibles: TANF (CalWorks), medically indigent children, medically needy no share of cost families, refugees and Medi-Cal only
- Voluntary Eligibles: Aged, blind and disabled, SSI and foster children
- Ineligible: Medi-Cal Share of Cost
- Regular Medi-Cal continues to exist

Formatted: Bullets and Numbering

Formatted: Bullets and Numbering

Formatted: Bullets and Numbering

Local Health Plans

- Northern CA
  - Alameda Alliance for Health
  - Contra Costa Health Plan
  - Health Plan of San Joaquin
  - San Francisco Health Plan
  - Santa Clara Family Health Plan
- Southern CA
  - Inland Empire Health Plan
  - Kern Family Health Care Plan and LA Care

Commercial Plans

- California Care/Blue Cross of California
  - Alameda, Contra Costa, San Francisco, San Joaquin, Santa Clara, Kern, Stanislaus, Tulare, and Fresno
- Health Net
  - Los Angeles, Fresno and Tulare
- Molina Health system
  - Riverside and San Bernadino

Service Area and Provider Network

- Service area is Alameda County
- Provider network consists of the Alliance's comprehensive, county-wide provider network
- Private and public providers
  - Over 1,000 providers and clinics
  - All major hospitals
  - Over 150 pharmacists

Formatted: Bullets and Numbering

Access to Health Care for Low-Income Families

- Alliance mission to serve the underserved and uninsured
- Continuity of coverage for working families from Medi-Cal to employment
- Affordable and comprehensive coverage for uninsured families up to 300% of FPL

Family Care Target Population

- Parents and siblings of Healthy Families and Medi-Cal members
- Immigrant families and undocumented children
- Low-income working families, including families that leave Medi-Cal
- Fills gaps in family coverage

Application Process

- One application per family
- Statement of Health for each person to be enrolled
- First month premium payment
- Income documentation, if needed
- U.S. citizenship or legal resident status is not required (e.g., a person who does not qualify for Healthy Families or Medi-Cal due to their immigration status is likely to be eligible for Family Care)

O. Family Care Benefit Package

- Comprehensive health benefits including physician visits, pregnancy care, hospital, prescriptions, mental health, health education, acupuncture, chiropractic services, etc.
- Dental benefits
  - Provided through Delta Dental
  - Including diagnostic, preventive, and restorative services, crowns, prosthetics

Formatted: Bullets and Numbering

P. Family Care Premiums and Co-pays

- Based on age
  - Examples: $10 for children (18 and younger)
  - $20 for parents up to 39 years
- $10 for office visits
- No co-pays for preventive services, inpatient and outpatient, lab, perinatal, family planning
- $5 for prescriptions
- $15 for ER visits
- Dental co-pays are $5
  - No co-pays for preventive and diagnostic services and other services

Formatted: Bullets and Numbering

Formatted: Bullets and Numbering

Q. Eligibility Criteria

- Alameda County resident
- Household income is ≤300% of federal income guidelines ($43,890 for a family of three)
- Legal or biological parents and siblings of children enrolled in Alliance Healthy Families, Medi-Cal, or Family Care
- Children may be enrolled without parents
- All related, uninsured children in the household, not enrolled in the Alliance, must be included on the application
- Parents and siblings of Alliance Healthy Families or Medi-Cal members are deemed to be financially eligible
- Short questionnaire to screen for some pre-existing conditions

Session: **C&L Detail**
Attendees: **Molly Delaney, Ellen Marks, C. Godfrey Jacobs, Guadalupe Pacheco, Juanita Dimas, Michele Prestowitz**

Juanita Dimas and Michele Prestowitz provided details of the culture and language (C&L) initiative. They pointed out that their major goal is to reach both providers and members with C&L materials and change the behavior of both constituencies. In the case of the providers, they would like to have them incorporate C&L initiatives (such as use of interpreters) in their everyday practice. They would also like to empower their members to demand and expect culturally and linguistically appropriate services.

A video was shown that demonstrated the importance of medical interpretation. The vast majority of the C&L staff time and budget is spent on translation and production of multi-lingual materials. It is estimated that 75% of Michele Prestowitz's time is spent on this activity. Translation activities were also reported to be the most boring for staff of the C&L initiative. From the Alliance's perspective, the ultimate aim of the C&L initiative is to reduce health disparities in the community served by the Alliance.

The Alliance strongly promotes the use of interpreters among its providers. This is done with various literature and newsletters, as well as the offer of monetary incentives. Yet, the Alliance reports that the vast majority of providers claim not to know about the availability of this service. The Alliance is mystified as to the reasons. Is it that the providers don't read the materials they receive? Or is it that they would rather not use interpreters because, perhaps, they find them intrusive?

Five years ago the Alliance collected information on languages in which each provider's office felt it was proficient. When the need arises for interpretation it can be accommodated on short notice, although 3 days' notice is preferred. The Alliance is planning to re-survey all of its providers about interpreter services. Providers will be offered monetary incentives on the basis of language proficiency and also will be "certified" as proficient by the Alliance.

