



Assessment of Strategies for Providing Culturally Competent Care in Title X Family Planning Clinics: Final Report

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Introduction

As the only Federal program dedicated solely to providing family planning and reproductive health, Title X provides a broad range of effective family planning methods and services to those who may need them the most, but to whom they may not be readily available. As a source of confidential, accessible, and inexpensive care, these programs provide an important venue for delivering culturally and linguistically competent services.

The OPA Office of Family Planning (OFP) contracted with Altarum Institute to evaluate strategies for providing culturally competent care in Title X-supported family planning clinics. This assessment is critical for OFP, as efforts to improve cultural and linguistic competency directly address the Department of Health and Human Services' priority to eliminate disparities in health status, health care access, and quality as well as to promote preventive health practices to improve the overall health outcomes for all.

Through the conduct of a comprehensive literature review, 15 key informant interviews, site visits to 9 Title X Programs and 3 Regional Training Centers (RTCs), and the development of a final synthesis report, the Altarum Project Team has been able to assist OFP in:

- Documenting the current strategies implemented – as well as the barriers, challenges, and gaps – by Title X family planning clinics to provide culturally competent care;
- Defining cultural competency within the Title X context;
- Identifying existing activities and highlighting innovative and successful strategies;
- Informing the development of strategies to support Title X providers in addressing culturally competent service delivery and reducing health disparities.

The Role of Culture

Understanding the role of culture – which can be defined broadly as a system of values, beliefs, and attitudes that are affected by other characteristics such as race, ethnicity, age, gender, sexual orientation – is critical in any approach to addressing health disparities. The literature review and qualitative data collection efforts highlighted that culture can influence the **health beliefs and practices** of individuals, providers, and systems as they may conceptualize health, disease, and wellness differently. Culture also affects **health-seeking attitudes and behaviors**, as individuals may have a historical mistrust of health care and social service professionals or have experienced racism, discrimination, and bias in the past when trying to access health care. Cultural and linguistic barriers also play a critical role in an individual's ability to seek and access care.

The study participants stressed the importance of demographics such as race/ethnicity, age, gender, socioeconomic status, and sexual orientation. Yet they moved beyond ideas tied to these categories to provide concrete, family-planning specific examples of how culture and language are embedded in

health beliefs and practices and health seeking attitudes and behaviors – and ultimately affect clients' ability to access and utilize services.

Barriers to and Supports for Addressing Cultural and Linguistic Competence

Even with strong leadership in place, the idea of integrating cultural and linguistic competence into policy and programs can be difficult to grasp or is seen as an overwhelming task. Common barriers within family planning programs, identified in the literature and interviews with key informants, Title X program staff, and RTC staff include:

- **Level of organizational support**—Efforts in some agencies are inhibited by the lack of explicit commitment to cultural competence in mission, policies, or among leadership. Many also lack mechanisms to regularly assess and tailor services to evolving community needs.
- **Access to resources**—Limited funding sources; limited evidence-based resources and training materials; difficulty recruiting and retaining diverse, specially trained staff; and scarcity of time to learn new practices and behaviors all inhibit program’s efforts to address the issues
- **Sensitive nature of family planning**—Sexual health is a taboo subject for many populations, and cultural views, socioeconomic status, language, and other may shape clients use and providers’ delivery of sexual health services.

Both the literature and the qualitative data strongly suggest that an effective approach to cultural and linguistic competence, is one that is integrated into policy and regulation, systems development, and organizational structure; and engages the community with a focus on family and consumers. Various definitions and frameworks exist to help health care providers better address cultural and linguistic competence, and can be tailored specifically to the Title X context. In addition, the 2001 Title X Program Guidelines offer a number of recommendations for how programs should address these issues, drawing in part from both Title VI of the Civil Rights Act of 1964 and the CLAS Standards (which were developed by the Office of Minority Health in 2001 to support the integration of cultural and linguistic competency at multiple levels, from the practice level with direct service providers, to the policies that are in place in a family planning clinic).

Strategies to Improve Cultural and Linguistic Competence in Title X Programs

Using on the 14 CLAS standards that address culturally competent care, language access services, and organizational supports for cultural competence to collect information from study participants, we identified the following four domains:

- **Organizational capacity** – incorporating cultural competence into planning, policymaking and infrastructure activities of the organization;
- **Provider and staff capacity** – implementing approaches to develop the ability of all program staff to understand and address the needs of diverse populations;
- **Language access** – approach taken to provide services for individuals with limited English proficiency; and
- **Community focused** – using knowledge of a community to drive program decisions, by engaging community members and organizations in the decision-making process.

The report documents approaches undertaken by Title X programs. The CLAS standards illustrate **what** Title X programs should be doing. Through this assessment, we documented **how** Title X programs are doing it. We present strategies that can be considered promising—that is, practices and strategies that are recommended in the CLAS Standards and appear to be working well in family planning settings. We did not evaluate their effectiveness or impact, which was outside the scope of this assessment.

Key Lessons Learned and Implementation Strategies

The study respondents shared numerous lessons learned as a result of their efforts to build capacity to provide culturally and linguistically competent care. The table below summarizes these lessons and provides insight into implementation strategies that may be replicated by other Title X Programs.

Lessons Learned	Implementation Strategies
Understand that developing cultural and linguistic competency is on ongoing process	<ul style="list-style-type: none"> Practice “cultural humility” Confront the “isms” Keep it real and relevant
Institutionalize your commitment to cultural and linguistic competency	<ul style="list-style-type: none"> Make cultural competence a legitimate policy initiative with financial support Conduct an organizational assessment and develop a plan to move forward Understand the importance of leadership and buy-in Involve all levels of the staff Connect policies to practice Integrate language access strategies
Build provider and staff capacity	<ul style="list-style-type: none"> Recruit and retain diverse staff Provide training to build staff capacity to deliver culturally and linguistically competent care
Know your community	<ul style="list-style-type: none"> Improve knowledge of the community Collaborate with community organizations and community leaders Conduct outreach to underserved populations

Recommendations

The study highlights numerous lessons learned to share as a result of the Title X program and RTC staff’s efforts to build their capacity to provide culturally and linguistically competent care. Respondents hope that OFP can help to:

- **Define culture and cultural competency broadly** by broadening the OMH definition to include more than race and ethnicity and why family planning values cultural differences; and providing specific strategies, policies, standards, practices, and metrics to help programs and providers implement and measure efforts.
- **Develop and share evidence and resources related to cultural and linguistic competence** by continuing to build the evidence base by stressing reporting and documentation and conducting longitudinal studies and demonstration projects and by tapping into new technology and stay connected to larger discussions of cultural competence.

- **Make cultural competency a priority at the Federal level** by continuing to prioritize cultural competence; dedicating funding; and sharing training materials, best practices, and data.

I. Background on Title X

In 1970, the U.S. Congress enacted Title X of the Public Health Service Act to provide high-quality, affordable family planning and reproductive health services to all persons who wanted and needed them. Title X ensured access to family planning services for millions of low-income or uninsured individuals for more than 30 years. This program provides services to approximately 5 million persons each year through a network of 4,600 clinics. While more than half of the funds are awarded directly to States, grants also are made to family planning councils, community health centers, Planned Parenthood affiliates, and other public and private entities that provide family planning services. Clients are provided with access to a broad range of contraceptive methods (including natural family planning) and reproductive health services such as patient education and counseling, pelvic and breast exams, sexually transmitted infections (STI) and HIV screenings, and STI treatment. These services clearly address reproductive health care for individuals as envisioned in the original legislation.

As the only Federal program dedicated solely to providing family planning and reproductive health, Title X provides a broad range of effective family planning methods and services to those who may need them the most, but to whom they may not be readily available. As a source of confidential, accessible, and inexpensive care, these programs provide an important venue for delivering culturally and linguistically competent services. Title X also funds ten Regional Training Centers (RTCs) across the country to provide training and technical assistance (TA) to Title X grantees. The RTCs play critical roles helping build grantees' capacities by offering a range of tools (e.g., organizational self assessments), conference workshops, training sessions, and individualized TA related to reducing health disparities and providing culturally and linguistically competent care.

Many of the clients of the Title X funded clinics come from underserved populations, are less than 25 years of age, are female, are African American or Latino, and live in areas of low socioeconomic status. Family planning programs offer the opportunity for women and, increasingly, men to seek and receive information about family planning and reproductive health in a nonjudgmental environment, sometimes providing the only contact that individuals have with medical professionals.

Through service delivery improvement grants, research grants and cooperative agreements, and assessment projects, Office of Population Affairs (OPA) has begun to identify valuable information regarding the barriers, challenges, opportunities, and lessons learned by Title X-supported clinics regarding addressing disparities and using culturally competent strategies.¹ It is becoming apparent that programs are providing a wide range of culturally competent services and facing challenges in doing so. Less apparent, though, is how Title X programs have been consciously addressing disparities and cultural competency at various levels – policy, administrative, practice and service delivery, client and family, and community – and how the OPA Office of Family Planning (OFP) can further support these activities.

¹ OPA has, for example, funded a series of service delivery improvement grants to support new approaches to engaging specific populations—including young women of color, Latina women, Latino men in rural areas, American Indian men, African American men, and Mexican immigrants. OPA has also funded male research cooperative agreements and assessment projects to examine the integration of HIV-prevention activities in Title X programs, the use of couples-focused strategies within Title X programs, teen perspectives on healthy romantic relationships, and a community-based sexual health intervention for young adult Latino and African-American men. See <http://www.hhs.gov/opa/index.html>.

II. Scope and Purpose of the Project

Title X is in a pivotal position to reduce disparities in reproductive health care. The OPA Office of Family Planning (OFP) contracted with Altarum Institute to evaluate strategies for providing culturally competent care in Title X-supported family planning clinics. This assessment is critical for OFP, as efforts to improve cultural and linguistic competency directly address the Department of Health and Human Services' (HHS) priority to eliminate disparities in health status, health care access, and quality as well as to promote preventive health practices to improve the overall health outcomes for all.

“What’s exciting about this project is that most of the early efforts in cultural competency spoke generically to these issues. We need to move to apply it to specific areas (e.g., family planning, maternal and child health) and begin to see how cultural competency can be integrated and how it can transform systems.”

Key Informant

This assessment project serves to move the field forward by examining specific strategies that are being created and adapted to provide culturally competent care within Title X-supported family planning clinics. Specifically, the project assists OFP in:

- Documenting the current strategies implemented – as well as the barriers, challenges, and gaps – by Title X family planning clinics to provide culturally competent care;
- Defining cultural competency within the Title X context;
- Identifying existing activities and highlighting innovative and successful strategies;
- Informing the development of strategies to support Title X providers in addressing culturally competent service delivery and reducing health disparities.

In order to accomplish these objectives, the project involved several key, interrelated tasks:

Figure 1: Key Project



Tasks

- A **comprehensive literature review** to explore how cultural competence has been defined across various health care sectors and within the context of Title X, as well as innovative strategies and best practices for providing culturally competent health care, including those tailored to family planning services.
- A series of **key informant interviews** with Federal and regional Title X staff, researchers, and experts in the field of cultural competence to further explore issues raised in the literature review and perspectives on strategies for addressing culturally competent health care and family planning.

- A series of **site visits** to a sample of Title X programs and Regional Training Centers (RTCs) to discuss the delivery of culturally competent family planning care – the sample was selected to reflect Title X programs and RTCs that have been actively engaged in planning and implementing innovative approaches to delivering more culturally competent family planning services and training programs. (See Appendix A for overview of participating Title X programs).
- The **final report** was then created to synthesize information gathered from the literature review and results of the analysis of key findings from the assessment can inform the development of a national strategy to support Title X providers in addressing culturally competent service delivery.

III. Methodology

As described in the following section, the project included the five interrelated steps:

A. Literature Review

A comprehensive review of the literature was conducted to explore how cultural competence has been defined across various health care sectors and within the context of Title X, as well as innovative strategies and best practices for providing culturally competent health care, including those tailored to family planning services. Specific topic areas explored during the review included:

- Impact of culture on access to and quality of care,
- Conceptual frameworks and models for culturally competent care,
- A rationale for integrating cultural competence within care,
- Evidence of the link between culturally competent care and improved health outcomes,
- Barriers to integrating cultural competence into care,
- Priorities for improving service delivery to diverse populations, and
- Promising practices for offering culturally competent care.

Sources reviewed included peer reviewed articles, issue briefs, guidelines, curricula, and other materials published in the English language from 1982-2007 and based on service systems within the United States and its jurisdictions. Information from the literature review was used to inform the development of data collection protocols in subsequent phases of the assessment.

B. Key Informant Interviews

Following completion of the literature review, a series of key informant interviews were conducted via telephone with Federal and regional Title X staff, researchers, and experts in the field of cultural competence. Discussions with key informants further explored issues raised in the literature review and perspectives on strategies for addressing culturally competent health care and family planning (see box). Key informants were selected based on previous publication of cultural competence-related articles/reports, participation in cultural competence-related initiatives, or recommendations from the PO. Altarum Institute created and submitted semi-structured draft telephone protocol to the PO for review and comment. Altarum made edits based on feedback received and created a finalized version of the protocol, which is presented in Appendix B.

Altarum Institute submitted a list of prospective key informants to the Project Officer (PO) for review. Once approved, Project Team members contacted each interviewee to explain the purpose of the request and schedule a convenient time to conduct the interview. Altarum Institute also sent, via email, interviewee documents providing an overview of the assessment project and a list of topic areas to be explored during the interview. On average, telephone interviews lasted between 60 and 90 minutes. Interviewers recorded notes into a discussion guide template for later analysis. Table 1 presents the list of key informants that participated in the telephone interviews.

- Key Informant Interview Topic Areas**
- Role of culture in accessing family planning
 - Defining cultural competence in family planning settings
 - Measures and frameworks used to assess cultural competence
 - Evidence supporting need to address cultural competence
 - Guidelines and strategies for addressing cultural competence
 - Training needs related to cultural competence
 - Major lessons learned
 - Title X program recommendations

Table 1: Key informants

Name	Title	Agency/Organization
Cindy Brach, MPP	Senior Health Policy Researcher	Agency for Healthcare Research and Quality
Betty Chern-Hughes, CNM, MS	Program Consultant for Region VI	Family Planning Regional General Training and Technical Assistance Project for the Office of Population Affairs
Alicia Galan, BS	Equal Opportunity Specialist	Office of Civil Rights, Office of the Chief of Staff, HHS
Yvonne T. Green, RN, CNM, MSN	Associate Director of Women’s Health	Office of Women’s Health, Centers for Disease Control and Prevention
Guadalupe Pacheco, MSW	Project Officer	Center of Cultural and Linguistic Competence in Health Care, Office of Minority Health
Walter Williams, MD, MPH	Associate Director	Office of Minority Health and Health Disparities, Centers for Disease Control and Prevention
Claire Brindis, DrPH, MPH	Director	Bixby Center for Global Reproductive Health, University of California San Francisco
Jacqueline E. Darroch, PhD	Senior Fellow	Guttmacher Institute
Tawara Goode, MA	Director	National Center for Cultural Competence, Georgetown University
Barbara Sugland, ScD, MPH	Co-founder and Executive Director	The Center for Applied Research and Technical Assistance, Inc. (CARTA)
Mary Jane Gallagher	President and CEO	National Family Planning Association

Wayne C. Shields, MD	President and CEO	Association of Reproductive Health Professionals
Robert Like, MD, MS	Director and Professor	Center for Healthy Families and Cultural Diversity, UMDNJ Robert Wood Johnson Medical School
Karen L. Anderson, MPH, MEd	Vice President, Policy and Planning	Family Planning Advocates of New York State
Gail Price-Wise, MPH	President	Florida Center for Cultural Competence, Inc.

C. Site Visits

Altarum identified a sample of Title X programs to conduct site visits to discuss the delivery of culturally competent family planning care. This sample was selected to reflect Title X programs that have been actively engaged in planning and implementing innovative approaches to delivering more culturally competent family services, as identified in the literature review or recommended by key informants and the PO. In addition, the sample also was selected to represent diversity in geographic areas and client populations served. A draft sample of sites to visit was submitted to the PO for review and approval. Site visits were designed to engage conversations with the following types of individuals:

- Title X program directors and other types of staff overseeing and implementing culturally competent strategies,
- Representatives from community partners that played a significant role in delivering culturally competent family planning care,
- Title X program clients selected through convenience sampling regarding their experience receiving care (in order to ensure a high level of diversity client participants across sites, focus groups were conducted in one of three different languages based on the primary languages spoken at each site), and
- Title X Regional Training Center (RTCs) directors and staff regarding the nature and extent of support provided to selected Title X programs regarding the delivery of more culturally competent services.

The following protocols were developed to guide discussions with these individuals during site visits:

- Interview Discussion Guide for Program Directors;
- Interview Discussion Guide for Outreach, Education, Clinical, and Other Staff;
- Interview Discussion Guide for Title X RTCs; and
- Focus Group Discussion Guide for Clients (in English, Spanish, and Thai).

As described in Table 2, each of the three site visit interview protocols covered the same general topic areas. However, the staff protocol was longer and designed to gather additional details about strategies to deliver more culturally competent outreach, education, and clinical services. Also the RTC protocol was designed to gain a better understanding of the type of training and technical assistance offered by RTCs to help Title X programs plan and implement strategies for delivering culturally competent care.

The focus group protocol covered a different set of topics intended to gauge diverse clients’ perceptions of programs and the extent to which they meet all of their service needs in culturally competent manners. Once completed, semi-structured draft site visit protocols were created and submitted to the PO for review and comment. Edits were made in finalized versions of the protocols based on feedback received, which are presented in Appendix C.

Table 2: Site visit interview and focus group topic areas

Site Visit Interview Topic Areas
<ul style="list-style-type: none"> • Role of culture in accessing family planning • Defining cultural competence in family planning settings • Measures and frameworks used to assess cultural competence • Evidence supporting need to address cultural competence • Guidelines and strategies for addressing cultural competence • Training needs related to cultural competence • Types of training and TA offered by RTCs to help Title X programs address cultural competence • Major lessons learned • Title X program recommendations for site visits
Site Visit Focus Group Topic Areas
<ul style="list-style-type: none"> • Perceptions of the Title X program overall • Perceptions of program staff and services offered • Perceptions of care received at the program • Impact of culture on health needs and concerns • Addressing culture during program visits • Literacy and language needs and services • Familiarity with terms “culturally appropriate” and “culturally competent”

Project Team members contacted each site and RTC to encourage participation, provide an overview of the assessment, and answer any questions. During these calls, Project Team members worked closely with each site’s key contact to determine who would be the most appropriate individuals to participate in onsite discussions and arrange the logistics for each visit. Table presents a list of Title X programs and types of specific individuals that participated in the site visits. On average, site visit interviews lasted between 90 minutes and 2 hours, while focus groups lasted between 45 and 60 minutes.

Table 3: Title X Programs that Participated in Site Visits

Agency/Organization	Location	Individuals Participating in Discussions
Family Planning Programs		
Action for Boston Community Development, Inc. (ABCD)	Boston, MA	<ul style="list-style-type: none"> • Program Director • Clinical provider • Education and outreach staff • Research grant specialist • Community providers
Asian Pacific Health Care Venture	Los Angeles, CA	<ul style="list-style-type: none"> • Program Director • Clinical providers • Education and outreach staff • Thai-speaking clients
Clinica Oscar Romero	Los Angeles, CA	<ul style="list-style-type: none"> • Program Director • Clinical providers • Education and outreach staff • Spanish-speaking clients
Navajo Family Planning Resource Network	Window Rock, AZ	<ul style="list-style-type: none"> • Program Director • Clinical provider • Education and outreach staff • English-speaking clients
	New York, NY	<ul style="list-style-type: none"> • Program Director • Clinical providers • Education and outreach staff
Planned Parenthood Association of Cameron and Willacy Counties	Brownsville, TX	<ul style="list-style-type: none"> • Program Director • Education and outreach staff • English-speaking clients
Planned Parenthood of Southeastern Pennsylvania	Philadelphia, PA	<ul style="list-style-type: none"> • Program Director • Clinical providers • Education and outreach staff
Variety Health Center	Oklahoma City, OK	<ul style="list-style-type: none"> • Program Director • Education and outreach staff • English-speaking clients
Regional Training Centers		
Region I: JSI Research and Training Institute	Boston, MA	<ul style="list-style-type: none"> • Training Director • Training Coordinator • Materials Development Associate • Director of Diversity Program
Region III: Cicatelli Associates Inc.	New York, NY	<ul style="list-style-type: none"> • Vice President for Family and Community Education • Title X Program Manager • Deputy Director of Training
Region X: Center for Health Training	Seattle, WA	<ul style="list-style-type: none"> • CHT Vice Presidents • Research Director

- Training Manager
- Training staff

D. Final Report of Key Findings

Following the conclusion of all data collection, the Project Team conducted analysis of the data to assess how cultural competence was defined within the context of Title X, the types of strategies used to deliver culturally competent family planning care, and the types of barriers and gaps that pose as challenges to the successful implementation and expansion of these activities. Data analysis was predominantly descriptive. Notes from telephone interviews and site visit discussions were first entered into a database created using the NVivo software program. Project staff then conducted an initial review of the notes to identify major themes, which were included in a codebook and entered into the NVivo database. The codebook was used to code all of the notes, allowing the Project staff to systematically assess the data for additional themes and patterns across subjects. The final report was then written to synthesize information gathered from the literature review, telephone interviews, and site visit discussions. Key findings from this analysis were used to identify recommendations that OFP can use to develop a national strategy to support Title X providers in addressing culturally competent service delivery.

Chapter 2 | Role of Culture

I. Introduction

Research consistently indicates that – despite variations by condition and population – health disparities occur in almost all aspects of health care, including quality of care, access to care, levels and types of care, care settings, clinical conditions, and within many subpopulations.² The *Healthy People 2010* goals to reduce the incidence and prevalence of unintended pregnancies, sexually transmitted diseases (STDs), and HIV – all of which disproportionately affect people of color, women, and younger individuals – must remain a critical focus of efforts to address sexual and reproductive health disparities:

- **Unintended Pregnancies.** Although unintended pregnancy rates in the United States are declining, the rates remain highest among teenagers, women aged 40 years or older, and low-income African American women.³ A critical factor contributing to the teen pregnancy rate is that approximately one third of adolescents had not received instruction on methods of birth control before age 18.⁴
- **Sexually Transmitted Diseases (STDs).** There are an estimated 15 million new cases of STDs reported each year, almost 4 million of which occur in adolescents.⁵ Women generally suffer more serious STD complications than men, including pelvic inflammatory disease, and cervical cancer from the human papilloma virus. African Americans and Hispanics have higher rates of STDs than whites.⁶
- **HIV/AIDS.** Using new technologies, CDC estimated that 56,300 new infections occurred in 2006.⁷ About one-half of all new HIV infections in the United States are among people under age 25 years, and the majority are infected through sexual behavior. African Americans continued bear a disproportionate burden of this epidemic, representing 45% of those new cases, while they make up only 13% of the population.⁸

Understanding the role of culture – which can be defined broadly as a system of values, beliefs, and attitudes that are affected by other characteristics such as race, ethnicity, age, gender, sexual orientation – is critical in any approach to addressing health disparities. As the United States experiences increasing population growth of diverse racial and ethnic communities and linguistic groups, it is clear that clients and providers bring individual, learned patterns of language and culture, all of which directly affect the health care experience. The impact of culture on access to and quality of care has received particular attention

“Culture and language is at the foundation of everything and grounds notions of one’s self, family, reproduction, and health seeking behavior.”

Key Informant

² AHRQ National Healthcare Disparities Report, 2006.

³ Leading Health Indicators. *Healthy People 2010*. Accessed September 8, 2009 at: http://www.healthypeople.gov/Document/html/uih/uih_4.htm#sex.

⁴ Gavin LG. et al. Sexual and Reproductive Health of Persons Aged 10-24 Years—United States, 2002-2007. *MMWR Surveillance Summaries* 2009; 58(SS06):1-58.

⁵ Gavin LG. et al. 2009.

⁶ Leading Health Indicators. *Healthy People 2010*. Accessed September 8, 2009 at: http://www.healthypeople.gov/Document/html/uih/uih_4.htm#sex.

⁷ Hall HI, Song R, Rhodes P, et al. Estimation of HIV Incidence in the United States. *JAMA* 2008;300:520-529.

⁸ CDC, HIV Prevalence Estimates—United States, 2006, *MMWR*, 57(39);1073-1076.

within the literature as it relates to health beliefs and practices and to health seeking attitudes and behaviors. The research indicates that:

- Culture can influence the **health beliefs and practices** of individuals, providers, and systems as they may conceptualize health, disease, and wellness differently. They also may vary in terms of familiarity and trust with a range of health practices (from Western medicine to traditional health practices and healers) and in degree of comfort using an integrated medical model.⁹
- Culture also affects **health-seeking attitudes and behaviors**, as individuals may have a historical mistrust of health care and social service professionals or have experienced racism, discrimination, and bias in the past when trying to access health care. Cultural and linguistic barriers also play a critical role in an individual's ability to seek and access care.¹⁰

Within the context of Title X, the impact of culture can be seen in many specific ways due to the diverse and complex nature of the programs and clientele, including:

- At the **program or organizational level**, culture shapes the way that an organization portrays its attitudes, values, and expectations.¹¹ For example, a man might want to seek services but does not feel welcome within a traditionally female-oriented clinic. A provider may wish to improve his or her ability to communicate effectively with clients of different cultures, but training and skill-building opportunities may not be available. An administrator may fail to conduct needs assessments and to engage clients and the community as partners in planning and program design.
- At the **provider level**, culture shapes attitudes, values, and responses. This can result in bias against different groups, stereotyping, cultural insensitivity, under treatment, and lost opportunities for prevention.¹² For example, a provider might rely on family members to translate sensitive information, might not acknowledge a client's use of alternative contraceptive measures, or might assume that his or her client has only heterosexual relationships and neglect to ask about other forms of sexual behavior.
- At the **individual level**, culture can affect behavior in terms of ideas and attitudes about sexuality, risk, health, and health behavior. It also influences how and when individuals seek to use health information and services.¹³ For example, relationship dynamics may mean that a woman may not feel empowered to negotiate condom use with her partner, a teenager might not understand her risk for contracting HIV until she hears from another teen who is HIV positive, or an individual might be more comfortable talking about sexual practices with a clinician of the same racial or ethnic background.

II. Study Findings About the Role of Culture in Family Planning

One key objective of this study was to better understand the cultural factors at the program, provider, and individual levels that influence the perceived need for family planning care and the experiences of clients when using these services. Therefore, all key informants, clinic staff, and clinic clients

⁹ Cohen E, Goode TD. Revised by Goode TD, Dunne C. *Policy Brief 1: Rationale for Cultural Competence in Primary Care*.

Washington: National Center for Cultural Competence, Georgetown University Center for Child and Human Development; 2003.

¹⁰ Cohen E, Goode TD; 2003.

¹¹ Cohen E, Goode TD; 2003.

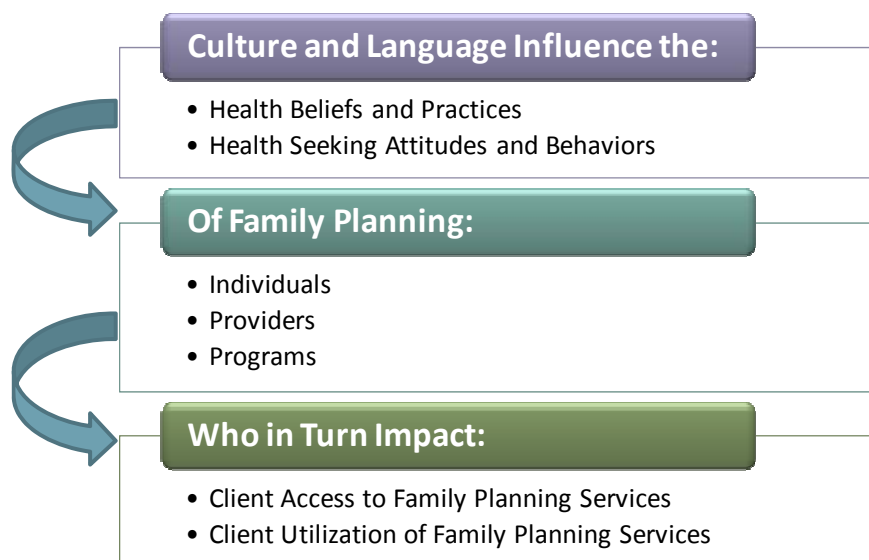
¹² Cohen E, Goode TD; 2003.

¹³ Research and Training Institute, Inc. *Region I Title X – Integrating HIV Prevention and Family Planning Services: Organizational Self-Assessment Manual*. Boston: JSI Research and Training Institute, Inc.; 2004.

participating in the study were asked to reflect on the same issue: **how do culture and language influence clients' ability to access and utilize family planning services?**

The study participants stressed the importance of demographics such as race/ethnicity, age, gender, socioeconomic status, and sexual orientation. Yet, as depicted in Figure 1 and described in the following section, they moved beyond ideas tied to these categories to provide concrete, family-planning specific examples of how culture and language are embedded in health beliefs and practices and health seeking attitudes and behaviors – and ultimately affect clients' ability to access and utilize services.

Figure 2. The Impact of Culture and Language on Access to and Utilization of Family Planning Services



A. Health Beliefs and Practices

Many study participants spoke of the critical roles that beliefs, values, and ideas related to family and relationship dynamics and health and family planning play in affecting clients' access to and utilization of services. Providers in particular struggled with how to respect a client's cultural beliefs and background while simultaneously stressing the importance of family planning and discussing the range of available options.

Family and relationship dynamics. Numerous scenarios were shared where a female or male family planning client did not feel empowered to access or use family planning services based on family and relationship dynamics. For example, in cultures where women have primary responsibility for pregnancy prevention, male partners may be reluctant to participate in family planning decisions (such as use of condoms) or feel that it is the woman's responsibility. While in other situations, no family planning decisions can be made without the presence of a spouse or other family member. And although the engagement of partners and families can provide opportunities for collaborative decision making, power dynamics and cultural hierarchies may leave the individual in need of family planning services powerless. For example, one key informant spoke of a former client who opted not to use birth control because her mother-in-law gave her herbs to prevent pregnancy, but ended up in the prenatal clinic because she was given the wrong herbs.

Many participants also felt that it is critical for family planning programs to understand cultural norms, values, and attitudes related to child rearing, as it affects the way in which a culture or cultural group views and discusses (or not) issues such as sexuality, nudity, virginity, personal discipline, appropriate practices, intra-familial or extra-familial relationships, and communication. In many families and cultures, topics related sex are taboo, which in turn can make it difficult for individuals to understand their bodies and feel comfortable discussing reproductive health issues. This can directly affect access to and utilization of family planning services. One focus group participant shared that her family emphasized that she wait until marriage to have sexual relationships. She felt the lack of appropriate education and conversations about sex in fact increased her risk for pregnancy.

This inability or unwillingness to openly discuss sexual health is not found only among clients. Many study participants discussed the overall lack of comprehensive sexuality education in the United States. One key informant felt this lack of education meant that many women do not fully understand how their menstrual cycles work. The lack of education – combined with “a cultural unease among health professionals about discussing sexual topics, limited time for health care appointments, and communications complexities” – means that women are “kept in the dark about their true risk of pregnancy.” Most study participants felt Title X clinics were in a unique position to improve the ability of individuals and providers to discuss sensitive health topics in non-judgmental and open environment.

Beliefs about health and family planning. Study participants felt that beliefs about a broad range of issues around women’s health – health promotion, disease prevention, pregnancy and birthing, menstruation, pregnancy, mental illness, abuse, and violence – may all affect access and use of services. For example, one focus group participant felt spiritual beliefs also affect whether preventive services should be sought, suggesting that people who may believe that it is “God’s will” if they get sick may feel less responsibility and power to control their health. Providers also talked of clients’ beliefs that “babies just come,” or that they should “have as many kids as God sends them,” and therefore they did not choose to use contraception.

“Cultural considerations are probably of critical importance because this [family planning] is one of the most private, complicated issues that women and families deal with. To have to speak about it in a way that you don’t feel is in your language or that is respectful of what mores you’ve learned, it just makes it that much harder. .”

Provider

Most study participants provided examples of where individuals’ beliefs about appropriate and inappropriate forms of family planning and contraception and issues around menstrual cycles and menopause affected decisions about reproductive health. One provider shared that some traditional Navajo women are wary of contraceptives because they have been told that menstruation and ovulation are part of being a woman and to interfere with these processes may be viewed as unnatural. Also, having many children was historically viewed as associated with greater wealth in traditional Navajo culture. Having children was also closely monitored part of the arranged marriage system, which helped to control genetic mixture between clans. Yet one younger focus group participant mentioned that even though most of her family was part of a traditional Native American church, it didn’t conflict with her interest in seeking help for family planning.

Families and individuals with more traditional cultural values may also not be that receptive to family planning services because they are associated with Western medicine. Traditional healers and

ceremonies may be at odds with the Western approach to health and wellness. Some community members may be more willing to go to traditional healers for advice and services about family planning and childbirth than they are to go to family planning clinics. Many key informants, clinic administrators and staff, and focus group participants stressed the importance of engaging traditional healers and community gatekeepers in collaborative approaches to engage diverse individuals and provide culturally and linguistically appropriate services.

B. Health Seeking Attitudes and Behaviors

Cultural and language differences make it even more important to establish a high level of trust and confidence among clients, providers, and programs. In this section we review the study participants' perceptions of the impact of culture and language on clients' ability to seek and access care and client-provider interactions. We also highlight specific language and literacy considerations.

Ability to seek and access care. In the words of one provider, it is of critical importance that individuals feel that they can come in and “know that they are going to get high quality services, that [the services] are going to be respectful of who they are, and that it really, really will be confidential.” Client perceptions of confidentiality, cost, quality, and appropriateness are critical considerations. Confidentiality concerns can relate to the sensitivity of reproductive health issues, the location of clinics in small communities where clients and clinic staff may know each other, and an individual's documentation status or immigration status. One provider shared that her program makes a special effort to address the perception among individuals in the community that they can't afford the services. The program communicates that they serve people regardless of their ability to pay and there are certain services that undocumented immigrants can be covered for, and those that the organization can't it will use its grant money to cover.

Potential clients also must feel comfortable in seeking services and confident that they will be reflective of their individual needs. In particular, many study participants stressed the need to build the capacity of family planning programs to address male reproductive health. One clinical provider felt that her program had not been able to make much progress in reducing high Chlamydia rates because they only treat immediate partners, not the extended network of other current and past partners who also may be infected. The large majority of the family planning patients are female and these services are only offered in areas of the hospital that cater to women, such as the OB ward. Men are more often treated in the adult services department, which was not viewed as particularly user friendly for seeking sexual health services. The provider felt that very few men feel comfortable walking in and directly asking for sexual health care. Instead they have another excuse for coming in and then disclose their sexual health concerns later in the visit. At another site, an educational services provider felt there needs to be a range of male health educators. She felt some of the males participating in the programs feel more comfortable talking to women, but that it would be helpful for

“Having cultural and linguistic competency in any service setting is essential for meaningful health education and to ensure that people are aware of what's available for health services; it is essential for access, making sure that you deliver services that are consistent with the cultural norms of the people you are trying to serve; and it is essential for decisions on diagnosis and treatment, participating in direct treatment decisions, understanding ones' rights and protections and conversations around informed consent, and compliance around any regimen recommended.”

Kev Informant

them to be around a guy who was sensitive and not using the “be a man” approach. She felt that without “guided gentle male support...it reinforces idea that men can only have feelings with women.”

Client-Provider Interactions. Because family planning is a very personal issue, the nature of the client-provider relationship plays a central role ensuring that clients feel comfortable enough to discuss sensitive sexual health topics. One key informant reported that her research has shown that when patients experience difficulty communicating with their provider because of limited English proficiency or fear of being negatively judged by their provider because they are poor or have different views about an ideal family size or contraceptive practices, they are significantly less likely to ask questions or voice concerns about family planning guidance or care provided. Because Title X often serves as an initial access point to care, clients can have a very difficult time understanding and navigating the health system.

One key informant talked about the impact of differences in level of education, backgrounds, and work experiences can have an impact on the use of language between client and provider. He suggested that these differences translate into how the provider hears the clients, how the client hears the provider, and biases of unrealistic expectations from both provider and patients. Study participants provided several examples of how this dynamic plays out in family planning settings, including:

- Health provider-client relationships may be viewed as hierarchical in some cultures, which may hinder the ability of clients to ask questions about health services;
- In many cultures women rely on male partners for input on reproductive health decisions, but providers often only focus on the woman;
- A provider may make assumptions about sexual orientation and therefore the clients’ sexual behavior, and will assume a lesbian doesn’t need barrier contraception without asking if she is also having sex with men;
- A provider’s advice to discuss contraception may have a very benign impact in some cultures, but may bring up concerns about sexual fidelity or instigating intimate partner violence in other cultures; and
- A provider may assume that if an individual is only having sex with men who were biologically women at one point then that individual doesn’t have to worry about STDs, which in one clinic led to discomfort among some people from the trans [transgender] community.