A number of C&L initiatives were described, including the following:

- UCSF prenatal care
  This is a phone survey looking at health disparities in pre-natal care. It examines both the technical pre-natal care as well as the interpersonal (communications, trust, etc.) care. It is intended to compare results among African-American, Latino, and white patients. Preliminary findings indicate that there are no significant differences in the technical care, except that whites were more dissatisfied.

  An interesting finding of this study is that the disparities pattern in the Alliance's membership is not the same as that found in the literature. It is not known why this is so.

- UCLA Cervical cancer study
  This is a study that examines the language, ethnic and gender concordance of providers and patients who get pap smears.

- Cultural Competency Initiative
  This is a two and a half year project funded by the California Endowment. It is intended to demonstrate how to measure cultural competency in a health care setting, and will employ methods and instruments developed by Miguel Tirado. Juanita Dimas will offer training to Alliance staff. Melissa Welch, M.D., a black Latina, will offer training on knowledge, skills, access, diagnosis, and treatment. The study features an initial assessment, followed by training, then a follow-up assessment in six months. It will focus on prenatal, postpartum and infant care and will have a process evaluation design. Provider participants will receive a rating on cultural competency. Incentives being offered are monetary rewards and recognition in service directories.

- Main Research Questions
  1. Can the level of cultural competence increase with training?
  2. Does the level of cultural competence relate to quality of health care?
  3. How to institutionalize assessment and training of cultural competency among provider network.

- Hablamos Juntos
  This is a grant application whose purpose is to provide language access to LEP Spanish speakers.

- Lanugage Proficiency Initiative
  Funded by California endowment in collaboration with Kaiser to identify and develop standards and objective measurement of provider language efficiency.

The Alliance offers a great deal of C&L activities. Their concern is that despite this, providers and members appear to be generally unaware of these offerings.

Session: **Finance and Contract**
Attendees: **Molly Delaney, Ellen Marks, C. Godfrey Jacobs, Kelvin Quan, Juanita Dimas**

Kelvin Quan led the discussion. He pointed out that the Alliance has always paid for interpreter services. He observed that interpreter costs have not been very substantial; in fact, they are probably not as much as they should be due to low utilization. He expressed an interest in the “research” view of the cost issue. He also said that the Alliance needs to do a match between what provider offices provide in language services and what the patient population needs.

Risk Share is a program run by the Alliance that rewards certain administrative behaviors of providers. It was stressed that the Alliance never does business on the basis

of disincentives. In other words, they reward providers for offering more services, not less. In the past several years the Alliance has distributed $3.5 million per year to reward providers as part of the Risk Share program. Doctors compete for these funds based on performance. The criteria are developed by a Health Care Quality Committee and are reviewed by the Board. The Alliance would like to apply this program to C&L activities. It could reward actions such as attending training and using interpreter services.

Thursday, February 21, 2002

Session: Staff/Project Officer briefing
Attendees: Molly Delaney, Ellen Marks, Adrienne Semidey, C. Godfrey Jacobs Guadalupe Pacheco

Guadalupe Pacheco and Adrienne Semidey joined the site visit on Thursday morning. The other members of the ORC Macro Team briefed both of them on the activities and discussions that had occurred the day before. The discussion centered on which of the standards could be collapsed so as to show that these CLAS standards would enhance what the Alliance is currently doing. For example, we should consider communication strategies that would affect patients/provider behavior.

It was agreed that any activity or intervention proposed would have to be cross-walked with an appropriate standard. There was also some discussion of the possibility of using a social marketing campaign as one of the interventions. Finally, several administrative issues were addressed regarding adjustments to the site visit schedule.

Session: Management Team
Attendees: Molly Delaney, Ellen Marks, C. Godfrey Jacobs, Irene Ibarra, Kelvin Quan, Juanita Dimas, Michele Prestowitz, Adrienne Semidey, Guadalupe Pacheco, and Alliance Division Heads

Approximately 16 Division Heads gathered to hear presentations from Guadalupe Pacheco and Godfrey Jacobs about this Pilot Project. Mr. Pacheco started with an overview of OMH and a discussion of the rationale for cultural competence. He also discussed OMH's Center for Linguistic and Cultural Competence in Health Care (CLCCHC). Mr. Jacobs then spoke about the background of the CLAS standards. He then explained why the Alliance was chosen as the pilot study site. In so doing, he pointed out that the Alliance had scored very highly on all 12 of the criteria that were established for site selection.

There then followed questions from the Management Team. These included the following:

- Number of sites considered
- Using California as a model
- Looking at provider organizations separately from the Alliance
- The evaluation framework

- The timeframe for the evaluation
- The possibility for extended funding

Session: Clinical
Attendees: Molly Delaney, Ellen Marks, C. Godfrey Jacobs, Juanita Dimas, Michele Prestowitz, Adrienne Semidey, Guadalupe Pacheco, Maureen Hanlon, Brenda Goldstein, Elizabeth Edwards

The discussion began with the observation that the Alliance is attempting to undertake more promotion of its activities in order to seek increased responses from its membership and provider network. Once again, the observation was made that it is hard to know whether the Alliance's activities are making any difference in the attitudes or behavior of its membership or providers.

In the clinical area, the main focus has been on asthma, perinatal, diabetes, and special needs. They are attempting to examine measurable outcomes such as the appropriate use of medications, utilization of the Emergency Room and hospital use. It was observed that health disparities are not as severe in the Alliance service area (a point made in previous sessions), and the speculation was that this is so because community clinics take good care of their populations. Hence, the clinical area is seeking a means to work with community clinics in order to make services more accessible and to take advantage of Alliance offerings. Another challenge faced by the clinical area is how to create programs not just to focus on language but also focus on culture, particularly the African-American population, the Alliance's biggest ethnic group

The site visitors posed the following question, "What is it that *you* would like to see accomplished through CLAS?" The director of the Clinical Division responded:

- Providers are very important to the Alliance. We need to find ways to relieve the burden of activities on the providers. How do we make them happy and help them do things that enhance their ability to practice good medicine?
- How do we get all services and activities as an integrated whole? For example, for those things that need to be done on an ongoing basis, how do we get the right thing done at the right time?
- The Alliance would like to help people learn how better to use the health care system. Hence, they would like to build systems that enable people to get help for themselves.
- Clear, short messages for providers and consumers, packaged so they are heard.

Session: Marketing
Attendees: Molly Delaney, Ellen Marks, C. Godfrey Jacobs, Juanita Dimas, Michele Prestowitz, Adrienne Semidey, Guadalupe Pacheco, and Duane Oshinomi

Mr. Oshinomi presented the various marketing initiatives that the Alliance is currently undertaking. He also provided examples of the materials that have been developed. Copies of these have been placed in the project's Resource Center at ORC Macro. He pointed out that the marketing division has placed ads for the Alliance on cable television

and on radio, as well. His division tracks the airing of these messages with enrollment. He is not certain of whether the two are related. There are 6 staff members in his department which handles the production of all the materials used by the Alliance in its promotional and informational campaigns.

It was pointed out that according to the County of Alameda Uninsured Survey (CAUS), 175,000 people in Alameda are uninsured. This was a study, with funding from the Alliance, done by UCLA in which different layers of language, culture and immigration status were examined.

Mr. Oshinomi stated that his most important wish is that the marketing activities would help to reach all communities in Alameda County and lessen the number of individuals who do not have access to health care services.

Session: **Board Strategic Planning**
Attendees: **Molly Delaney, Ellen Marks, C. Godfrey Jacobs, Irene Ibarra, Kelvin Quan, Juanita Dimas, Michele Prestowitz, Adrienne Semidey, Guadalupe Pacheco and 6 Board of Directors Strategic Planning Committee members**

Irene Ibarra introduced the site visitors to the Board members. She stated that it was fortuitous that this meeting was being held at the same time as the site visit since she wanted the Board to understand the visit's significance, and the importance that OMH, ORC Macro, and the Alliance attach to this pilot project. Guadalupe Pacheco then gave a brief overview of OMH's purpose in sponsoring this project. Godfrey Jacobs then briefly presented how the project would be implemented. The Committee expressed its enthusiasm and support for this undertaking.

Session: **Core Group**
Attendees: **Molly Delaney, Ellen Marks, C. Godfrey Jacobs, Irene Ibarra, Kelvin Quan, Juanita Dimas, Michele Prestowitz, Adrienne Semidey, Guadalupe Pacheco**

This session occurred in two parts. The first part was held from 4:30 – 6:00 p.m. on Thursday, while the second convened from 8:00 – 9:30 a.m. on Friday. The discussion centered on the seven chosen standards and possible ways to measure their implementation. For Standard #1 the question was posed, "To most effectively accomplish this goal what would you do?" The answer was that we would have to implement all the other standards and ideally, measure health outcomes.

As to Standards # 1 & 3, it was suggested that what needs to be examined at the Alliance is what is it that is not working systematically. It also was suggested that we need to consider what would be necessary to get out the message of the Alliance. The ultimate interest is on the entire membership and provider network of The Alliance. Any intervention should be connected with a clinical issue e.g., asthma, diabetes, prenatal care, special needs of children.

It was suggested that all implementation efforts would have to have a county-wide focus and would have to be integrated across all departments. The same issues and themes occur with all seven standards that have been preliminarily chosen for study. Central to each and indeed all of the efforts contemplated, is the reduction of health disparities.

The discussion then turned to the issue of changing the behavior of providers. As had been cited before, the issue of the overload factor with physicians was again raised. The dilemma is how to provide better information to the providers who say that they are already inundated with information that they do not read. It was suggested that the Alliance may have to both lead and cajole in order to realize any difference in the behavior of the providers. It was suggested that the Alliance might wish to follow the Assets model in which the Alliance would find those providers who are doing things correctly and then replicate their processes throughout the provider community.