A number of study participants also discussed the level of comfort that some clients may have in terms of receiving care from provider who is or is not of the same sex. For example, some of the female Thai focus group participants described feeling uncomfortable fully disrobing during visits, and especially in front of male doctors, and attributed this to cultural upbringing. One shared that “...from childhood, I was taught that female should be modest. Do not show skin, cover yourself up. It’s not like Europeans, who wear shorts and mini-skirts. I was taught from childhood.” Another talked of her experience waiting for a mammogram while there were male staff members around. “I was afraid he, or anyone, would walk by. I was shy. It should be more private.” They both felt that having Thai staff members was helpful because they knew about their modesty and gave them the option for a male or female doctor.

Considerations Related to Language and Literacy. Although language and literacy play a critical role in affecting an individual’s ability to seek and access care and to client-provider interactions, the interviews and site visits revealed so much information in this area that a separate section is warranted.

Many study participants felt that language and health care literacy affect the accuracy of the health information that a client receives, and is therefore a patient safety issue. For example, language can be a barrier to access and use due to the fact that clients with limited English proficiency (LEP) or aren't able to effectively communicate with clinics to make appointments, express their medical concerns, or ask questions. Providers and clients need to be able to understand each other; if clients with limited English proficiency lack access to language assistance services they will have a difficult time understanding the care they receive and experience reduced satisfaction with services. In addition, if that information isn't available through some channel in that community in a language they understand, it would create an initial barrier because they don't even know the services exist.

Providers often rely on family members in many health settings to translate due to language and literacy differences. Yet topics like sexual partners and STDs are not issues that individuals want to family members know about. In the words of one provider, "What could be worse than having your 12 year old translate your gynecological exam?"

Study participants felt that LEP clients will be more likely to seek services if they are aware that language services will be available. For example, a provider reported that her clinic has seen many more Spanish-speaking patients now that they know there is bilingual staff available. The patients tell their friends that they clinic has Spanish-speaking staff and available services. A focus group participant at another site reported that the majority of clinic staff are Latino and most are from Mexico and can easily relate to their patients. Everyone agreed that it is important to them that staff are able to speak Spanish. But it was also important to understand that just

because an individual speaks Spanish, for example, it doesn't mean that they are culturally competent or qualified to provide interpretation services. One provider reported being grateful for the language line, but that it concerns her sometimes because she is unsure of the beliefs of the person who is assisting with the phone call. To her, every once and awhile the dialogue back and forth for a simple "yes" or "no" question seems to be a little longer than necessary.

Literacy and health literacy also were raised as issues by key informants and clinic administrators and staff, particularly in terms of the extent to which a client is able to navigate the health system. One key informant felt that there are a lot of expectations for literacy beyond reading, including advocating for oneself, recognizing cues for action, and being able to take medication as prescribed. One provider in Arizona mentioned that for them, the current major cultural barrier is less around English proficiency than it is around literacy level and the reliance on written materials. The client population they see is diverse and ranges from women with very low literacy and who don't organize their lives around written materials up to women with advanced degrees who are very comfortable with written materials.

I. Rationale for Culturally and Linguistically Competent Family Planning Services

Family planning clinics play an important role in meeting the needs of diverse populations. Clinics are likely to be located in dense urban and sparsely populated rural areas, which often have high concentrations of poor, racial and ethnic minority, and immigrant populations. Nearly 24 million women obtain contraceptive care to avoid unintended pregnancies in the United States each year, and 25% of these women receive this care from Title X-supported family planning clinics. The proportion of women accessing contraceptive care at Title X clinics is higher among members of racial and ethnic minority groups (40%) and among poor women (50%).¹⁴

Family planning clinics have the capacity for targeting services to underserved populations, can provide a broad range of primary care services beyond contraceptive care, and can connect clients to other social service systems. Funding guidelines for Title X have afforded family planning clinics considerable flexibility in designing services and programs to better accommodate the clients they serve. The outreach and education that many clinics are able to provide reaches a large segment of the local community with important sexual and reproductive health messages and information on how to access family services. As family planning clinics are serving a higher proportion of hard-to-reach and high-risk populations, many have established special programs to target these clients. As a result, publicly funded clinics are often more attuned than private providers to the socio-cultural issues that are barriers to care in their geographic service areas.¹⁵

One key informant commented that as the country increases in diversity, providers who don't understand emerging population dynamics will not be able to adequately serve these clients. Because of the Title X client diversity, OFP has undertaken this assessment to improve the capacity of family planning clinics to provide culturally and linguistically competent care. This chapter explores how the term—cultural and linguistic competence—has been defined in the literature; is viewed by experts in the fields of cultural competency and family planning; and how it is viewed in the field among family planning providers.

Office of Minority Health Working Definitions

Culture: “Integrated patterns of human behavior that include the language, thoughts, communications, actions, customs, beliefs, values, and institutions of racial, ethnic, religious, or social groups.”

Competence: “Having the capacity to function effectively as an individual and an organization within the context of the cultural beliefs, behaviors, and needs presented by consumers and their communities.”

Cultural and linguistic competence: “A set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among professionals that enables effective work in cross cultural situations.”¹⁵

¹⁴ U.S. Department of Health and Human Services, Agency for Healthcare Research and Quality. *National Healthcare Disparities Report, 2006*. Rockville, MD: U.S. Department of Health and Human Services; 2006. Available at: <http://www.ahrq.gov/qual/nhdr06.htm>. Accessed January 23, 2008.

¹⁵ Becker S. Couples and reproductive health: A review of couple studies. *Studies in Family Planning*. 1996; 27(6): 291-306.

¹⁶ U.S. Department of Health and Human Services, Office of Minority Health. *What is Cultural Competence?* Washington: U.S. Department of Health and Human Services; 2008. Available at: <http://omhrc.gov/templates/content.aspx?ID=2804>. Accessed January 22, 2008.

A. Definitions

The concept of cultural competence draws on the definitions of culture, discussed in the previous chapter, and how culture influences health beliefs and behaviors. While there is no single definition of cultural competence, researchers and practitioners have developed several definitions in the past decades, the most influential being that of Cross and colleagues. Their important work served as a foundation for the field and has been adopted by a number of organizations in the past 20 years.¹⁷ The Office of Minority Health (OMH) adapted these definitions for their own use, which are now widely adopted among Federal agencies within HHS.

“You know one of the words that always comes to my mind in terms of “culturally competent services” is the whole idea that people are comfortable—that patients are comfortable, staff are comfortable with the culture, with those beliefs and values...so I think functioning effectively is certainly very important in terms of competence but somehow the whole concept of being comfortable...I’m not sure I can think of another word.”

Title X Program Director

The OMH definitions were discussed during key informant interviews and site visits conducted with Title X-funded family planning clinics, to get feedback on these concepts and definitions. During interviews with key informants, one interviewee was concerned about the literacy level of the definition and felt that terms like “integrated patterns of human behavior” and “congruent behavior” are not easily understood and “too complex to be readily accessible to many services providers.”

Another interviewee stated that there is no broad consensus as to what cultural competence means in family planning settings. This was supported during site visits with Title X-funded clinics; many did not have a standard definition or approach to cultural and linguistic competence. While familiar with the concepts in the OMH definitions, few clinics reported having an operational definition for cultural competence. Only a few clinic directors stated they have used that language with their staff. Clinics shared other terminology that was used to capture this concept, including culturally sensitive; patient-centered; creating a comfortable client environment; and being able to “work with someone from a different culture.” In one California-based clinic, the term patient-centered is well understood among staff and a priority for staff training.

During site visits, some clinic staff expressed that cultural competence requires direct knowledge of or experience with a particular cultural group, while others felt it encompasses more than that. One director of a clinic serving Navajo people, felt that younger Navajo women “may have difficulty with it because they are not familiar with Navajo cultural beliefs...not a lot of written materials they can refer to on these cultural beliefs, they primarily have to rely on stories that have been passed down.” Several key informants stressed that cultural competence goes beyond knowing a language or familiarity with stereotypes. A number of clinics agreed that sharing a language or ethnic/racial identification with a client does not ensure a culturally competent encounter.

All key informants commented that the Cross and OMH definitions are widely accepted and felt they could be applied to any health care setting. The definition of cultural competence was described as broad, comprehensive, and relevant. One key informant noted that it represented a significant shift from viewing cultural competence as just an individual provider issue, to thinking about it at a systems

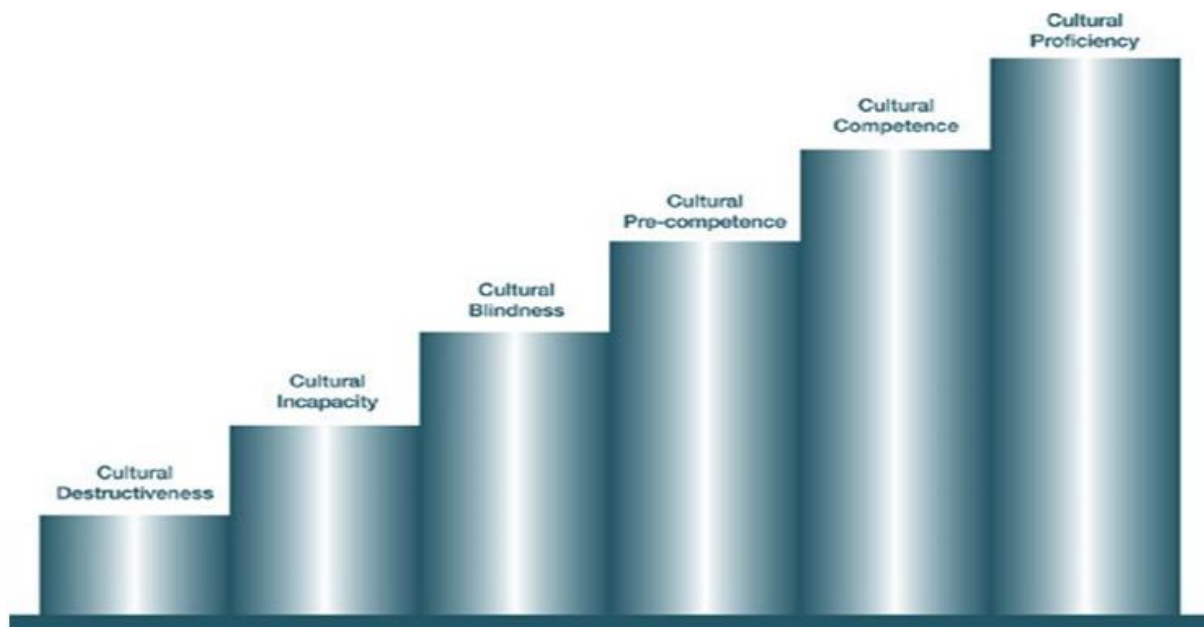
¹⁷ National Center for Cultural Competence Web site, <http://www.ncccurricula.info/culturalcompetence.html>.

level. The next section highlights some frameworks that have expanded on initial definitions of cultural competence.

B. Cultural Competency Frameworks

Important frameworks in the literature describe cultural competence as a process that is fluid, develops over time, and includes components that are both concrete and intangible. Cross and colleagues¹⁸ emphasized that achieving cultural competence, whether at the individual or organizational level, should be thought of as moving along a continuum that includes the six stages represented below—from cultural destructiveness to cultural proficiency.

The Cultural Competence Continuum



The Cross framework defines each stage as follows:

- **Cultural destructiveness** acknowledges only one way of being and purposefully denies or outlaws any other cultural approaches.
- **Cultural incapacity** supports the concept of separate but equal, marked by an inability to deal personally with multiple approaches but a willingness to accept their existence elsewhere.
- **Cultural blindness** fosters an assumption that people are all basically alike, so what works with members of one culture should work within all other cultures.
- **Cultural pre-competence** encourages learning and understanding of new ideas and solutions to improve performance or services.

¹⁸ Cross T, Bazron B, Dennis K, Isaacs M. *Towards a Culturally Competent System of Care: A Monograph on Effective Services for Minority Children Who Are Severely Emotionally Disturbed: Volume I*. Washington: Georgetown University Press; 1989.

- **Cultural competence** involves actively seeking advice and consultation and a commitment to incorporating new knowledge and experiences into a wider range of practice.
- **Cultural proficiency** involves being respectful of cultural differences and practices and proactively promoting improved cultural relations among diverse groups.¹⁹

This framework is one of the most commonly used models to address the various levels of awareness, knowledge, and skills among individuals and organizations. As indicated in the figure above, the framework focuses on the complex process of achieving cultural competence, a point that was made by all key informants and family planning clinics.²⁰ A number of key informants described this concept as difficult to measure and one that is evolving, as the body of research grows and increases our understanding. Researchers in this field point to the need to move beyond conceptualizing cultural competence, to applying and testing actual measures of cultural competence in real-world settings, while also identifying the challenges related to the availability and feasibility of data; the need for more sophisticated instrumentation and tools; and short-term versus longitudinal measurement issues.²¹

Measuring the impact of cultural and linguistically competent strategies is further complicated by the fact that it is just one of many factors that influence health outcomes. One key informant acknowledged that the field of cultural competency has had a narrow focus on changing individual behavior and not placed enough weight on the environmental factors and social determinants of health, such as education and income that can lead to disparities in reproductive health.

Several seminal reports have identified cultural and linguistic competence as an important mechanism for addressing health disparities. *Healthy People 2010* focused on eliminating health care disparities that occur by race and ethnicity, gender, education, income, geographic location, disability status, and sexual orientation.²² *Healthy People 2010* has helped Federal agencies; State, county, and local health departments; national organizations; and communities to frame and measure their goals related to reducing health disparities. While *Healthy People 2010* focused on disparities in overall health, a 2002 Institute of Medicine (IOM) report focused specifically on disparities in health care delivery.²³ It defined racial and ethnic health disparities as complex, rooted in historic and contemporary inequities, and as involving many participants at all levels within the health care system. The report suggested that a comprehensive, multilevel strategy was needed to address the issue and should include the following:

- Increasing awareness of the health care gap between racial and ethnic groups;
- Promoting consistency and equity of care through the use of “evidence-based” guidelines to help providers and health plans make decisions about which procedures to order or pay for based on the best available science;
- Increasing the proportion of underrepresented U.S. racial and ethnic minorities among health professionals;

¹⁹ Cross et al., 1989.

²⁰ Goode TD, Harrison S. *Cultural Self-Assessment*. 2004. Available at: <http://www.ncccurricula.info/assessment/B3.html>. Accessed January 21, 2008.

²¹ Goode T. *Effective Strategies for Addressing Health Disparities and Cultural Competence*. Washington: Georgetown University Press; 2006.

²² U.S. Department of Health and Human Services. *Healthy People 2010: Understanding and Improving Health*. Rockville, MD: U.S. Department of Health and Human Services, 2000. Available at: <http://www.healthypeople.gov/Document/tableofcontents.htm#under>. Accessed January 23, 2008.

²³ Institute of Medicine. *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care*. Washington: National Academies Press; 2002.

- Educating patients to improve knowledge of how to access care and participate in decision-making and educating providers on an ongoing basis using cross-cultural, case-based, and rigorously evaluated training;
- Ensuring interpreters are available in clinics and hospitals to overcome language barriers that may affect the quality of care; and
- Collecting, reporting, and monitoring patient care data to assess progress in eliminating disparities, evaluate intervention efforts, and assess potential civil rights violations.²⁴

Both the literature and key informant interviews demonstrated that cultural competency should be integrated at multiple levels, from the practice level with direct service providers, to the policies that are in place in a family planning clinic. The Culturally and Linguistically Appropriate Services (CLAS) Standards developed by the OMH in 2001 embody this multi-level approach. The CLAS Standards are comprised of 14 Standards designed to improve the ability of health care organizations and providers to be more responsive to the needs of patients, consumers, and communities. These standards ultimately aimed to contribute to the elimination of racial and ethnic health disparities and to improve the health of all Americans.²⁵ The 14 Standards are organized around three themes: culturally competent care, language access services, and organizational supports for cultural competence. Within this framework, there are three types of Standards of varying stringency:

- CLAS **mandates** are current Federal requirements for all recipients of Federal funds.
- CLAS **guidelines** are activities recommended by OMH for adoption as mandates by Federal, State, and national accrediting agencies.
- CLAS **recommendations** are suggested by OMH for voluntary adoption by health care organizations.

The CLAS Standards provided a critical framework for health care organizations and providers to operationalize cultural and linguistic competency. In addition, a much wider group of stakeholders – policymakers, accreditation and credentialing agencies, purchasers, patients, advocates, educators, and the health care community in general – have used the CLAS Standards to institutionalize, assess, and advocate for culturally and linguistically appropriate health services.

Most key informants agreed that the CLAS standards have been a useful framework through which to think about the delivery of care and have drawn attention to important concepts such as community

“CLAS standards...focus more on respectful care, understanding needs and assets that people bring to a health care organization. This requires an organization to understand community and who it serves related to history, demographic makeup, family planning challenges, teenage pregnancy, HIV, substance abuse, assets and strengths.”

Key Informant

²⁴ U.S. Department of Health and Human Services, Agency for Healthcare Research and Quality. *National Healthcare Disparities Report: Summary*. Rockville, MD: U.S. Department of Health and Human Services; 2004. Available at: <http://www.ahrq.gov/qual/nhdr03/nhdrsum03.htm>. Accessed January 23, 2008.

²⁵ U.S. Department of Health and Human Services, Office of Minority Health. *National Standards for Culturally and Linguistically Appropriate Services in Health Care*. Washington: U.S. Department of Health and Human Services; 2001.

engagement and involvement. One key informant believes the CLAS Standards have “set the gold standard” for delivery culturally competent care and address the multiple levels that affect health care delivery—provider and staff level, organizational level, and community level. Another key informant questioned whether the CLAS Standards have been adopted by smaller organizations, including family planning clinics. During site visits with Title X-funded clinics, only a few clinics were familiar with the CLAS standards.

II. Applicability to Family Planning Settings

The OMH definitions were referenced during key informant interviews and site visits conducted to get feedback on their applicability to family planning settings. Most key informants agreed that the OMH definitions of culture, competence, and cultural and linguistic competency are widely accepted and are applicable in family planning settings. While most key informants had positive comments about the definition, there were some critiques. Some thought

“I think cultural competency is very broad and I work with and live with clients who tend to be Spanish speaking only but there is also...the gay community that we see as well. And being culturally competent to that population goes further than just the language we speak. It’s so much more than that.”

Title X Program Director

the definition of cultural competency was comprehensive, while others felt that the OMH definitions were not broad enough and overly focused on race and ethnicity as the dominant cultural factors, and felt that the term “cultural competence” is typically thought of in the context of race and ethnicity.

The interviews conducted with key informants and during site visits highlighted the need to think about cultural differences that may be more important in the family planning settings and should be considered within the context of the client, community, and health care delivery system. Important references that are important in family planning settings because of the diversity of the population served were identified as missing from the definition. A number of factors were identified by key informants and family planning clinic staff as important to include in an OFP definition of cultural and linguistic competency.

Considering the client composition of Title X clinics, most respondents found factors related to socio-economic status and gender dynamics to be particularly important to include. Socio-economic status was mentioned most often during interviews because of OFP’s role in ensuring access to millions of low-income or uninsured individuals and because class (i.e., income and education) is considered an important social determinant of health and linked with disparities in health outcomes. The issue of gender was raised by key informants because family planning traditionally serves women, and clinics may be very comfortable serving women and less prepared to address the health needs of its male clients in what has been thought of as an established female environment. The social norms related to client age was mentioned often during the site visits with Title X-funded clinics as management staff see themselves aging out and feeling challenged by the adolescent populations seeking clinic services, who communicate differently and have been raised in a very technologically-driven culture.

In thinking about how OFP should define and frame cultural and linguistic competence, several important considerations about broadening the OMH definition of cultural competence were proposed during key informant interviews and site visits, including:

- Including references to, socio-economic status, sexual orientation, gender, age, disability in the term “social groups; and
- Including information about why family planning values cultural differences.

The consensus was that any definition adopted by OFP should consider the underserved and high-risk populations Title X has traditionally served, so that a potential client in any life circumstance—homeless, sex worker, uninsured person, person with HIV positive status, immigrant—feels welcomed in family planning settings and receives appropriate care.

“Although I think this definition really is very encompassing I’m not sure how we would use it. I mean I’m not sure of what value it is in administering a program. I want you to work for me and you have to be culturally competent...read this, this is what you have to do. I’m not sure how I would use it.”

Title X Program Director

One key informant suggested that beyond adapting the OMH definition of cultural competence, OFP should go a step further by explaining how to implement it, in terms of specific policies, standards, and practices. Key informants acknowledged the importance of the Cross and OMH definitions for introducing key concepts but they felt these definitions were more useful to academicians or researchers, and less so to those out in the field. This assertion was confirmed in interviews with Title X staff during site visits. Most clinics understood the OMH definitions but did not find them particularly helpful and thought they were too theoretical and not specific. One clinic director shared that it works as a definition, but if she gave it to her staff with the instruction that they should be more culturally competent, they would be hard pressed to know how to implement this. The overarching recommendation was to provide additional information that would explain how to apply this concept in the clinic setting. In addition to a definition, it was suggested that OFP also:

- Explain how cultural and linguistic competence pertains to the day-to-day work of clinic staff;
- Develop operational definitions in terms of standards, policies, and practices that a clinic would have to undertake to provide culturally and linguistically appropriate care;
- Include examples of strategies and how those were implemented; and
- Provide specific targets that clinics can use to measure their progress.

All agreed that these suggestions would make the definition more concrete to those in the field, relevant to their daily work, and easier to apply and monitor. Several key informants commented that the CLAS Standards, while not very detailed, were developed to provide examples of important strategies that health care organizations and providers should undertake to improve linguistic and cultural competence.

Section II | Strategies to Improve Cultural and Linguistic Competence

In section II, we present examples of strategies used by Title X clinics to improve cultural and linguistic competence. We begin with a brief overview of:

- Background information to provide context,
- Reported barriers and supports in implementing cultural competency strategies, and
- The organization of Section II.

I. Introduction

The magnitude of disparities makes them both critical and difficult to address. The 2002 Institute of Medicine (IOM) report *Unequal Treatment* focused specifically on disparities in health care delivery, and defined racial and ethnic health disparities as complex, rooted in historic and contemporary inequities, and involving many participants at all levels within the health care system.²⁶ This report suggests that a comprehensive, multilevel strategy was needed to address the issue and should include the following:

“Cultural and linguistic competence is a new and emerging field – what we know now is beyond what we knew 5 years ago.”

Key Informant

- Increasing awareness of the health care gap between racial and ethnic groups;
- Promoting consistency and equity of care through the use of “evidence-based” guidelines to help providers and health plans make decisions about which procedures to order or pay for based on the best available science;
- Increasing the proportion of underrepresented U.S. racial and ethnic minorities among health professionals;
- Educating patients to improve knowledge of how to access care and participate in decision-making and educating providers on an ongoing basis using cross-cultural, case-based, and rigorously evaluated training;
- Ensuring interpreters are available in clinics and hospitals to overcome language barriers that may affect the quality of care; and
- Collecting, reporting, and monitoring patient care data to assess progress in eliminating disparities, evaluate intervention efforts, and assess potential civil rights violations.²⁷

After conducting a comprehensive review of the literature, the National Center for Cultural Competence (NCCC) found that the evidence supporting the impact of culturally and linguistically competent interventions on health outcomes show “great promise,” but significant gaps due to methodological issues (e.g., lack of definition and measurement of cultural and linguistic competence and designs that isolate effects of cultural and linguistic competence) continue to exist. Despite these limitations, NCCC

²⁶ Institute of Medicine. *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care*. Washington: National Academies Press; 2002.

²⁷ HHS, 2004. IOM, 2002.

also found that emerging evidence demonstrates a link between culturally competent strategies and improved health outcomes in several areas related to clinical care, health promotion and screening, quality of care, patient-provider concordance, and increased access to and use of services. There also is compelling evidence of a correlation between culturally competent policies and practice and favorable health outcomes.²⁸

After reviewing the available literature, Goode and colleagues concluded that the field of cultural competence is in the early stages of development and has focused primarily on defining concepts and identifying research questions. The authors make the important point that the field must move beyond conceptualizing cultural competence to applying and testing actual measures of cultural competence in real-world settings, a sentiment also supported by the key informants.²⁹ Several key informants felt that although the knowledgebase is still developing, the evidence in support of cultural and linguistic competence was robust enough, that greater resources should be invested to support implementation and evaluation efforts. One key informant feels that Title X and other health programs need to demonstrate the efficacy of these approaches in practice.

II. Barriers and Supports to Addressing Cultural and Linguistic Competence

Improving cultural and linguistic competence throughout the service delivery system requires an ongoing organizational commitment to implement and monitor how well each strategy is working. The most important support identified by key informants and during the site visits with Title X programs and RTCs, is **strong leadership**. During one site visit, the staff remarked that reducing health disparities was a priority for their director and for subsequently for all program staff. In the programs where cultural and linguistic strategies were integrated and had become routine in the day-to-day practice, it was clear that this issue had been prioritized by the leaders within the organization—executive director and medical director—someone in a position to allocate staff time and resources. This level of organizational commitment appears to be an important contributor to success.

“The greatest challenges that staff are not paid for it. To be blunt, [we] have been addressing cultural competence issues based on very flat grants. Addressing cultural competence does cost more. It takes more time. It takes more resources. But to sustain it...there is just not the [available] resources. Staff are committed...but it’s really, really hard.”

Title X Program Director

Even with strong leadership in place, the idea of integrating cultural and linguistic competence into policy and programs can be difficult to grasp or is seen as an overwhelming task. Sometimes staff or resource issues will arise that may threaten to slow or derail the process of striving toward cultural and linguistic competence. The following are a number of common barriers within family planning programs, identified in the literature, by key informants, as well as during the site visits with Title X programs:

- Lack of organizational commitment or support, for example, in mission, policies, leadership, or resources;
- Lack of support for diversity in leadership and workforce (e.g., recruitment, hiring, and promotion practices that do not foster diversity; lack of incentives or rewards for effectual language skills);

²⁸ Goode TD, Dunne MC, Bronheim SM. *The Evidence Base for Cultural and Linguistic Competency in Health Care*. Washington: Georgetown University; 2006.

²⁹ Goode et al., 2006.

- Lack of space for accommodating additional programs to address the community’s needs and insufficient space for improving clinic accessibility, safety, appearance, or privacy;
- Limited training materials, including scarcity of evidence-based resources, as well as approaches that define cultural competence too narrowly or that may contribute to stereotyping, such as improper use of ethnic profiles;
- Fear and resistance to change (e.g., staff members’ fear of the unknown or the new, fear of being viewed as biased or incompetent, anxiety about making mistakes);
- Perceived limited financial resources for staff, training, and other essential activities, and lack of sustained funding to support ongoing development of cultural competence; and
- Scarcity of time to learn new practices and alter behaviors, along with feelings of pressure due to time constraints^{30,31,32}

Of the list above, the final two were mentioned most often by Title X programs. A **lack of time and resources**, were seen as the greatest barriers to prioritizing cultural and linguistic competence and fully implementing strategies. All program directors and staff mentioned that that in a busy clinic environment, it is very challenging to find the time and resources to focus on developing staff knowledge and skills around cultural competency, to attend available trainings in the area, or undertake other recommended activities.

The literature supports that an effective approach to cultural and linguistic competence, is one that is **integrated into policy and regulation, systems development, and organizational structure**; and **engages the community** with a focus on family and consumers.³³ The literature, key informants, and interviewees stressed that family planning programs will need to reinforce their commitment to cultural and linguistic competence both through formal policies and in daily practice; provide staff with information on why this commitment is needed and sufficient training on how to implement cultural and linguistic competence practices; and use creative approaches to tap into financial, human, and other resources in the surrounding community to sustain support services for diverse clients.

These efforts are in part supported by the Title X Program Guidelines³⁴, which specifically require that grantees:

³⁰ JSI Research and Training Institute, Inc. *Region I Title X – Integrating HIV Prevention and Family Planning Services: Organizational Self-Assessment Manual*. Boston: JSI Research and Training Institute, Inc.; 2004.

³¹ Alliance of Community Health Plans Foundation. *Making the Business Case for Culturally and Linguistically Appropriate Services in Health Care: Case Studies from the Field*. Washington: U.S. Department of Health and Human Services; 2007. Available at: <http://www.omhrc.gov/Assets/pdf/Checked/CLAS.pdf>. Accessed January 20, 2008.

³² Hart J, Ross E, Silva S. *A Collaborative Evaluation of Strategies to Encourage Couples-Focused Health Service Delivery in a Sample of Title X-supported Family Planning Clinics*. Prepared for the U.S. Department of Health and Human Services, Office of Public Health Service, Office of Population Affairs, Contract No. HHSP23320045014X. Washington: U.S. Department of Health and Human Services; 2005; Hart J, Ogleton M. *Examining HIV Prevention Activities in the Title X Family Planning Program: Final Report*. Prepared for the U.S. Department of Health and Human Services, Office of Public Health Service, Office of Population Affairs, Contract No. 282-98-0009. Washington: U.S. Department of Health and Human Services; 2003.

³³ National Center for Cultural Competence. *Culturally Competent Guiding Values & Principles*. Washington: Georgetown University Press; 2005. Available at: <http://www11.georgetown.edu/research/gucchd/nccc/foundations/frameworks.html#ccprinciples>. Accessed January 21, 2008.

³⁴ U.S. Department of Health and Human Services, Office of Public Health and Science, Office of Population Affairs, Office of Family Planning. *Program Guidelines for Project Grants for Family Planning Services*. Bethesda, MD: U.S. Department of Health and Human Services; 2001.

- Describe cultural and linguistic barriers to services, existing services addressing cultural needs, and need for additional services to address cultural needs as part of the assessment of the need for family planning services among persons in the geographic service area;
- Ensure that staff are broadly representative of all significant elements of the population served and are sensitive to and able to deal effectively with the cultural and other characteristics of the client population;
- Establish an advisory committee whose members are broadly representative of the community that must review and approve all informational and educational materials developed and made available at the clinic prior to their distribution to ensure that the materials are suitable for the population and community for which they are intended and that they are their consistent with the purposes of Title X;
- Develop written plans for client education that outline plans to ensure that the education provided is presented in an unbiased manner and appropriate to the client’s age, level of knowledge, language, and socio-cultural background; and
- Employ staff counselors that are knowledgeable, objective, nonjudgmental, sensitive to the rights and differences of clients as individuals, culturally aware, and able to create an environment in which clients feel comfortable discussing personal information.³⁵

The 2001 Title X Program Guidelines also references the Title VI of the Civil Rights Act of 1964 and the CLAS Standards in its list of selected resources to provide additional guidance on client services. Development of the CLAS standards was undertaken by OMH to support a “consistent and comprehensive approach to cultural and linguistic competence in health care.” This process involved a review of existing standards, the development of draft standards, a review by a national advisory committee, and incorporation of input from a range of public and private stakeholders.³⁶ Since their release in 2001, the CLAS Standards have served as a national framework for guiding the provision of health services that are more responsive to the needs of individual patients, particularly those from vulnerable and historically underserved populations.³⁷

III. Organization of Section II

As the only set of comprehensive standards on cultural and linguistic competence, we chose the CLAS standards as an organizational framework in collecting information from key informants and during site visits with Title X programs and the RTCs. Based on the 14 CLAS standards that address culturally competent care, language access services, and organizational supports for cultural competence, we identified the following four domains:

³⁵ U.S. Department of Health and Human Services, Office of Public Health and Science, Office of Population Affairs, Office of Family Planning. *Program Guidelines for Project Grants for Family Planning Services*. Bethesda, MD: U.S. Department of Health and Human Services; 2001.

³⁶ U.S. Department of Health and Human Services, Office of Minority Health. *National Standards for Culturally and Linguistically Appropriate Services in Health Care*. Washington: U.S. Department of Health and Human Services; 2001.

³⁷ The Lewin Group, Inc. *Health Resources and Services Administration Study on Measuring Cultural Competence in Health Care Delivery Settings*. Washington: U.S. Department of Health and Human Services; 2001. Available at: <http://www.hrsa.gov/culturalcompetence/measures/default.htm>. Accessed January 20, 2008.

Chapter 4 | Organizational capacity – incorporating cultural competence into planning, policymaking and infrastructure activities of the organization;

Chapter 5 | Provider and staff capacity – implementing approaches to develop the ability of all program staff to understand and address the needs of diverse populations;

Chapter 6 | Language access – approach taken to provide services for individuals with limited English proficiency; and

Chapter 7 | Community focused – using knowledge of a community to drive program decisions, by engaging community members and organizations in the decision-making process.

Each subsequent chapter in Section II presents a discussion of each domain area that includes the primary strategies and challenges faced by Title X programs. This assessment documented approaches undertaken by Title X programs. The CLAS standards illustrate **what** Title X programs should be doing. Through this assessment, we documented **how** Title X programs are doing it. We present strategies that can be considered promising—that is, practices and strategies that are recommended in the CLAS Standards and appear to be working well in family planning settings. We did not evaluate their effectiveness or impact, which was outside the scope of this assessment.

For each domain area, we describe promising practices and strategies undertaken by these selected clinics and provide a realistic picture of how family planning programs are approaching efforts to improve cultural and linguistic competence. While we present approaches and strategies by domain, in some ways, this classification is arbitrary. There is overlap among the strategies presented. There are natural connections and potential opportunities for synergy when integrated across multiple levels of an organization. We hope that Title X programs find these strategies useful and are able to adapt and replicate them within their unique settings.

Chapter 4 | Organizational Strategies

I. Introduction

Demonstrating a strong commitment to cultural and linguistic competence necessitates an organizational environment that adopts **policies**, **structures**, and **practices** at multiple levels that enhance the quality of and access to care for diverse populations. Such commitment requires consistent leadership and support from the board, administrators, and staff, as well as meaningful involvement of clients and the broader community.³⁸

An organizational commitment is reflected in the implementation of policies and the allocation of staff time and resources. This level of commitment prioritizes cultural and linguistic competence and promotes the institutionalization of cultural knowledge and approaches.³⁹ Several key informants agreed that Title X programs must be intentional about building their organizational capacity around cultural and linguistic competence and designate the necessary resources to do so.

This section will discuss how Title X programs are focused on increasing their organizational capacity to address cultural and linguistic competence and will highlight strategies in the following areas:

- Policy,
- Planning,
- Organizational Assessment,
- Infrastructure and Support Activities, and
- Quality Improvement.

There are many potential indirect costs of implementing and sustaining cultural competence within organizations and systems. These costs include the time required to plan, implement, and evaluate effective practices; support and mentor providers as they change behaviors, attitudes, and

³⁸ Technical Assistance Partnership for Child and Family Mental Health. *Sample Cultural and Linguistic Competence Plan for Advancing Cultural and Linguistic Competence in Systems of Care*. Washington: Technical Assistance Partnership for Child and Family Mental Health; 2007. Available at: http://www.tapartnership.org/cc/CLC_Plan_Template_FINAL.pdf. Accessed December 15, 2007.

³⁹ NCCC Web site, 2009.

Corresponding CLAS Standards

Standard 1

Health care organizations should ensure that patients/consumers receive from all staff member's effective, understandable, and respectful care that is provided in a manner compatible with their cultural health beliefs and practices and preferred language.

Standard 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.

Standard 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.

Standard 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.

Standard 10

Health care organizations should ensure that data on the individual patient's/consumer's race, ethnicity, and spoken and written language are collected in health records, integrated into the organization's management information systems, and periodically updated.

practice; conduct community engagement activities; conduct staff training and professional development activities; and routinely review research findings to assess their relevance for policy development and clinical protocols and practice. More research is needed to quantify these (The Evidence Base for Cultural and Linguistic Competency in Health Care, written by NCCC faculty, published by The Commonwealth Fund).

More research is needed examining organizational capacity – meaning the existence of culturally and linguistically competent policies, structures, and practices and their potential impact on cost-benefits and reducing staff turnover and liability – also is lacking.⁴⁰

II. Policy

Integrating cultural and linguistic competence into organizational policy is one of the most important approaches because it can impact practice across an organization. Title X programs and RTCs referenced a range of policies relating to all aspects of the organizations—from clinical services, staff development, to community outreach. The NCCC has identified the importance of organizational policy because it:

- Sets the mission and vision of organizations,
- Supports practitioners with resources to implement culturally and linguistically competent practice,
- Institutionalizes cultural and linguistic competence in the organization”.⁴¹

In addition to developing new policies, organizations should also establish criteria to review existing policies to ensure that they support the development and implementation of culturally and linguistically competent systems of care.^{42,43} Several key informants noted during interviews that simply having a policy in place is insufficient—it must be implemented, monitored, and revisited periodically. Policy development should be thought of as a continual process and should reflect the organizational and community needs, which are not stagnant and also undergo change. Title X program staff commented that having written policies has helped reinforce standards and behavior and changing the organizational culture.