Session: Provider Relations
Attendees: Molly Delaney, C. Godfrey Jacobs, Guadalupe Pacheco, Renee Shiota and Denise Peebles, Juanita Dimas

The purpose of the provider relations department is to recruit, educate, certify, monitor and decertify providers. They also conduct site reviews and provide practice guidelines to the 299 primary care physician members and the 1300 specialist members. Any provider in the Alameda County area can join the Alliance. Once they become part of the Alliance they have to go through the various credentialing and reviews mentioned above. There have been instances when physicians have either not been admitted or have been decertified as providers for the Alliance. Facility site reviews are conducted every two years for the primary care physicians only. Provider relations staff will soon begin OB-Gyn facility reviews.

Among the providers in Alameda County there is a very good commitment to the Alliance. It is speculated that this is because of the generous payments, reimbursements, and risk share allowances that are paid each year, as a reflection of the Alliance's commitment to serve the community members and providers.

The question posed to the clinical group was also posed to the provider relations representatives. "What is it that you would like to see accomplished with the CLAS standards?" The answers were as follows:

- Training for providers
- Develop and evaluate curriculum
- Define those things that equate to a culturally competent medical practice
- See provider community "come on board"

Some of the regular activities that provider relations conducts include the following:

- Provider bulletins
- Training of providers with new site review tools
- Orientation

- Monthly or quarterly site reviews

The provider relations group indicated that in their opinion most of the providers do not understand the CLAS initiative. They feel it is important that the CLAS standards be customized for providers such as specific ethnic groups that they serve. This is necessary because each of those populations has different cultural norms. In June 2002 a new State site review tool will be unveiled. It is anticipated that there will be a great deal of training provided on this tool in the coming months.

Session: Member Services
Attendees: Molly Delaney, C. Godfrey Jacobs, Guadalupe Pacheco, Troy Lam

Member Services handles all requests from members. This includes ordering or updating materials, disseminating provider listings, and providing assistance in the area of language assistance. Member Services also handles issues of access for any service that is offered by the Alliance. Additionally, this division conducts the following:

- Financial (Federal poverty level) determination for membership in a particular plan
- Eligibility
- Monthly update letters to members on their status
- Reminder postcards and follow-up calls to parents with children in the Healthy Families program
- Renewal packets

Troy Lam reported that he and his staff are fluent in 7 different languages, and that most of them use them in a typical day at the Alliance. He helps members understand their rights, initiates welcome calls and responds to daily inquiries by members. The Member Services group has a number of items on its "wish list". These include the following:

- Valid data which is needed to do effective outreach. However, the Medi-Cal data base is flawed.
- Close coordination with provider relations group, since happy providers refer new members
- Certification of doctors as being culturally and linguistically competent. "If patient knows the doctor is C&L competent, patient will go."
- English as a second language (ESL classes for members who need it)

D. Major Themes

During the site visit, a number of important themes emerged from discussions among the ORC Macro staff and their counterparts at the Alliance. It should be noted that some of these are from the viewpoint of the Alliance and will need verification.

- Need to find ways to change behavior of both providers and members
- Need to demonstrate change both linguistically and culturally
- Need to measure costs of implementing activities related to C & L standards
- Need to have all Alliance services and activities as an integrated whole
- Thus far, implementation is more important than research to the Alliance

- Most important to address health disparities as an overarching issue
- there is low utilization of services provided by The Alliance
- The Alliance is most interested in placing an emphasis on knowledge and skills versus sensitivity—and go directly to Behavior Change
- The Alliance recognizes room for improvement in their communication mechanism, but can't understand why it doesn't work.
- The Alliance wants a program that makes providers happy—makes their jobs easier—not add more to do. They would like to see CLAS incorporated into already established activities.
- The Alliance wishes to reach communities and empower their members with increased access to and quality of health services.

E. Major Questions

Following the site visit, the ORC Macro team determined that there are significant questions that will need to be addressed as part of the pilot project study. These include the following:

- What are the distribution mechanisms for Alliance materials?
- Do the intended audiences receive Alliance materials?
- Do the intended audiences read the materials?
- Do providers in fact claim no knowledge of the availability of interpreters?
- What are the intended audiences' preferences for receiving information?
- What can be done to increase providers' awareness and use of services and information?
- Should we focus on the private care physicians only since they are easier to access?
- Why are the health disparities patterns different in the Alliance's service population than that found in the literature?
- Can we intervene on both the linguistic *and* cultural issues?
- How can we measure cultural competence in a health care setting? (See Miguel Tirado's report)
- Given that African-Americans constitute the largest demographic group in the Alliance's service area, which activities are designed for this group?
- Should our focus be on a specific ethnic group or a broader framework?.
- Why don't providers know about interpreters? Why don't they use interpreters?
- Work with county clinics—explore what they actually do.

F. Possible Interventions

As part of their debriefing following the site visit, ORC Macro staff discussed potential interventions, including enabling and disabling factors. It must be noted that these interventions are very preliminary in nature, and may not be what eventually are proposed. Following is a summary of these preliminary ideas and intervention questions.