A. Integrate Cultural Competency Into Organizational Mission and Vision

One of the major recommendations emerging from the literature was to establish cultural competence as a core value and guiding principle, often reflected in an organization’s mission and vision statements. Creating and revising these organizational statements to affirm support of a cultural and linguistic competence perspective to

“I think what pulls people is our mission and the fact that we are all single minded in fulfilling that mission and we have the same goal.”

Title X Program Director

⁴⁰ Goode et al, 2006.

⁴¹ NCCC Web site, 2009.

⁴² Bustamante-Forest R, Giarratano G. Changing men’s involvement in reproductive health and family planning. *Nursing Clinics of North America*. 2004;39(2):301–318.

⁴³ Goode, 2006.

governance, management, and service delivery provides a strong foundation for an organization.^{44,45} These are the public documents describing what a Title X program does and is working toward.

A number of the Title X programs described themselves as mission-driven organizations that place a high importance on their organizational values. They feel this approach is an asset and creates a climate that attracts like-minded staff members who are respectful of clients' unique needs and committed to providing the highest quality care. One program shared that part of their mission includes providing culturally competent services.

Based on a review of the literature, Goode recommended that family planning agencies involve board members and administrative staff in designing and implementing these types of activities.⁴⁶ This was an approach adopted by a Title X program in California who involved their staff during a year-long process in developing their core values. This initiative was led by the Clinical Medical Director, who felt that involving staff at all levels was critical to their success and promoted a sense of ownership. In conversations with various staff members during the site visit, all staff shared positive feedback about this process and felt their opinions were considered and that their involvement was meaningful. Once these core values were adopted, they are reinforced throughout the organization—they are part of new employee orientations, are incorporated into staff's annual evaluations, and are posted throughout the clinic (more detail provided in the case study).

B. Strengthen Policies on Staff Training to Enforce Culturally Competent Protocols and Practices

Key informants also mentioned other important policies that affect service provision, particularly those that determine clinical protocols and provider and staff training. These policies support a practice model that supports the integration of cultural competence in the delivery of services. Providing ongoing cultural competence development and training for all staff is highly recommended in the literature.⁴⁷ All key informants underscored that training will more likely be prioritized if there are policies in place, that outline specific performance expectations with regard to clinical practice and service delivery.

Some Title X programs have placed more importance on cultural competence of staff by including specific training during new employee orientation where managers develop an orientation plan with each new employee that outlines specific responsibilities related to service delivery and addressing cultural competence. The program director felt this was a useful tool to gauge how well the manager is familiarizing new staff with policies and procedures.

C. Adopt and Implement Policies to Ensure Access for Limited English Speakers

Key informants stressed that family planning programs should have policies in place to address language access because programs are expected to comply with Title VI—the section of the Civil Rights Act prohibiting discrimination on the basis of race, color, and national origin in programs and activities receiving federal financial assistance—and any related State and local laws to ensure equal access to those with limited English proficiency (LEP).

⁴⁴ HHS, 2000.

⁴⁵ Bustamante-Forest and Giarratano, 2004.

⁴⁶ Goode, 2006.

⁴⁷ Cohen E, Goode TD. Revised by Goode TD, Dunne C. *Policy Brief 1: Rationale for Cultural Competence in Primary Care*. Washington: National Center for Cultural Competence, Georgetown University Center for Child and Human Development; 2003.

Finding itself serving populations speaking multiple languages, a Title X-funded clinic developed a manual for providing linguistically competent health care services, to ensure that LEP patients receive meaningful access to its programs and avoid negative consequences that could result from inaccuracy of the language service. Working with the Association of Asian Pacific Community Health Organizations, this clinic developed a manual as internal policy and as a resource to help other programs ensure compliance with Title VI.

The manual outlines four key elements common to successful programs serving LEP person:

1. Assessment,
2. Development of written policies and procedures,
3. Training of staff, and
4. Vigilant monitoring.

The manual describes each element and provides sample documents as resources. Additional strategies to address the needs of LEP individuals are described in Chapter 6.

D. Policy Challenges and Lessons Learned

The common challenges mentioned across Title X programs is the level of effort involved in developing and enforcing policies. One clinical director stated that even when policies are the books, it is necessary to remain vigilant about enforcing policies requires time, energy, and effort.

“Staff from the different departments came together to talk about how well are they doing, what’s going on, what can they do better?”

Title X Program Director

III. Planning

The integration of planning was epitomized by a Title X program that changed its organizational approach to cultural competency by promoting increased communication across departments. Not wanting cultural competence to be seen as an addendum, the program is attempting to fully integrate cultural competence into everything they do. To achieve this, the clinic director changed how planning efforts are undertaken. Rather than having each department prepare a separate plan, the director is supporting cross-department planning around cultural competence to develop strategies to better serve teens and immigrant populations. The director supports and sustains this collaborative effort to develop a work plan that will outline funding strategies, responsibilities, and timeline.

A. Build in Time for Strategic Planning

Strategic plans represent a particularly important means of formally declaring an organization’s commitment to cultural and linguistic competence and infusing associated objectives across all levels of health care organizations.⁴⁸ In developing strategic plans addressing cultural and linguistic competence, the Federal Center for Mental Health Services, through its Technical Assistance Partnership for Child and Family Mental Health, identified six critical domains that should be addressed. These domains are

⁴⁸ Technical Assistance Partnership, 2007.

applicable to a wide range of health care services and are structured to reflect the accountability and participation of all stakeholders within the entire system of care within which health care organizations operate. They include the following:

- Governance and organizational infrastructure,
- Services and supports,
- Planning and continuous quality improvement,
- Collaboration,
- Communication, and
- Workforce development.⁴⁹

Title X programs that discussed their strategic planning efforts during site visits were addressing most, if not all of these domains. One program described a board-led strategic planning effort to reduce health disparities. Through their planning efforts, the board decided there was a need to increase outreach to African American and Latino populations. They are in the process of implementing their plan and evaluating their efforts. The director added that making their plan a Board priority keeps staff focused. Another clinic also involved their Board of Directors in strategic planning. Their goals were to identify strategies to expand morale, maintain their level of community organizing, and find additional financial support for medical services. Needs assessment data was used in the planning process. As a result of planning, the clinic formed a communications committee to focus on developing strategies to improve morale, such as staff recognition events.

The development of a formal, clearly written plan outlining steps to incorporate cultural competence will increase the likelihood that these steps will become an integral part of how family planning clinics function on a day-to-day basis.⁵⁰ During one site visit, a program shared their 2006-08 strategic plan that outlined the following goals:

- Increase knowledge and skills,
- Facilitate access to reproductive health care services,
- Build communities that nurture and support reproductive justice, and
- Ensure organizational effectiveness.

In developing their strategic plan, program staff wanted to emphasize cultural competency and felt that achieving their goals was contingent on their continued ability to respond to the changing demographics in their area, particularly among emerging immigrant communities. They are improving training opportunities on cultural competency by facilitating learning opportunities between the clinical and educational staff. The program also focused on increasing their outreach efforts, strengthening community partnerships, and preparing educational materials that are appropriate for limited English speakers. Preparing materials tailored to a community is viewed as more than just the translation of words—it involves the translation of concepts because they aim to capture the words and phrases that resonate with different populations. For example, they found that using the phrase “family planning” is not well understood by some populations, compared with phrases such as “birth control” and “health”.

⁴⁹ Technical Assistance Partnership, 2007.

⁵⁰ Goode, 2006.

Role of workgroups and committees:

- Review policies and practices
- Review and develop educational materials
- Develop population profiles
- Develop core values
- Create a set of communication norms for the organization
- Update staff performance tool with cultural competency measures
- Address informed consent process

Title X programs recommended building in regular planning efforts. One program described an annual strategic planning process that although it did not explicitly focus on cultural competency, had the goal of improving the quality of services. Management has devoted Friday mornings, when the clinic is closed to patients, to holding training and planning activities. This permits all staff to participate in planning efforts. Staff work in small committees, which are intentionally structured to include staff across clinic groups and to provide leadership opportunities for staff not in leadership positions. The director is pleased with the outcomes of their planning efforts and feels that staff participation has increased each year and that staff has benefited by gaining new skills.

B. Form Workgroups to Address Specific Planning Priorities

Convening workgroups to work on cultural competency should ideally reflect the diversity within the organization and can be used to plan, implement and monitor an organization's cultural competence efforts. Creating a structure for these activities will increase likelihood for success.^{51,52} One Title X program is using this approach has formed a team to focus specifically on cultural competence. Their Cultural Competency Team includes representation from each department and is responsible for addressing organizational issues, such as reviewing policies and practices.

Almost all Title X programs use committees and workgroups to address planning priorities. Programs used committee structure to focus important organizational needs, related to policy, education, and communication. One program has formed a curriculum team to review curricula every few months to ensure it remains culturally appropriate and meets client needs. The team also considers literacy level and presentation of information for both the client and the educators, who are using the curriculum. For example, the youth coordinator is on the curriculum team to ensure the facilitation guide is not overly dense and includes clearly laid out instructions. This in turn makes the process of delivering the curriculum easier for the peer educators.

"The past committee consisted solely of the family planning counselors, so they were already familiar with family planning topics. The new committee is a much more diverse group, consisting of culturists, traditionalists, and other community members of various ages. The challenge is getting this new committee up to speed on family planning topics and strategies for ensuring that services are delivered in a culturally competent manner."

Title X Program Director

C. Planning Challenges and Lessons Learned

The greatest challenges mentioned by Title X programs and RTC are the time required to manage any planning process and the costs involved associated with staff time and the level of commitment. One program director finds herself challenged by scheduling the planning meetings, managing the process, and keeping activities moving forward and making progress on their goals. A clinic director recently

⁵¹ Bustamante-Forest and Giarratano, 2004; Goode and Jackson, 2003.

⁵² HHS, 2000.

involved all staff—more than 100 individuals—in a year-long process to develop core values. Although she could have met with her executive staff and developed core values in the course of a few weeks, she realized that there was value in the process itself, both to the clinic and to staff. Taking a year to complete the process was worthwhile.

Examples of domains to incorporate into a self assessment tool:

- Presence of policies
- Patient satisfaction with services they are receiving (the extent to which those services address patients' cultural needs)
- Provider knowledge and skills
- Fiscal resources allocated
- Training effectiveness
- Attitudinal barriers to the provision of care
- Cross cultural communication skills
- Values and belief systems around health and other issues
- Clinical decision making
- Health management and empowerment
- Cultural aspects of epidemic

Cultural and Linguistic Competence Assessment Increases an Organization's Capacity to:

- Gauge the degree to which they are effectively addressing the needs and preferences of culturally and linguistically diverse groups
- Establish partnerships that will meaningfully involve clients and key community stakeholders
- Improve client access to and use of services and enabling supports
- Increase client satisfaction with services received
- Strategically plan for the systematic incorporation of culturally and linguistically competent policies, structures, and practices
- Allocate personnel and fiscal resources to enhance the delivery of services and enabling supports that are culturally and linguistically competent
- Determine individual and collective strengths and areas for growth

National Center for Cultural Competence

Important lessons learned:

- **Create the right structure for planning efforts.** What is not built into the schedule will most likely not get done. Having staff work in small groups allows for greater participation and involvement.
- **Include representation from across the organization into all planning efforts.** Inclusion will draw on a diversity of experiences and perspectives that will strengthen the planning efforts and increase buy-in across the organization.
- **Prepare staff to provide meaningful participation.** In some cases, staff will need specialized training and coaching to help them develop the knowledge or skills necessary to help them feel equipped to participate or lead planning efforts.
- **Be patient with planning efforts.** Involving more staff in planning activities will take more time but will ensure better outcomes.⁵³

IV. Organizational Assessment

As the cultural competence continuum framework demonstrates, health care organizations and individual providers can differ widely in their level of awareness and knowledge of cultural and linguistic

⁵³ Goode T, Jones W, Mason J. *A Guide to Planning and Implementing Cultural Competence Organizational Self-Assessment*. Washington: Georgetown University Press; 2002.

principles. In an ever-evolving process, an organization's or a provider's relative position on the cultural competence continuum can change over time. The literature suggests that it is therefore important to assess regularly and systematically our own attitudes, practices, and structures related to cultural and linguistic competence within health care organizations. Similarly, the socio-cultural factors that influence how consumers interact with the health care delivery system can vary by population or geographic area. Collecting demographic data and information about health beliefs, needs, preferences, and satisfaction with care from client populations also is an aspect of the assessment process.

The NCCC identified a number of organizational benefits to conducting cultural and linguistic assessments. In addition to benefits identified by NCCC, an organization can translate findings from cultural and linguistic competence needs assessments into actions and systems for measuring progress. It is important for family planning programs to establish a baseline for cultural and linguistic competence indicators that could include the following:

- Mission and goals,
- Organizational and clinical policies and practices,
- Staff and leadership composition,
- Hiring and staff recruitment plan and practice,
- Staff development and training,
- Public relations and outreach,
- Physical facility, and
- Volunteer management practices.⁵⁴

Once the baseline is established, it is important to remember that cultural competence is a process unique to each program. While programs may often be compared or compare themselves with national aggregate data or benchmarks (e.g., CLAS standards), ideally, a program should only be compared to itself over a period of time.

An organizational assessment will identify both areas of strength and areas in need of additional attention and resources. Unfortunately, few organizational assessments have been developed and validated specifically for family planning clinics.⁵⁵ However, several agencies and organizations have developed a set of general indicators or questions that can be used to assess organizational, staff, budget, and service components of reproductive health services (see text box).

The organizational assessment should be completed within a reasonable timeline and led by a team of dedicated individuals (from both inside and outside the clinic) that will conduct and communicate the results of the assessment and ensure that adequate action is taken to address areas needing improvement.

A. Hold the Program Accountable for Data Collection and Analysis

⁵⁴ Goode, Jones, and Mason, 2002.

⁵⁵ Alliance of Community Health Plans Foundation, 2007.

During site visits, programs themselves outlined the need to identify assessment criteria as the first important step in ensuring organizational assessment. As one clinic stated, in the absence of indicators to guide, “How are we going along this journey,” it is easier just to, “Let it go and say it doesn’t matter.” The clinic also underscored that having to submit data to Planned Parenthood that they collect on the established indicators keeps them accountable to collecting the data. Planned Parenthood compiles the data, sends it back to the individual clinic as a status update report, and also uses data on those indicators to conduct an internal cultural competency self-assessment at the parent agency level. Programs referred to assessment indicators and data sources that are, to a great extent, at a lower level than domains suggested in the literature. Examples of indicators used at the clinic level are:

- Amount of literature in other languages;
- Number programs targeting different populations;
- Diverse demographics of clients;
- Staff diversity, especially of management staff;
- Meeting new criteria for bilingual staff positions;
- Past year’s encounter data (from the patient service record forms based on FPAR); and
- Program’s data on family-planning related services.

The socio-cultural factors that influence how consumers interact with the health care delivery system can vary by population or geographic area. Collecting demographic data on and information about health beliefs, needs, preferences, and satisfaction with care directly from client populations, in particular, is an important aspect of the assessment process. Gathering this data may involve going beyond analyzing an existing program dataset, for example, holding focus group discussions or using other methods of data collection.

B. Develop and Implement an Assessment That is Easy and Streamlined

One clinic first implemented a self-assessment as a pilot site for a Ford Foundation-funded initiative. The pilot aimed to explore the degree to which a clinic could look at their effectiveness in cultural competency through implementing a streamlined, easy-to-administer, easy-to-score assessment without interfering with service provision.

The clinic was already inclined to be “on board” with implementing the assessment when they learned it was designed with a consideration for not interfering with service delivery. To be additionally transparent and to incorporate staff understanding from the outset, the pilot project lead presented the assessment onsite to clinic staff. Clinic administration underscored that a key benefit of this being a *self*-assessment is the value of allowing everyone to own the process and empowering staff to say, “This is something we want to take on and then figuring out slowly, carefully, how you move it forward,” although having benchmarks and a “pure evaluation” also is helpful when introduced at the right time. It was designed to empower staff, rather than be punitive. The timing of this self-assessment was also important; the clinic organization was in the process of initiating other community-oriented programs at the same time, so there was positive synergy among the new initiatives. Assessment components included:

- **Staff survey.** This 10-minute survey resulted in 100% compliance, considering the inclusivity of the entire process and sensitivity toward staff participation, including providing donuts;
- **Staff diversity information.** The clinic was required to complete information on staff diversity and compare it to client demographics;
- **Comparison of assessment findings to CLAS standards.** In order to see how the organization compared; and
- **Mini-grants.** The pilot project administrators awarded \$2,000-\$3,000 to the clinic organization, who could decide which area they wanted to address with the funds.

C. Incorporate Client Input in the Self-Assessment

Noting the absence of a client component into the original pilot that would enable a client perspective on how the agency measures up with respect to cultural competence, the Planned Parenthood that piloted the streamlined assessment later incorporated client input into a new pilot tool. They solicited staff feedback on the tool and later the parent agency came onsite to administer the tool.

D. Develop a Sustainable Process

Once the self-assessment tool had grown into a more comprehensive process, the parent Planned Parenthood agency assembled a panel of representatives who had undergone the assessment themselves and implemented a train-the-trainer, capacitating staff throughout their State to self-administer the tool at their own clinic sites. The parent agency provided technical assistance along the way to help programs reach the point where they could administer the self-assessment without requiring “people coming in from the outside.”

Programs seem to do self-assessments for a variety of reasons, primarily either because it is requested by a parent agency (i.e., Planned Parenthood) or because the program itself has determined it as a useful tool in working toward pervasive cultural competence. One clinic described implementing the self-assessment in order to adapt services to target men specifically. The self-assessment took the form of discussions where staff members were encouraged to be open and honest. The discussions led to value clarifications and the discovery that staff were not comfortable seeing male patients (which addressed the “provider knowledge and skills” and the “attitudinal barrier” domains identified earlier). In addition to highlighting the need to create a safe environment for staff to share their thoughts, the most important outcomes of the assessment were the CEO’s enlightened understanding of the (lack of) readiness of the program staff to change, and the changes that resulted in the program and the clinic site: they transformed the “look” to be more inviting for males; implemented training and shadowing for providers to learn more about examining and treating male patients, as well as having a urologist come onsite for training and support; and worked to change staff perceptions about men’s needs.

E. Organizational Assessment Challenges and Lessons Learned

One of the biggest challenges to organizational assessment is the lack of an established tool specific to family planning and cultural competence. A number of programs have successfully navigated this challenge and have defined their own indicators and process. Creating a safe, comfortable environment for staff and patients to provide meaningful information in the assessment process can be challenging

and require conscious effort, in particular by program leadership. Ensuring a streamlined process that interferes little with program operations and service delivery, and which can be administered by onsite staff is another challenge. Finally, identifying meaningful mechanisms for incorporating and addressing findings from the assessment is an ongoing challenge for programs and also requires additional openness and foresight by program leadership.

V. Infrastructure and Support Activities

Strategies focused on building infrastructure and providing support throughout the program and clinic can provide a strong foundation to improve the provider-patient interaction and address barriers to care such as LEP or inadequate public transportation in a service area. As documented in the literature, these strategies can serve as important points for intervention, particularly for hard-to-reach populations.⁵⁶ Interventions can include internal policy development and the provision of support services, including the following:

- Policies and allocated resources for a full range of support services, such as provision of translation and interpretation services, free or reduced cost transportation, assistance with appointments and referrals, and patient navigators (See Policy Integration strategies above and “Strategies to Improve Cultural and Linguistic Competence” section for additional information);
- Draft treatment or service plans which include the identification of familial preferences for and availability of traditional healers, religious and spiritual resources, alternative or complementary healing practices, natural supports, bilingual services, self-help groups, and consultation from culturally and linguistically competent independent providers, except when clinically or culturally contraindicated;
- Assessing and modifying the physical facility to reflect the population of focus and to be welcoming, clean, and attractive by providing cultural art, magazines, refreshments, and more;
- Locating services geographically such that they are accessible and acceptable to the population; and
- Identifying and linking systems of care to community-based individuals who could serve as cultural brokers.^{57,58,59} (See the discussion of interpreters and lay health workers in “Strategies to Improve Cultural and Linguistic Competence”).

A. Modify the Physical Facility to Reflect the Population Focus

Of the infrastructure and support strategies promoted in the literature, modifying the delivery site’s physical space was most commonly raised during site visits. A number of programs identified deliberate actions taken in order to address the physical facility. Changes to the physical space range from practical to purely aesthetic. One clinic painted over their pink, “feminine” walls, and diversified magazines and television programs displayed in the waiting room in order to attract more male patients. Others have modified artwork throughout the clinic to be more reflective of patient culture. Programs will also address changes through the practical signage in the clinic, adapting posters about language assistance

⁵⁶ Betancourt JR, Green AR, Carrillo JE. *Cultural Competence in Health Care: Emerging Frameworks and Practical Approaches*. New York: The Commonwealth Fund; 2002.

⁵⁷ Bustamante-Forest and Giarratano, 2004.

⁵⁸ Ndong I, Becker RM., Haws, JM, Wegner MN. Men’s reproductive health: Defining, designing and delivering services. *Family Planning Perspectives*. 1999;25(Suppl):S53–S55.

⁵⁹ HHS, 2000.

or clinical services in order to make the posters more culturally appropriate. Considering that patients often wait for over 2 hours to see a provider, just cleaning up and creating a more comfortable place to sit can make a difference.

Even family planning programs with less control over physical aspects of their space, especially sites managed by a larger clinic or hospital, attempt to maintain a dedicated office and exam room space where they can modify wall art and signage, rather than moving all of their materials from office to office upon each patient visit.

VI. Quality Improvement

High-quality care includes care that is based on the best available scientific information and is tailored to the unique needs of clients. Health care organizations must establish ongoing tracking systems to track demographic and socio-cultural trends in the service area and to ensure that services reflect current knowledge and clients are satisfied with the care received. Recommendations to improve quality monitoring include the following:

- Policies and procedures to review periodically the current and emergent demographic trends for the geographic service area;
- Methods to identify and acquire knowledge about health beliefs and practices of emergent or new populations in the geographic service area;
- Development and implementation of a continuous quality improvement plan and customer satisfaction survey process for health care services provided; and
- Policies and procedures to evaluate the quality, appropriateness, and consumer satisfaction with interpretation and translation services provided.^{60,61}

As underscored by an NCCC article, “It All Starts at the Front Desk,” the front desk is not only often the first point of human contact patients have with the program or care delivery site (beyond any program interaction they have out in the community), but also often the first opportunity that the clinic has to collect information on the patient. The data collection needs to flow bi-directionally, so that the program gathers information *from* patients and patients are able to provide feedback *to* the program. Collecting data on the patient population is a key assessment component that feeds into organizational assessment, strategic planning, and quality improvement. (See also “Conduct Regular Needs Assessment” in the Community Strategies section.) An Advisory Committee comprised of a diverse group of patients and community members can serve as an ideal standing source of patient and community data, both collected through formal mechanisms, such as meetings and other planned activities, as well through informal, ongoing dialogue with Advisory Committee members.

A. Implement Patient Satisfaction Surveys

A common method of gathering patient information, at least one Title X program detailed a promising method for administering and analyzing patient satisfaction surveys. The program also incorporated questions that relate to outcomes measures developed as part of an outcome measure project lead by an external person. Patients were provided with a form to complete after their exam. The form was in

⁶⁰ Bustamante-Forest and Giarratano, 2004.

⁶¹ HHS, 2000.

English and Spanish; clinic staff members were available to assist the few patients not literate in either language. Survey Monkey was just for data collection and analysis. Questions included:

- What do you think?
- How did we do?
- What would you like to see for us to do differently?
- This is what we meant to do, did we do it?
- Did you know more about birth control than you did before?
- We aimed to impart this type of information to you, did we?

Another Title X program adds a “mystery shopper” component to their survey process. First, they distribute an annual patient survey over the course of 1 month when patients come in for visits is a good way to have patients provide feedback about services and can enable patients to answer those questions privately. Then, they add “mystery shopper” calls to their information gathering by designing a set of 10 questions for the year that clients are likely to ask and train staff on specific responses to those questions. Mystery callers then call the center and ask the questions, such as, “What hours are you open?” “Am I required to get a Pap smear?” or other questions, especially those which may relate to information that has changed in the clinic. Responses are recorded and reviewed. This information is then used for program administration to see where they may need to provide additional training geared at continuous quality improvement.

B. Implement an Electronic Health Record Practice Management System

At least one program visited developed a new registration tool (designed for their medical mobile unit), which they were using along with a new electronic health record practice management system. The purpose of the registration tool was to create a mechanism for gathering patient information, such as origin, ethnicity, and other demographics, in a manner that patients would be more comfortable with and could check off themselves, rather than responding to questions that might be asked in a space that is, at best, only semi-private. Once collected, the information could then be entered into the data system on the back end. With a goal of generating reports that will better demonstrate the program’s patient demographics, visit types, birth control methods selected by patients, patient outcomes, and other health issues, they are still within the first year of implementation of the electronic system and are navigating the learning process and how to run effective reports. They are confident their data system can help staff understand and address clinical quality related to cultural issues and health disparities. Additional considerations in gathering patient data are:

- Providing patients with an explanation for why the data is collected and what the program plans to do with the data; and
- Fine-tuning how race data is collected and the quality of that information. Latinos, for example, often do not classify themselves as White or Black, resulting in data that may not reflect the patient population specifically enough.

C. Review and Utilize Regional Data

Regional Training Centers can be a source of regional data provided to individual programs. Data can reflect changes in birth control methods, income or insurance status, gender, age, ethnic/racial background, language background, and poverty indicators for example. This information can be a helpful compliment to data collected and analyzed at the program level and can be especially useful for heavily visited programs, which may be focused more on internal operations and have less time or fewer resources to be out in the community becoming familiar with the broader picture outside the individual program setting.

D. Involve Staff in Data-Driven Planning

One Title X program engages clinic staff in planning that involves a review of encounter data. Annual planning occurs across monthly meetings. One Friday morning each month, the clinic closes to patients and staff members meet in small groups by lifecycle clusters to review data and develop goals for the year. Key lessons learned by one program that implemented this process include:

- **Have staff meet in small groups (5-7 people) to address a specific topic.** This can be an effective way to allow meaningful input from all staff, as well as to get staff buy-in.
- **Cultivate leadership skills among staff.** Group leaders are coached in order to help them lead more effectively. Each year, the clinic has witness greater staff involvement, resulting in growth around staff leadership skills.
- **Build time into the monthly meeting schedule.** Regular meetings enable staff participation and demonstrate an organizational/program commitment to the process.
- **Incorporate followup activities into the annual plan and dedicate staff time.** Ongoing, planned activities ensure the process continues and the Annual Plan is a living document and process.

E. Quality Improvement Challenges and Lessons Learned

Two of the greatest challenges are time and cost. For example, if the clinic closes to patients in order to analyze and incorporate data that requires staff time and results in cost tradeoff to the program. Additionally, programs which have implemented new electronic data systems incur an additional cost to acquire the system, train staff, and maintain the software.

I. Introduction

As highlighted in the literature review and qualitative data collection activities, investing in the capacity of staff plays a critical role in demonstrating a family planning program's commitment to a culturally competent approach to family planning. Workforce capacity includes the number of personnel available, their knowledge, skills and behaviors, and the processes that are in place to effectively organize and mobilize them. This section presents an overview of the:

- Challenges faced in recruiting and retaining a diverse staff that is well-prepared to integrate cultural competence concepts into practice; and
- Types of strategies highlighted by respondents to overcome these barriers related to recruiting and retaining diverse staff, building staff capacity, and training staff.

A. Perceptions of Staff Diversity

Most the staff we spoke to felt that their program's staff was very representative of the clients they serve in regard to race/ethnicity, languages spoken, age, and gender. However, several Program Directors and other types of staff members indicated they would like to address the following deficiencies regarding the diversity of their staff:

- **Lack of diversity in senior-level staff.** Two of the programs reported that the proportion of African Americans and Latinos serving in the senior staff positions is much lower than those serving in entry- and mid-level positions.
- **Disparity in bilingual staff.** One program noted that almost all support staff speak Spanish (the primary language spoken by clients), including the receptionists, medical assistants, outreach workers, and interpreters. In contrast only one of the five nurse practitioners and none of the two social workers are able to speak Spanish.
- **Low level of male staff.** One program noted its lack of males across all staff positions, from call center representatives to educators and outreach workers.

Staff differed in their perception of whether the background of staff has a significant impact on the quality of care provided to clients. Some expressed that sharing the same race/ethnicity or language as a client is less important than having good communication skills that can help bridge cultural differences that may exist between staff and clients. In addition, having a general awareness of cultural issues that may be relevant to sexual health care and experience caring for diverse populations may be sufficient for offering quality care.

Corresponding CLAS Standards

Standard 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.

Standard 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.

In some situations, having similar backgrounds can be a disadvantage in connecting with clients. One program director gave an example in which a Spanish-speaking Latino provider tended to be “harder on” Latino clients than other clients who were non-compliant with care recommendations. While this provider may have felt a particular obligation to improve compliance rates among fellow Latinos, the director explained, the provider ended up driving these very clients away. Another program director said that it may be more effective to pair clients from certain populations with a provider from a different population. She noted that her Indonesian clients come from a very small community and are very reluctant to discuss sensitive topics like family planning out of fear of this information being spread around; they are more likely to open up to non-Indonesian providers in order to protect their privacy.

“The bottom line is about compassion, listening, and meeting patients where they are at. If you are a good clinician I think you can do that with anyone. Sometimes it’s a little more difficult. From a clinician’s perspective, I think the onus is on us to create that environment that meets the patient where they’re at, whether its’ language issues or whatever the broad cultural issues are.”

Title X Program Director

Others saw having a similar background as clients as an important factor in offering effective care. They also question whether offering training on cultural competence can match the important benefits of having a staff that is directly representative of clients. Respondents described these benefits as:

- **Possessing in-depth cultural knowledge.** Staff that grow up in a culture possess firsthand knowledge of culturally derived values, attitudes, and behaviors that may impact care. One clinician indicated that a staff member who was an immigrant herself made her more familiar with some important differences between the type of services available in her native country and those offered in the U.S. Some immigrant clients, for example, may not have been exposed to the range of contraceptive choices available or the concept of family planning prior to coming to this country.
- **Garnering trust.** Staff members of similar backgrounds may be more likely to be viewed as a trusted sources of information and guidance. Several respondents highlighted the importance of trust for effective family planning care. For example, there may be a risk of clients feeling coerced to choose a certain form of contraception over others if they do not trust their provider. For youth, who often feel judged by older adults, staff members that are closer to their own age may be more able to relate and encourage more openness to their recommendations.
- **Attracting diverse patients.** Having a diverse staff can help to build a favorable reputation for a program; clients across many sites helped to spread the word that the program has staff from their culture or those that could speak their language soon after learning of their availability.
- **Combating stereotypes.** Staff may be less like to make judgments about how clients view sexuality and family planning if they come from the same culture. Some staff, for instance, may make assumptions that certain topics such as homosexuality or domestic violence are not appropriate to discuss with clients from certain populations. Having a person from that population broach those subjects may make may clients more receptive. In addition, staff from the same cultures may be less likely to harbor stereotypes about care-seeking behavior and compliance.

“...getting a lot of cultural sensitivity training does not mean that you’re going to be culturally sensitive either. And thinking that you’re culturally sensitive does not make you culturally sensitive.”

Title X Educator

II. General Challenges

A key finding from the site visits was that a program’s staff members play an instrumental role in its efforts to deliver care in a more culturally competent manner. Many Title X programs therefore cited recruiting staff who are reflective of the client population and possess skills to effectively interact with diverse clients as important priorities. However, they also identified a number of barriers to staff recruitment efforts.

A. National Provider Shortage

Some respondents noted that a shrinking pool of candidates is linked to a national shortage of certain types of providers. Fewer medical school students are choosing to pursue family practice, for example. One staff representative felt that there has been a lack of comparable Federally funded financial incentives (e.g., loan repayment or forgiveness) for some LPNs and RNs as there are for advanced practice nurses, which has made it difficult to attract more individuals into the field. Another respondent indicated that the shortage is so significant that even though a State-wide survey found that family programs in her four-county area offer among the

“We used to have absolutely no problem recruiting providers and now with the shrinking pool of family practice graduates, and you may be aware that residency programs in family practice have been closing all over the nation and less medical students are choosing family practice as a specialty so our pool of applicants is smaller and thus it’s a little harder to recruit.”

Title Program Director

highest salaries, they still have a difficult time recruiting nurses because they are so few and demand is increasingly high. Also, despite OFP’s goal to increase the number of men served in Title X programs, there continues to be a shortage of male applicants for staff positions. This is significant given that male clients are often more comfortable receiving sexual health services from male staff.

B. Disparity in Recruitment Success Rates by Type of Staff

In general, Title X program representatives reported that it is usually easier to recruit for entry-level positions such as Youth Program Coordinators and Medical Assistants than it is for advanced positions requiring more education and experience. In addition, programs are more likely to find bilingual individuals to fill entry-level positions than they are to fill advanced positions. The types of providers that have been especially difficult to recruit for include:

- Family planning doctors,
- Licensed practical nurses (LPNs),
- Registered nurses (RNs),
- Nurse practitioners, and
- Social workers.

C. Limited Ability to Offer Competitive Salaries

Respondents indicated that family planning programs tend to offer lower salaries than other types of health care programs, particularly for clinical provider positions. One program representative noted that prospective staff often prefer working in the private sector because the salaries are usually higher than in programs within the public sector. Another representative also found it be especially challenging to

retain entry-level staff, as evidenced by their higher turnover rates than for more senior staff, because they are offered the lowest salaries and often leave in pursuit of higher pay.

In addition, findings from the literature review also revealed that challenges exist to improve the cultural competency of staff once hired, including:

- Lack of leadership support for measures that promote a diverse and culturally competent workforce, such as targeted recruitment and incentives to acquire new skills to better serve different populations;
- Perceived limited financial resources for staff development and cultural competence training;
- Scarcity of time to learn new practices and alter behaviors;
- Limited availability of evidence-based training materials, particularly those specifically tailored to family planning; and
- Staff members' fears about having their practices with diverse populations scrutinized and resistance to changing to new practices.

III. Strategies for Recruiting Diverse Staff

A. Requiring Specific Characteristics

Organizations can increase the likelihood of attracting certain types of candidates by making desired characteristics explicit in job announcements. Specific examples of these traits mentioned by key informants and Title X program staff included:

- Dedication to caring for underserved populations,
- Previous training on cultural competence,
- Knowledge of and experience caring for specific populations,
- Proficiency in languages other than English,
- Demographics similar to clients served (e.g., race/ethnicity, gender, age), and
- Residence in the geographic service area.

"Many of the providers are here not for money because we don't pay them that much, but they are really in it to serve that community and to serve the population."

Title X Program Director

During discussions with respondents close community ties was strongly emphasized as an important criteria for selecting new staff. Several experts noted that organizations they have encountered that have built a diverse and effective staff tend to be those that are strongly grounded in the community and try to hire locally. This goes a step beyond ensuring that staff are reflective of the demographic profile of clients by ensuring that staff are also reflective of the same neighborhoods and social networks of clients in the service area. Many program representatives echoed this sentiment and indicated that staff coming from the local community are very in touch with the day-to-day experiences of their clients. One program also highlighted the fact that it has hired staff who were former clients, which gives them added insight into client's perspective of family planning care.

B. Supporting a Variety of Job Positions

Respondents indicated that a key part of trying to hire locally is ensuring that available positions appeal to prospective employees in the community. A number of positions such as family planning counselors and nurses require extensive training, experience, and in some cases certification. Some community members may not yet have had the opportunity to pursue extensive training and certification, while others may not want to pursue these at all. Entry-level positions like community health workers and medical assistants allow individuals to draw upon the strengths they do have possess, such as backgrounds closely matching those of clients, close community ties, firsthand knowledge of cultural practices relevant to sexual health, and the ability to speak more than one language. For those staff who do want to advance in their family planning program, respondents reported that once they are hired they become eligible for additional training opportunities to increase their skills, which will in turn help them to advance within the organization to more advanced positions.

Some Title X programs also embraced the creation of community health workers (CHW), who are lay persons trained to provide patient outreach and education. The development of these programs has been identified as a promising practice for the delivery of some types of primary care. One expert cited evidence of success in helping patients to better manage their diabetes and to quit smoking. Community members tend to be very receptive to CHWs and promotoras because they tend to be recognized community leaders and share similar backgrounds. However, a program director noted that more work still needs to be encourage programs to fully accept CHWs as part of the staff team and to provide them with a sufficient level of support to achieve their full potential.