- Why is the Alliance not heard through its current means of communication with its providers? what are the barriers ? why are services not acted on by providers and members? What would it take to make that happen?
- All potential interventions must be "cross walked" with the standards
- Need to connect interventions with clinical issues (e.g. asthma, diabetes, prenatal care, special needs of children)
- Contradiction: can't ask providers to do more, but the Alliance is asking them to do more (survey, training, CMEs, etc)
- Given that the providers (especially the PCP's) complain of being overburdened with Alliance requirements, how can they be persuaded to do things (i.e. our proposed interventions) that enhance their services?
- Combine communication to providers with empowering/informing members
- Most important to address health disparities
- Take note of the Alliance's frustration – i.e. relatively small population in which it is difficult to determine whether it is our intervention that is making the difference or the providers'
- Problem—some providers don't understand CLAS; think they already know it/don't need it
- Outreach—social marketing opportunity: the Alliance sends lots of letters, reminder postcards, calls, direct mail, multilingual materials—but are they appropriate in appearance and word choice?
- Catalysts in place: translated materials, multilingual staff at the Alliance, interpreter services, member newsletter, and initiatives.

G. Additional Information Needed

- relationship of materials and services developed for respective demographic groups in service area
- demographic breakdown of African-American families
- more about what is being done in CLAS-related matters.

Office of Minority Health

R. ORC Macro

Site Visit
February 20-22, 2002

WEDNESDAY

Fremont Conference Room

9:00 - 9:30 – Welcome (Irene, Kelvin, Juanita, Michele)
9:30 - 10:30 – General orientation
10:30 - 11:30 – Alliance overview (Irene & Nina, Director, Corporate Development & Gov't Relations)
11:30 - 1:00 – Lunch
1:00 - 3:00 – C&L detail (Juanita & Michele)
3:00 - 5:00 – Finance and Contract (Kelvin & Juanita)

THURSDAY

Fremont Conference Room

9:00 - 9:15 – Welcome (Irene, Kelvin, Juanita, Michele)
9:15 - 11:00 – Alliance and C&L overview to Guadalupe and Adrienne (Juanita)
11:00 - 12:00 –
12:00 - 1:30 – Lunch
1:30 - 2:30 – Management Team **(Hayward Conference Room)**
2:30 - 3:30 – Clinical (Maureen Hanlon, Brenda Goldstein)
3:30 - 4:30 – Marketing (Duane Oshinomi)
4:30 - 6:00 – Core group (defining priority areas; Irene, Kelvin, Juanita)
6:00 - 7:00 – Board Strategic Planning (15-20 mins.; Irene, Kelvin, Juanita)

FRIDAY

Oakland Conference Room

9:00 - 10:30 – Core group (details for next steps; Kelvin, Juanita, Michele)
10:30 - 11:30 – Provider Relations (Renee Shiota & Denise Peebles)
11:30 - 1:00 – Lunch
1:00 - 2:00 – Member Services (Troy Lam)
2:00 - 3:00 – Wrap up

CLAS Pilot Project
HHS Office of Minority Report

A. Background and Purpose

The ORC Macro team conducted a site visit at The Alameda Alliance for Health (the Alliance) on October 28-29, 2002. This was the second site visit held at the Alliance pursuant to the implementation of the CLAS pilot project for the Office of Minority Health. During an initial site visit conducted by ORC Macro in February 2000, baseline information was collected regarding the Alliance's implementation of its cultural and linguistic (C&L) initiative, including the fourteen CLAS standards. Information gathered at that site visit included an extensive array of documents that were provided by the Alliance. The team carefully reviewed all available information and prepared a preliminary profile or "snapshot" of the Alliance's organizational activities related to C&L.

The purpose of the second site visit on October 28-29, 2002 was to share this picture with the Alliance; to check the degree of concurrence with the Alliance's view; to fill any identified gaps; and to clarify this picture further. Based on the additional information and insights obtained during the site visit, the ORC Macro team is preparing a detailed profile and analysis of the Alliance's C&L activities. The profile report will be initially submitted to the OMH Project Officer. Following his approval, the report will be shared with the Alliance.

Section B, below, provides a narrative summary of the two-day site visit, while Section C presents the agenda.

B. Narrative Summary

Monday, October 28, 2002, 10:00 a.m. - 5:00 p.m.
Attendees: Alameda Alliance for Health: Art Chen, M.D. (Medical Director), Juanita Dimas, Ph.D. (Cultural and Linguistic Programs Manager), Juan Esteva (Research Assistant), Irene Ibarra (CEO), Eduardo La Calle (Research Assistant), Kelvin Quan (CFO)

ORC Macro: Iris Garcia, Ph.D., (Consultant), C. Godfrey Jacobs (Project Director), Bryan Rhodes (Research Analyst), William Scarbrough, Ph.D. (Research Coordinator)

Office of Minority Health: Guadalupe Pacheco (Project Officer)

Summary

To begin the meeting each person present was asked to introduce themselves to the group and explain their relationship to the CLAS project. Once everyone had introduced himself or herself, Guadalupe Pacheco explained the overall goals of the project to the group, emphasizing the importance of this project in taking research involving the CLAS standards to the next level.