“Oftentimes those roles [community health workers] are the least supported in the community health centers. I mean there are exceptions, but by and large in terms of the support it’s like ‘okay, you are just a spare pair of hands’...we want those roles to be respected and looked as if they are part of the medical team, of the prevention team, of the health care team.”

Title X Program Director

C. Emphasizing Non-Salary Perks of Employment

Because family planning programs often have difficulty offering competitive salaries, some may emphasize other perks available to candidates for staff positions. Programs may offer a particularly flexible work schedules to help accommodate personal and family responsibilities. Staff members at one program allows staff who have gone on maternity leave reduce their hours to part-time status when they return. Staff may also request shifting their hours to the evening or on weekend to accommodate childcare needs. One respondent explained that this level of flexibility allows programs to reinforce their goal of being a family-friendly organization to both their clients and staff.

Programs may also offer candidates a very generous benefits package to help compensate for lower salaries. Types of benefits cited as a particularly effective in recruiting efforts included:

- Large amount of vacation time,
- Paid sick leave,
- Additional paid days for other reasons (e.g., personal time upon reaching an anniversary or paid leave for one’s birthday),
- Medical and dental insurance coverage,
- Retirement plan, and

- Professional development and training.

Some respondents have found that that these types incentives were more highly favored than the offered salary because they help contribute to a higher degree of job satisfaction, a sense of job security, and opportunities to help advance one’s career.

D. Advertising for Vacant Positions

Family planning program representatives reported using a variety of ways to attract qualified candidates for vacant positions, including:

- Word of mouth,
- Local mainstream and cultural newspapers,
- Websites tailored to the reproductive health and nonprofit sectors,
- Recruitment agencies, and
- Internal referral programs.

One staff member noted that recruitment agencies were more likely to be used to recruit the more challenging to fill vacancies, such as for bilingual social workers, and could be particularly helpful. Internal referral programs are also used, in which existing staff receive a monetary bonus if an individual they refer for an open position is hired. In one program, staff estimated that this method accounted for nearly 25% of new hires.

IV. Strategies for Retaining Diverse Staff

A. Implementing and Maintaining Staff-Friendly Policies

Staff-friendly policies are those that help develop working conditions likely to contribute to high job satisfaction and a positive culture for staff. Respondents reported that many of the same policies that attracted staff to their program are the same that help retain them year after year, such as:

- Flexible working hours;
- Paid days off for vacation, sickness, or cultural holidays;
- Health insurance coverage; and
- Retirement plans.

Other types of policies may help lead to better day-to-day quality of life while staff are at work. Providing sufficient time and space for breaks can help staff relieve stress and connect with one another during downtime. Allowing bilingual staff to freely speak their native language while at work, at least during their breaks, can contribute to a work environment that embraces self-and cultural-expression.

One Program Director noted that it may be easier to secure these policies if there is a structure in place to advocate for them. She indicated that it was not until a union was established about 5 years ago that a formal staff retention plan was enacted. This plan outlined a series of actions to help retain all levels of staff, with a particular emphasis on doctors and dentists who previously experienced a high turnover rate. In addition, the union provided a unified voice for staff during negotiations over staff policies. The

union successfully fought for and won full medical insurance coverage for staff *and* their families and lower premiums for covering family members. The union also helped secure a provision to make it more difficult to fire employees—they must first have three “strikes” against them for demonstrated poor performance before they can be let go. The program representative offered that participating in the union offers staff a sense of community and that policies they help enact contribute to job security, two keys factors in staff retention.

B. Promoting a Staff Culture that Embraces Diversity

Respondents reported that it is important for staff to maintain the same level of commitment to serving diverse, underserved populations in a culturally competent manner that initially attracted them to the position. Family planning programs can help foster this commitment by creating an internal staff culture that is driven by their mission and organizational goals. For example, one Title X program established a committee with representatives from all departments to identify a set of five core values for all staff to follow: (1) character, (2) health, (3) inclusion, (4) respect, and (5) fairness. In support of these core values, the committee also created a set of communication norms for staff to follow, whether they are communicating with clients or with each other. Examples of these norms included:

- Speaking on behalf of yourself,
- Listening to others,
- Describing what you hear back to others to ensure you don’t misinterpret things, and
- Making sure both parties have sufficient time to understand each other.

In addition, Program Directors at several other Title X programs indicated that they also encourage an internal culture that embraces staff diversity in an array of other ways such as by:

- Ensuring diverse food options are served at staff meetings and events;
- Celebrating staff members’ personal events such as birthdays, engagements, and baby showers; and
- Celebrating holidays in a respectful manner, such as by refraining from calling a winter holiday celebration a “Christmas Party” and instead referring to it as an “Annual Kickoff Party”.

C. Providing Mechanisms for Staff Input

It is important for staff members at all levels to feel they are valued members of the organization. Providing outlets for staff to express themselves can help convey the message that their ideas are respected. One program reported using annual performance reviews to systematically ask all staff about their recommendations to improve any aspect of the program, from working conditions to the delivery of care. Other programs indicated that they regularly asked for feedback from staff during staff meetings. One education staff member indicated that she was able to initially raise the idea of starting a new sexual health initiative for the prison population at a staff meeting. As other staff members became interested in her concept, she eventually secured the support and resources she needed from upper management to plan and implement this initiative the following year.

D. Offering Professional Development and Career Advancement Opportunities

Having a clear, recognized path to attaining more advanced and senior positions has been considered an important strategy for retaining staff across many different types of health care organizations. This strategy is perhaps even more poignant for minority staff in family planning settings. Across all visited sites, racial/ethnic minorities were more likely to fill front-line administrative and direct care positions than they were to fill leadership positions directing the organization, smaller clinics, or types of services. Experts indicated that promoting minority staff into positions of greater power can have a number of benefits, including sending a strong message to clients that minorities are highly valued by the organization and putting minority staff into a position to make cultural competence a higher priority issue.

A number of representatives from family planning programs provided examples of staff that entered the organization entry-level positions and successfully progressed to more advanced positions. One program attributed its significant reduction in the rate of turnover from 24% in 2005 to just 15% in 2009 to the development of new career paths for key positions. For example, one path allowed phone operators to advance to one of three positions: (1) health care associates, (2) associates, and (3) counselors. Another path provided support for RNs to advance to nurse practitioners with additional education and training. A representative from another described an initiative that allows medical assistants to take coursework at a local community college and earn a certificate upon completion. Medical assistants who receive the certificate become well-positioned for a promotion to a family planning counselor.

E. Tracking and Rewarding Culturally Competent Practices

Several Program Directors noted that family planning staff are particularly passionate about the work they do and take pride in the fact that they provide services to underserved clients who would not be able to access elsewhere. Some staff are therefore wary of assessments that critique the quality of care they provide to diverse populations and can become offended by them. Organizational leaders are often sensitive to these concerns and are themselves reluctant to assess cultural competence indicators during performance reviews. Furthermore, some leaders feel that cultural competence assessments add an extra burden to staff that are frequently overstretched and expected to perform under already high expectations with often limited resources.

“Staff have to separate their personal values from the values that the organization has and how they interact with clients. Staff need to use language that is appropriate to our workplace. And I like that managers have stuff written down that helps them reinforce that to their co workers...”

Title X Program Director

Key informants therefore recommend the establishment of objective indicators of culturally competent practices that are tied to incentives as a way of putting a more positive and encouraging spin on monitoring these practices. The most frequently cited indicators were those related to effective communication with clients. One key informant highlighted an example of doctors in UCLA’s hospitals receiving a slightly higher salary (approximately \$100 more each month) if they speak Spanish. Similarly, a representative for a visited Title X program reported that staff who are able to speak the Mayan-dialect of Spanish receive a small salary increase as well. Another clinic also reported rewarding outstanding achievement among its staff through its Employee of Month program. As an added incentive, the selected employee also receives free parking during that month.

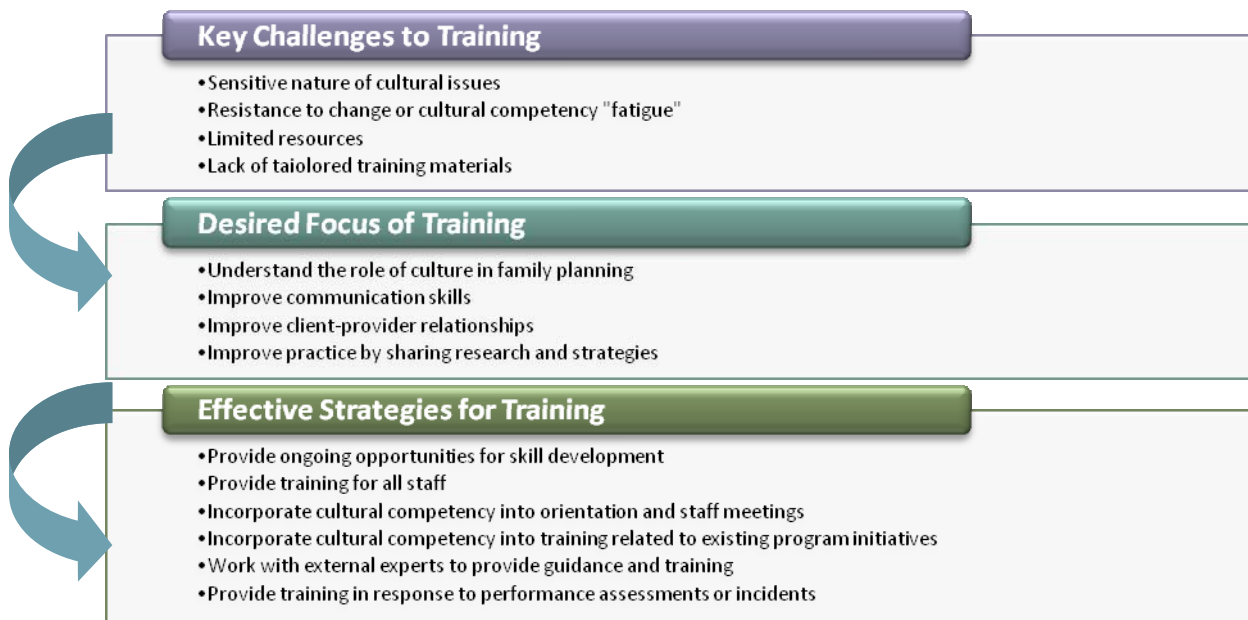
A Program Director at another Title X program reported also assessing the ability of staff to communicate with clients through a new measure on the staff performance appraisal tool. However,

performance on this measure was not directly to an incentive as in the other examples. The measure still proved to be a useful means of improving specific types of interpersonal skills, such as conducting outreach to diverse populations to recruit them into care and adhering to the organization’s set of communication norms when interacting with clients.

V. Strategies for Providing Training to Build Staff Capacity to Deliver Culturally Competent Care

The review of literature also emphasized that simply recruiting and retaining a diverse staff is not enough to ensure the delivery of culturally competent care. Even in situations where providers share the same racial/ethnic backgrounds as their clients, there may be other types of differences present that inhibit effective interaction, such as differences in age or gender. Similarly, providers may have limited experience providing care to certain subpopulations such as lesbian, gay, bisexual, and transgender (LGBT) individuals or those with disabilities. Therefore, the research recommends that staff should receive regular, comprehensive training to improve skills in culturally competent care delivery—that helps them work effectively with *any* individual or group. As depicted in Figure 3 and the narrative that follows, the key informants, program administrators and staff, and RTC staff supported the research findings and shared their thoughts about key challenges to training staff in culturally competent practices, the desired topics, and effective implementation strategies.

Figure 3. Strategies for Training Staff in Culturally Competent Practices



C. Key Challenges to Training

Respondents discussed a number of challenges to efforts to improve the cultural competence of staff through training and other means, such as:

- **Sensitive nature of cultural issues.** It can be emotionally charging to have staff explore how their personal perceptions of culture can influence their interactions with each other and with their clients. Staff may feel uncomfortable when asked to identify their own potential biases

toward certain populations. This process may create new or exacerbate existing tension between staff and, in some instances, lead to feelings of resentment or feeling personally attacked and accused of harboring prejudiced attitudes. In addition, some staff may experience discomfort when discussing cultures with whom they have very limited experience. Respondents indicated that this discomfort may particularly occur with stigmatized populations such as lesbian gay, bisexual, transgender, and questioning (LGBTQ) individuals.

- **Resistance to change.** Respondents noted that is sometimes an assumption that individuals attracted to the field of family planning are more likely to be culturally attuned and sensitive to diverse populations by their very nature. As a result, some may view their current practices as sufficient and may see a substantial need for undergoing additional training on cultural competence. Similarly, staff that have been working at their program for a long time may be more set in their ways and more resistant to learning new ways of client interaction. In addition, the RTCs noted that it was often difficult to get engage staff in cultural competency training because of a “been there, done that” attitude that sometimes develops in response to previous attempts to address the issue.
- **Limited resources.** Staff across all Title X programs and among the RTCs identified the lack of funding and available time as two of the largest barriers to supporting training on cultural competence, especially on an ongoing basis. Consequently, many trainings offered either internally or by RTCs occur just once or twice a year and do not have the ongoing support needed to ensure staff are going beyond changes in knowledge and attitude to truly change behaviors. Even if Title X programs or other types of organizations serve as sources for additional cultural competence training in other regions, there are often limited funds available for staff to travel to these sites. And although distance learning is a common strategy for maximizing training dollars, respondents noted that discussions around cultural competency can be very difficult to facilitate over the phone or internet.
- **Lack of tailored training materials.** Respondents also noted that there is a shortage of training materials providing information about caring for some underserved populations, including American Indians/Alaska Natives and emerging immigrant groups. In addition, some training materials focus broadly on the delivery of primary care, rather than addressing specific aspects of reproductive and sexual health. While many of the Title X programs, RTCs, local health departments, and community-based organizations are a helpful source of materials, respondents noted that they are costly to create, require time and effort to be both linguistically and cultural appropriate, and are often difficult to replicate in other settings because of regional differences in cultural norms and dialects.

B. Desired Focus of Training

All respondents were asked to share their thoughts on the intent and focus of training to build cultural competency among staff. Title X program staff were also asked to identify areas in which they desired additional training. The RTCs' discussions were informed by the formal and informal needs assessment processes they undertake. The most commonly mentioned focus areas of training were to:

Help providers better understand the role of culture in family planning. As discussed in the initial chapters on the role of culture and defining and framing cultural competence, respondents overwhelmingly feel that it is critical for staff in family planning programs to understand what culture is, how manifests itself, how it affects sexuality, and the role that it play in client-provider interactions. Many were interested in learning techniques for assessing cultural competence and bias among staff.

Improve communication skills. The most commonly mentioned focus area related to communication was interpreter and medical translation training, including training for staff on how to work with interpreters (see Chapter 6 for a more in-depth discussion). Strategies for creating an open communication environment were also stressed, with a focus on helping staff demonstrate respect and be aware of and appropriately adapting body language, eye contact, and choice of words. Several clinic staff also mentioned the need for tools that are not based on the written word to better address differences in language, literacy, and learning styles.

Improve client-provider relationships. Respondents felt that all staff should recognize that all people, regardless of their background, harbor some level of bias towards other cultures. Therefore, it is important to assess one's own biases and acknowledge that one's prejudices may be unconsciously conveyed to others and perceived negatively. They also felt that staff would benefit from understanding cultural attributes of underserved populations. One expert noted that some types of cultural information are more pertinent than others. Knowledge about things such as celebrated holidays or different types of ethnic foods is less useful to ensuring quality care than knowledge of things like values related to desired family size or the practice of female genital cutting in certain populations. Staff should also understand that every population has its own subcultures that may be relevant to reproductive health (e.g., gender, sexual orientation, and disability status).

In addition, respondents felt that is important to recognize that some characteristics of clients that are relevant to care may not be culturally derived, but instead due to larger socioeconomic forces. Limited educational opportunities, for example, can lead to lower reading and health literacy levels, while fewer job prospects can lead to lower incomes that make it difficult to prioritize sexual health over other pressing needs. Therefore, it is important to help staff become sensitive to other circumstances in clients' lives that may make it difficult to keep appointments or comply with care.

Respondents overwhelmingly stressed the need to move beyond understanding to truly change behavior. Strategies are needed to:

- Work with clients to help them understand the importance of family planning while simultaneously being respectful of cultural beliefs;
- Help clients understand their bodies and types of contraceptives; and

- Better address the needs of specific populations, including GLBTQ, men, younger populations, rape survivors, and individuals experiencing intimate partner violence.

Improve practice by sharing research and strategies.

Finally, key informants and clinic administrators and staff all felt that practice could be improved greatly through the sharing of literature and research on disparities and effective interventions related to health in general. They suggested resources such as the National Center for Cultural Competence, DiversityRX, and various Communities of Practice focusing on cultural competency as potential resources. They also stressed the need to share promising practices and strategies from family planning programs, published or unpublished, and felt that the Title X central office and Regional Training Centers could play a critical role in disseminating this information.

“I’d like to know what other people have done to make them successful with these issues. What have you done that’s worked for your staff to change behaviors, thinking, practices, etc. I mean if we don’t have to reinvent the wheel let’s not.”

Title X Program Staff

C. Strategies for Training Implementation

Respondents discussed a number of strategies for implementing training to build staff capacity to deliver culturally competent care, including:

Provide ongoing opportunities for skill development. Respondents overwhelmingly stressed that training:

- Is not a one shot deal and must be an ongoing, development process; and
- Should move beyond a basic, didactic discussion of the cultural aspects of different populations to include concrete examples and activities to develop staff skills.

An expert offered one strategy, citing the example of research findings that indicate that Hispanics, on average, are more likely to have poor medication adherence than other populations. The expert felt that this information should not be used to make automatic assumptions that one’s Hispanic clients will not take medications as prescribed, but rather to encourage the provider to explore if barriers are present that may hinder compliance and to create an individually tailored treatment plan accordingly. The RTC staff spoke of the need to address cultural competency broadly, and offer trainings to help staff tie cultural competency to quality, customer service, and client centered care.

The RTCs play a critical role in providing ongoing opportunities. Ongoing formal and informal needs assessments help them identify Title X program needs, and the RTCs reported changing their assessment strategies over time to encompass more staff, ask targeted questions, and provide more detailed and insightful analysis of the findings (e.g., by job category). These assessment processes, combined with evaluations of trainings, help identify a variety of training strategies. Some innovative practices include:

- Helping programs conduct organizational-assessments that incorporate the stages of change so they can plot out how they are going to approach cultural competency or proficiency based on what they are ready to achieve. This allows programs to strategically tackle a smaller number of issues or recommendations in a 6- or 12-month period—and helps to decrease staff anxiety about undertaking such complex and systemic issues.