At this time the group from ORC Macro presented their preliminary findings to the Alliance. Godfrey Jacobs began by giving an overview of the study goals and objectives, as well as explaining a timetable for completion of the project. Bill Scarbrough then reviewed the logic model which had been developed for the "CLAS Pilot Project: Technical Approach," and is the backbone for exploring the system features involved in adapting and sustaining the CLAS standards. The ORC Macro team also explained the

methods used in order to build a profile of how the Alliance is putting the CLAS standards into operation. The team described the development of instruments to extract and qualitatively analyze data from documents provided by the Alliance. Iris Garcia then gave an overview of the findings garnered from these instruments. At 12:30pm the group had lunch and further discussed the presentation.

After lunch the ORC Macro team continued presenting the preliminary results of the study. Discussions focused on graphics developed by the ORC Macro team depicting the Alliance's interpreter services, provider network management, data collection and tracking, quality monitoring, and CLAS management strategy. The ORC Macro team gained valuable feedback from the Alliance on these and other issues.

Tuesday, October 29, 2002 9:00 a.m. - 4:00 p.m.

Attendees:	**Alameda Alliance for Health: Art Chen, Juanita Dimas, Juan Esteva, Irene Ibarra, Eduardo La Calle, Kelvin Quan**
ORC Macro:	C. Godfrey Jacobs, Bryan Rhodes, William Scarbrough
Office of Minority Health:	Guadalupe Pacheco

Summary

Day two of the site visit focused on several of the issues that had been raised on day one. Much of the dialogue concerned the issue of accountability at the Alliance. Through these discussions the Alliance presented a picture of the lines of accountability throughout the organization. The Alliance spoke of how a commitment to cultural and linguistic issues

permeates all the departments of the organization. As an example the Alliance team described the lines of accountability for the translation of member materials. The Alliance explained that since production of member materials in general was done in the Marketing Department this is also where accountability for the translation of these documents would occur. The various members from the Alliance went on to explain how accounting for cultural and linguistic issues has been integrated into their respective departments.

The management philosophy of the organization was also discussed with the Alliance representatives. The Alliance said that cultural and linguistic services were seen as essential to their organization, and were not to be reduced even when faced with budget restrictions. The Alliance mentioned that since much of their budget is received from a financially burdened state they have been affected by recent budgetary cuts. Despite this the Alliance has remained dedicated not to reduce services to members or increase costs, but rather look for ways to cut costs internally. The management of the Alliance also discussed with the ORC Macro team their commitment to improving health disparities among all cultural and linguistic groups as an overall goal of the organization, which informs all management decisions. These conversations helped to show the underlying organizational values at the Alliance.

After lunch the ORC Macro team spoke with representatives of the Alliance's Cultural and Linguistic Program Department (Juanita Dimas, Juan Esteva, and Eduardo La Calle). This afternoon session was used to identify gaps in the information gathered by the ORC

Macro team. Once these gaps had been identified a plan was formulated for filling these gaps. Methods discussed for gathering more information included the acquisition of more documents and interviews with appropriate people related to the Alliance (management, MCO staff, providers, members, etc.). Then the next steps for the Alliance and the ORC Macro team were examined, and at 4:00pm the meeting was brought to a close.

OMH Study on CLAS Implementation
In a MCO Setting

Site Visit
Alameda Alliance for Health
October 28-29, 2002

AGENDA

Monday, Oct. 28

10:00 a.m.	Welcome and Introductions
10:15 a.m.	Presentation: Study Design & Methods
11:15 a.m.	Break
11:30 a.m.	Presentation: Validation of CLAS Implementation Profile
12:30 p.m.	Lunch
1:30 p.m.	Presentation: Validation of CLAS Implementation Profile (cont'd.)
3:00 p.m.	Break
3:15 p.m.	Presentation (cont'd.)
5:00 p.m.	Adjournment

Tuesday, Oct. 29

9:00 a.m.	Wrap up from Day 1
9:30 a.m.	Discussion of Proposed Interview Strategies
10:15 a.m.	Break
10:30 a.m.	Discussion on steps to accessing MCO data
12 Noon	Lunch
1:30 p.m.	Determination of gaps and needed documents
4:00 p.m.	Adjournment

Appendix F: Interview Protocols

CLAS Project
Interview with Irene Ibarra (Alameda Alliance for Health)
June 16, 2003
1:00 - 1:30 p.m.

Purpose: The primary purpose of this discussion is to elicit information on the Alliance's business strategy related to the implementation of the CLAS standards.

Background: We are currently working on several fronts, one of which is making certain that we paint a fair and accurate picture as we finalize the MCO profile. Experts believe that we need more information from you, Irene, on the business philosophy and strategy associated with the implementation of CLAS. In the final version of the Profile, we would like to address this issue so that MCO's not currently implementing CLAS or fearful of the business implications of doing so, may have a better sense of the organizational philosophy that underpins the C&L program at the Alliance.

Questions:

1. We've heard you say on several occasions that you view the C&L initiative as just a normal way of doing business. Could you elaborate on that as it relates to the Alliance's underpinning philosophy and its business strategy?

2. How did you move from a philosophical mode to an operational mode with the C&L program?

3. Where does CLAS fit in the vision of the Alliance?

4. How does your view of CLAS affect the allocation of resources?

5. What would you say or have you said to counterparts of yours who assert that they can't afford to implement CLAS?

6. In your years as CEO of the Alliance, can you attribute any particular organizational outcomes to the implementation of the C&L program?

7. Are there any other specific recommendations, based on your experience at the Alliance, that you would like to make to other CEO's of MCO's?

CLAS Project
Interview with Kelvin Quan (Alameda Alliance for Health)

Purpose: The primary purpose of this discussion is to elicit data on costs associated with the implementation of the CLAS standards at the Alliance.

Background: We are currently working on collecting outcome data for the CLAS project. Experts believe that we need information on the costs associated with the implementation of the CLAS standards. In the final version of the Profile, we would like to address this issue so that MCO's not currently implementing CLAS or fearful of the cost implications of doing so, may have a description of the costs and benefits of implementing the CLAS standards. Hence we wish to capture as much information on the costs of implementing CLAS in order to paint a fair and accurate picture.

1. What is the CLAS impact on:
   - Overall operations
   - Administrative costs
   - Overall costs
   - Unit costs

2. Have you conducted cost analyses of CLAS?

3. Have you collected any data over time on the comparative costs of implementing CLAS?

4. Below you will find a preliminary list of indicators. Please review the list and provide us with your comments as well as any suggestions for additional indicators.
   a. Rate of member enrollment
   b. Percent of market share
      iii. Medicaid
      iv. SCHIP
   c. Administrative costs as a percent of total costs
   d. Emergency Room Rate
   e. Preventable visits

5. What conditions or constraints exist that might hinder or enhance the performance of those indicators? Please specify for each indicator listed.

Appendix G: CLAS Standards Implementation

Appendix E: CLAS Standards Implementation

CLAS Standard	Formal Implementation*	Informal Implementation*
1. Health care organizations should ensure that patient/consumers receive from all staff members effective, understandable, and respectful care that is provided in a manner compatible with their cultural health beliefs and practices and preferred language.	• C&L Mission Statement: *"to evaluate, implement, and integrate cultural and linguistic competency across plan operations in order to create a culturally competent organization, increase access to care, enhance quality of care and health outcomes, maximize patient satisfaction and retention and reduce health disparities."*	
2. Health care organizations should implement strategies to recruit, retain, and promote at all levels of the organization a diverse staff and leadership that are representative of the demographic characteristics of the service area.	• Recruitment of competent workforce at all levels.	• Implemented as second nature in order to meet cultural and linguistic needs of members.
3. Health care organizations should ensure that staff at all levels and across all disciplines receive ongoing education and training in culturally and linguistically appropriate service delivery.	• Workforce orientation to C&L programs.	• C&L program staff part of various organizational workgroups, participate in interdepartmental meetings.
4. Health care organizations must offer and provide language assistance services, including bilingual staff and interpreter services, at no cost to each patient/consumer with limited English proficiency at all points of contact, in a timely manner during all hours of operation.	• Managed by Member Services Department. • Use subcontracted vendor and/or AT&T language line. • P&P for face-to-face as well as telephonic interpreter service. • Interpreter service available 24-hrs a day. • Information on languages requested reported to C&L program annually.	

CLAS Standard	Formal Implementation*	Informal Implementation*
5. Health care organizations must provide to patients/consumers, in their preferred language, both verbal offers and written notices informing them of their right to receive language assistance services.	• Policy to notify members in preferred language. • Inform members through: welcome packs and member newsletters.	• Inform members through verbal contact with member services.
6. Health care organizations must assure the competence of language assistance provided to LEP patients/ consumers by interpreters and bilingual staff. Family and friends should not be used to provide interpretation services (except on request by the patient/consumer).		• Attempt to contract with most reputable interpreter vendors.
7. Health care organizations must make available easily understood patient-related materials and post signage in the languages of the commonly encountered groups and/or groups represented in the service area.	• Policy stipulating use of separate translator, editor and typesetter. • Back translation of legal and complex documents. • Site visit review checks for bi-lingual signage at provider offices.	• Translators asked to make recommendations about cultural appropriateness.

CLAS Standard	Formal Implementation*	Informal Implementation*
8. Health care organizations should develop, implement, and promote a written strategic plan that outlines clear goals, policies, operational plans, and management accountability/oversight mechanisms to provide culturally and linguistically appropriate services.	• Dedicated full time C&L staff. • Workgroups: internal C&L task force, health plan workgroups and a cultural competency quality improvement program workgroup. • C&L work plan to improve system features and member services. • Alliance mission statement: "*The Alameda Alliance for Health is a public health plan dedicated to providing continuous, comprehensive, high quality care to the traditionally under-served children, families and individuals in Alameda County. The Alliance values member satisfaction and is committed to high standards of integrity, accountability and service to its diverse community.*"	• Workgroup communication through interdepartmental meetings, memos, and presentations.
9. Health care organizations should conduct initial and ongoing organizational self-assessments of CLAS-related activities and are encouraged to integrate cultural and linguistic competence-related measures into their internal audits, performance improvement programs, patient satisfaction assessments, and outcomes-based evaluations.	• CC-QIP programs focus on MCO structural features (e.g. information systems to better document incoming data), and care coordination and delivery to members (e.g. prenatal care). • Patient satisfaction surveys given in member languages. • Patient satisfaction data stratified by REL.	• Ongoing organizational self-assessment.

CLAS Standard	Formal Implementation*	Informal Implementation*
10. Health care organizations should ensure that data on the individual patient's/consumers' race, ethnicity, spoken and written language are collected in health records, integrated into the organization's management information systems, and periodically updated.	• REL codes and data gathered from HIPAA, Medi-Cal and Healthy Families. • Reports generated from internal administrative reports, HEDIS, and CAHPS. • Data analysis done for: member enrollment data, grievance data, asthma admissions, prenatal care, immunizations, breast cancer screening, cervical cancer screening, and well-child visits. • Analysis of prenatal care and cervical cancer screening data done in partnership with academic institutions.	
11. Health care organizations should maintain a current demographic, cultural, and epidemiological profile of the community, as well as a needs assessment to accurately plan for and implement services that respond to the cultural and linguistic characteristics of the service area.	• Contractual requirement to complete Medi-Cal and Healthy Families Group Needs Assessments (GNA). • GNAs provide data on public health of community (stratified by REL) and the health status of racial and ethnic subgroups.	• C&L program uses GNA data to develop work plan goals and objectives.
12. Health care organizations should develop participatory, collaborative partnerships with communities and utilize a variety of formal and informal mechanisms to facilitate community and patient/consumer involvement in designing and implementing CLAS-related activities.	• Community Advisory Committee (CAC) comprised of consumers, physicians, leaders of community based organizations, and government officials.	• Alliance gains feedback from the community via REL subgroups, community forums, and contact with coalition groups.

CLAS Standard	Formal Implementation*	Informal Implementation*
13. Health care organizations should ensure that conflict and grievance resolution processes are culturally and linguistically sensitive and capable of identifying, preventing, and resolving cross-cultural conflicts or complaints by patients/consumers.	• Inform members of grievance policy (right to file complaint) in member's preferred language. • Interpreter service provided for limited/non-English speaking members. • C&L program staff consulted on all complaints related to C&L. • Grievance policy provides for staff-peer observation, CAC review, a Medi-Cal managed care ombudsman, Medi-Cal state fair hearing, and independent medical reviews	
14. Health care organizations are encouraged to regularly make available to the public information about their progress and successful innovations in implementing the CLAS standards and to provide public notice in their communities about the availability of this information.	• CLAS reporting done via member and provider newsletters, organizational reports and documents, stand-alone reports, print media, and conference presentations. • CLAS reporting done via website.	• CLAS reporting aimed mostly at providers, community-based organizations, regulatory agencies, and funding sources.
	**Formal Implementation* indicates where specific official documents were found to indicate that this action was occurring. (e.g. policies and procedures, official reports, explicit work plans, etc.).	**Informal Implementation* denotes that some indication that this action was occurring was found, but not mentioned explicitly in any official documents. (e.g. memos, conference presentations, letters, etc.).

Appendix H: Project Advisory Group

CLAS Project Advisory Group

Iris A. Garcia, Ph.D.
Senior Policy Analyst
Executive Office of Health & Human Services
Massachusetts Division of Medical Assistance
Office of Clinical Affairs
University of Massachusetts Medical School
600 Washington Street
Boston, MA 02111
617.210.5696
617.210.5865 fax
igarcia@nt.dma.state.ma.us

Tom Chapman, Ed.D
Hospital for Sick Children Health Foundation
1808 I (Eye) Street N.W.
Washington, DC
202.832.4400
202.454.1221
tchapman@cscn.org

Robert Weech-Maldonado, Ph.D.
Assistant Professor
Department of Health Policy & Administration
College of Health and Human Development
Penn State University
119-C Henderson Building
University Park, PA
814.865.1926
814.863.2905 Fax
rxw25@psu.edu

Yoku Shaw Taylor, Ph.D.
Research Scientist
202.429.1954
yshawt@hotmail.com

***Sharon M. Lee, Ph.D.**
Professor & Director of Graduate Studies
Department of Sociology
Portland State University
P.O. Box 751
Portland, OR 97207
503.725.3962
503.725.3957 fax
lees@pdx.edu