- Using sessions during conferences to infuse cultural competency by moving away from using panels that simply represent different communities. Instead, case studies are featured in interactive sessions where providers share best practices, discuss what’s worked in their settings, and engage in dialogue with each other about how the models might be translated to other settings.
- Offering a 5-day institute that allows participants to build community and address values clarification and self-assessment throughout the process. One interviewee felt that the key is “...really helping people feel safe enough to look at how they do their work and how they might do their work differently.”

Provide training for all staff whenever possible. While most experts we spoke to stressed that cultural competence training should be offered to all staff, there was a wide range in the target audience for this training across visited Title X programs. The most common audience for cultural competence training included providers, counselors, and other education and outreach staff. Administrative staff such as receptionists and organizational leaders such as Program Directors and Clinical Directors were less likely to participate in this type of training. Experts explained that front office positions help set the tone of each client’s visit to a family planning program. In instances where staff in these positions are judgmental or rude to clients of certain backgrounds, these clients can feel unwelcome and either end their visit prematurely or decline to come back for follow-up care. This is especially significant for contraceptive services and certain STI treatments that depend on consistent and long-term adherence and monitoring.

One expert also noted that even organizational leaders who have had a long history serving clients and working in underserved communities can benefit from additional training on cultural competence. She has encountered many organizations with staff in leadership positions who are unfamiliar with some clients’ cultural characteristics and how broader structural issues can act as barriers to effective service delivery.

The RTC staff all discussed the need to focus on addressing cultural competence at the system-level through training. Buy-in from leadership is required in most cases for RTCs to even consider designing and delivering a training or series of training on cultural competence. The RTCs also understand the realities of staff turnover, so it is important to help programs incorporate tools and approaches that will sustain themselves regardless of the staff that are there.

“They do these checklists to know where I’m at on these particular issues...so we become aware of our own biases to become truly culturally competent. I have found that that’s been effective when you do that. I think it helps people say, ‘I didn’t realize I felt like that.’”

Title X Program Director

Incorporate cultural competence into orientation and staff meetings. Respondents suggested that new staff hires may be provided with background information about the program and how its mission, values, and goals shape the expectations for staff in delivering care to diverse clients. One respondent indicated this information helps orient new staff to the way the program approaches cultural competency. One program also reported that this process is guided by a formal staff orientation plan tailored for each job description. Following staff orientation, senior follow up with managers regarding how well they covered all aspects of the orientation plan with the new staff member.

Several programs reported taking advantage staff meetings as a venue for delivering cultural competence training. The strategy has important benefits, such as using staff time that has already been reserved for mandatory attendance and having access to a captive audience that is used to addressing important issues of staff competency during meetings. One program described reserving at least one of the quarterly all-staff meetings each year to deliver cultural competence training. These meetings take up the entire 1.5 to 2 hour meeting length and typically include conducting a cultural competence self-assessment and series of role-playing exercises that allow staff to interactively experience how culture may affect interactions among staff or between patients and staff. At the conclusion of the training, evaluation forms are administered to assess how the information was received and retained by staff.

Incorporate cultural competence into training related to existing program initiatives. Some programs also integrated cultural competence concepts into other types of staff training. This is often done for training on delivery of HIV/AIDS services. Similar to family planning, HIV/AIDS is also a very private topic for many populations. Trainings may therefore address the importance of learning a patient’s background, establishing trust, and asking questions in a careful manner such as when asking if patients would like to have an HIV test. These skills may also be emphasized when organizations prepare to offer more targeted services to special populations. Examples of such trainings reported by Title X programs include:

- **Youth.** In preparation for the opening of a new teen health clinic, one program provided peer educators with training on effective strategies for delivering information on sex, sexual abuse, and HIV to teen clients.
- **Males.** A Program Director described that about 8 years ago her program conducted an assessment to identify barriers that contributed to a low number of males being served. This assessment found that mostly female clinicians were not very comfortable treating males. In response, female clinicians were sent to shadow providers at other sites with greater experience caring for males. Participating clinicians reported that the experience gave them greater confidence in their ability to serve men and they began encouraging their female clients to start bring their male partners in for care as well.
- **Immigrants.** One program’s center used the experience and lessons learned from operating a mobile medical unit in nearby immigrant neighborhood to develop a new series of staff trainings on emerging populations. Education staff who served on the unit led these trainings on the characteristics and service needs of Latino and West African immigrant populations that was eventually offered to all staff at the center.
- **People with disabilities.** In response to prioritizing efforts to reach out people with disabilities and to make family planning services more accessible to them, one program has offered training on caring for clients with various disabilities, including deafness and hard-of-hearing and blindness. More recently, a training was held on autism regarding factors that are believed to cause it, different forms of autism such as Asperger’s syndrome, and strategies for overcoming challenges to delivering sexual health care to clients with autism.

Work with external cultural competency experts to provide guidance and training. While many programs reported that they were able to draw on expertise of their own staff, particularly in the education and outreach departments, to offer culturally relevant trainings, in some cases it was deemed more appropriate to bring in outside experts to address certain topics

“We approach the topic of cultural competency and cultural proficiency from the standpoint of avoiding two of the biggest pitfalls. First, avoiding creating new stereotypes, and second, that this is an undoable task.”

or populations. The RTCs and state-based trainings served as a major source for trainings conducted by external experts. One organization reported bringing in representatives from a Statewide family planning advocacy organization to present data about the demographics of clients seen and to identify strategies for making greater inroads with populations that have been harder to reach. Another program also indicated that they invited a representative for a Mayan community-based advocacy organization to provide a presentation an overview of the Mayan culture and the care needs of individuals from the local Mayan population.

Key informants, Title X program representatives, and RTC representatives all believe that effective cultural competency training depends on the skills of the trainer to present cultural information in a way that does not further stereotype minority groups. Several Title X staff who have undergone such training described that the experience created a sense of hostility and accusations aimed at particular staff members. Respondents indicated that trainers should create a more positive atmosphere that emphasizes learning new skills, rather than assigning blame.

Provide cultural competence training in response to performance assessments or incidents. Several organizations also provided examples in which they tailored the type of training and guidance provided to staff based on the results of a personal assessment performance in practicing culturally competent care. The Family Planning Trainer at one site conducts site visits at least twice a year with all family planning counselors to directly observe how they interact with clients. She then provides counseling for staff to address any issues with body language or choice of words that may make clients feel uncomfortable. In the call center of another program, managers have begun pairing new call center representatives with those with a longer tenure in the position so that they can model how conversations with existing and prospective clients should go. Although it is preferable to offer cultural competence training early on to avoid problematic encounters with patients, sometimes these incidents can also represent important teachable moments to correct behaviors and avoid repeating them in the future.

I. Introduction

Limited English Proficiency (LEP) creates an enormous barrier in health access, with respect to both the patient's initial entry into services, as well as effectively accessing and understanding the information or care offered once the patient has entered the system. Even for patients who have some command of the English language, in the context of health care settings, LEP individuals may not be able to speak, read, write, or understand English at a level conducive to effective communication with providers. This presents a challenge to patients and providers and affects the system as a whole. Addressing language barriers is essential for increasing awareness of available services and providing culturally- and linguistically competent care and is a vital step in improving access to care.

Successful interactions with diverse clients depend on effective communication, especially with the increasing number of LEP individuals requesting care at family planning clinics. Language services refer to a broad array of services designed to enhance verbal and written communication with LEP clients.

Typically, multiple types of language services should be available at a family planning clinic to adequately address the language needs of different clients (Bancroft, 2007). Based on a review of available literature, recommendations to enhance verbal and written communication with LEP clients include:

- **Language Access Plans.** Formal plans that describe policies and procedures documenting how to serve LEP clients. These plans typically include policy language related to Title VI of the Civil Rights Act or state-level language access laws, as well as simple steps that staff can follow to more effectively interact with LEP clients.
- **Interpreters.** Individuals who listen to a communication in one language and orally convert the communication to another language while retaining the same meaning. The availability of formal interpreters can reduce dependence on family members and friends of clients, who lack specialized training in interpretation and may be unfamiliar with important medical technology. The use of untrained interpreters, especially children, has been shown to lead to multiple errors, confusion, misdiagnoses, and problems with medications, illness, and even death. Different types of interpretation services follow:

Corresponding CLAS Standards

Standard 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.

Standard 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.

Standard 6

Health care organizations must assure the competence of language assistance provided to limited English proficient patients/consumers by interpreters and bilingual staff. Family and friends should not be used to provide interpretation services

“Creating access is definitely the number one thing. By us providing the language services or trying to be as culturally competent to that population that we serve, we created a new access point for that population to access the medical services.”

Title X Program Director

- **Onsite interpretation.** In-person translation services provided onsite by either trained, professional contract interpreters or full-time, dedicated staff interpreters.
- **Teleconference interpretation.** Language banks, or a large pool of interpreters that are usually available on a volunteer or low-cost basis, are used to interpreters fluent in the languages required to clients via a high-speed Internet connection that transmits simultaneous video and audio signals.
- **Remote telephone interpretation.** LEP clients who require language assistance at one clinic are provided with in-house interpreters trained in medical interpretation who are in a centralized location. High-quality interpretation is provided via a speakerphone and dual headsets, which are used to minimize concerns over confidentiality.
- **Bilingual and multilingual staff.** Employees who are proficient in English and one or more additional languages have knowledge of the specialized terms used, and who understand the role of an interpreter.
- **Translators.** Individuals who replace written text from one language to equivalent written text from another language. At a minimum, important forms and educational materials such as pre-appointment guides and counseling information should be translated into the languages most often spoken within the clinic population.
- **Strategic partnerships with community-based organizations.** Partnerships with community partners that serve LEP clients may help improve a family planning clinic’s language access services by doing the following:
 - Helping to identify and recruit new interpreters;
 - Serving on a steering committee, board, or advisory group to guide the development of effective language services;
 - Offering culture brokers or mediators;
 - Providing community feedback on whether language services are working well;
 - Demonstrating when language barriers are complicated by cultural barriers; and
 - Assisting with outreach and spreading the word about language assistance to the community.⁶²

“I think financial commitment. Interpreters are not cheap because it is an additional cost, but as an organization you made a commitment that this is a patient right and we provide it regardless of how costly that may be. It’s just, that’s the policy and you just do it. You enforce it. And then everybody has an understanding.It’s just that commitment being communicated throughout the whole entire staff is what I think makes it work.”

Title X Program Director

Common barriers and strategies were cited across the clinics visited under this contract. Overall, patients underscored the importance of receiving services in their native languages. Ideally, providers and patients speak the same language, which is encountered in some clinics or with some languages. However, almost universally, there is some level of requisite interpretation. In addition to the obvious advantage of facilitating dialogue across the patient and clinic staff, interpreters also serves as a vehicle

⁶² Goode, 2006; Alliance of Community Health Plans Foundation, 2007; Hart et al, 2005.

for establishing rapport and trust with patients. Across clinics visited, staff shared that clients will often seek out interpreters, in particular when both patient and interpreter are from the same culture, which increases the patient’s comfort level.

Pervasive organizational commitment is critical to effective, continuous, and high-quality service provision to LEP populations. Although interpretation is both a financial and a logistical commitment, developing a deliberate interpretation policy and communicating and enforcing it throughout the entire organization was a strongly identified key to success.

II. General Challenges in Implementing Strategies that Improve Access for LEP Populations

As initially indicated in the Organizational Capacity section, there are a number of challenges in serving and improving access to care for LEP populations, and, equally, challenges in implementing strategies that address access to care for LEP populations. Those challenges range include cost, commitment, and recruiting and hiring trained staff.

There is no “one size fits all” solution for improving services for LEP patient, especially considering the number of disparate dynamics across clinics included:

- How interpreters are viewed and their distinct role in the clinic;
- The clinic’s approach to hiring, training, and orienting interpreters;
- The mechanism for identifying interpretation needs and assigning an interpreter; and
- The visit-specific relationship between the patient and the interpreter(s).

“Sometimes LEP is LEP - language problem. Sometimes it’s an indicator or proxy for cultural differences. The research we did in one of the LEP communities, it wasn’t language. There were cultural/religious differences, and they did not understand, and the clinic didn’t understand that the services they needed to market, if you will, to that population, were not implants and IUDs. They were methods that had to be less permanent and more consistent with their religious beliefs.”

RTC Staff Member

As such, some of the challenges and strategies identified in other sections of this report address LEP challenges and, similarly, some of the challenges and strategies that are specific to LEP also incorporate a focus on cultural differences or challenges, including the interpretation strategies and especially the culturally-appropriate outreach strategies.

Barriers and challenges cited by patients and staff interviewed in visited clinics include:

- Accurately assessing a patient’s language needs and abilities;
- Developing and providing language-appropriate materials on a range of topics;
- Offering interpretation services (e.g. scheduling, the interpretation experience);
- Improving initial access to services (e.g., reaching out to community members and addressing transportation which may prove additionally challenging for LEP populations); and
- Ensuring language access is addressed throughout all aspects of the patient’s experience (e.g., financial screening).

Our review of the literature, discussions with regional training center staff, and input from site staff and patients highlighted a variety of strategies for addressing these challenges and barriers.

III. STRATEGIES

Clinic and Regional Training Center staff identified a number of commonly-implemented strategies for improving access for LEP individuals. Generally, they fall under the following major categories

- Assessing a patient’s language needs;
- Meeting language needs during service provision;
- Linguistically- and culturally-appropriate outreach using promotoras; and
- Developing materials, policies, or practices to improve access for LEP individuals.

A. Assessing a Patient’s Language Needs

Having succeeded in attracting a patient into the program, one of the next and most basic components of addressing LEP needs is accurately assessing a patient’s language needs. One program, recognizing some unique language needs and having experienced clinical blunders by making assumptions about patients’ language needs, implemented a color-coded system.

Just as some clinics “color-code” patients with diabetes or other chronic conditions, one FQHC has found immense success with color-coding dialect-speaking patients’ charts. They use an “orange” code, which indicates the patient is a dialect speaker (indigenous Latino) and may require interpretation (some of the indigenous patients speak English and dialect). Interpretation needs are assessed and addressed right at the front desk area so that by the time the patient reaches the area for taking vital signs, he or she already has an interpreter. The same interpreter follows the patient from start to finish, which ensures continuity. The provider will also assess the patient’s need for interpretation. For example, the patient’s chart may have been orange-coded when they first came to the clinic several years before. However, they may have learned Spanish and have the ability to communicate well with a Spanish-speaking provider, without the need to bring in a dialect-speaking interpreter. The clinic helps patients complete clinic forms, explain insurance options, apply for insurance coverage, and offers interpreters for indigenous patients.

B. Meeting Language Needs

Meeting direct language needs of patients during service provision is one of the more basic and common, yet not easiest, strategies shared by clinics and raised by RTC staff. Staff and patients interviewed identified a few methods of addressing the linguistic needs of LEP patients:

- Using providers who speak the same language as their patients,
- Providing in-person interpretation,
- Providing telephonic interpretation, and
- Using signage or visual aids.

Staff across all clinics visited generally agreed that using family members is an undesirable and unacceptable form of interpretation.

To summarize, from the patient and clinical staff perspective, the ideal mechanism for communicating with LEP patients is using providers who speak the same language as their patients. Of the patients who participated in focus groups, many stated that they did not need interpretation services because their provider could communicate with them in their preferred language. The majority of patients who did require interpretation had generally positive comments. A few patients stated that they do not like using interpreters at all because “it’s not the same” using an interpreter compared with speaking directly with the provider. One patient’s reluctance stemmed from not being sure that everything is interpreted correctly. Another patient was less inclined to ask questions when using an interpreter because they sensed the interpreter’s time constraints and did not want to “call them back” to interpret lingering questions.

Using clinical providers who speak the same language as their patients. Programs able to hire providers who speak the same language as their patients generally set culturally-appropriate hiring as a priority. They tend to include language in job descriptions that indicate a preference, or a requirement, for candidates to speak a preferred language. Often, they aim to hire from within the community, though have more success hiring non-clinical staff from within the community, depending on the location and remoteness of the program location. Knowing their budgets are limited, at least a few programs described various recruiting strategies to attract culturally-appropriate candidates, including a strong benefits package and attracting dedicated candidates by promoting the program’s mission-orientation.

One clinic that serves a highly-diverse patient population that speaks a number of varied languages still makes a strong effort to hire clinicians from the same general culture, even if the clinicians are not members of the sub cultural of a majority of patients and even if the clinicians do not speak the same language as the majority of patients.

Providing in-person interpretation. Most of the programs that we visited provide some form of in-person interpretation, although the degree varies. Successful interpretation requires a commitment to:

- Securing appropriate resources,
- Hiring the right people,
- Making that commitment clear across all staff and within the community,
- Careful scheduling to ensure that interpreters are available to address the appropriate patient language, and
- Training.

“When you have a third party [interpreter] coming in, as much as you try to coordinate and communicate well with each other, there are some times maybe the assumption that oh, I thought you did that.....there is always a chance of something falling through the cracks.”

Title X Program Director

As stated by one RTC staff member, “The ones that have made some small steps are the ones who have really reached out into the community to recruit staff so that it’s not a separate interpreter, but it’s how to match your clinical services with your community and having the people in the community be able to interpret.” Having interpreters who are an integral part of an organization’s staffing base can validate their role and also enhance the work they do. One Clinic Director proudly shared that “Our interpreters are truly that bridge to patients. That’s why I said, we call them interpreters now, makes them very formalized, but they are more than that. That’s what it is. They just talk to patients.”

One of the greatest challenges in providing onsite interpretation, as underscored by a number of program and RTC staff is matching the service with the patient: “You have to make appointments and hope the interpreter and the patient show up at the same time.” A further testament to the cost of committing to onsite interpretation is that programs find greater success in hiring fulltime interpreters. Often, those programs will have to cross-train interpreters to engage in other activities, such as social services or financial screening, but as long as those interpreters are trained in medical interpretation and onsite fulltime, there is a greater likelihood that they will be available when needed.

Training interpreters. Addressed in greater depth in another section of the report, another solid challenge is ensuring adequate training of interpreters. Trained interpreters are generally seen as more “reliable.” Also underscored by program and RTC staff, “making sure that those folks who are doing the interpreting have the clinical, medical background to really interpret, and it’s not just someone who can speak the language...and there are really not a lot of dollars for that kind of training.” A few programs indicated that area non-profits or health insurance companies actually provide interpreter training and even certify interpreters. The most effective trainings seem to be those that provide, or even require, ongoing follow-up training at least once a year. In some cases, the program itself requires follow-up training, on- or off-site, in order for interpreters to stay current. Furthermore, providing training not only for interpreters, but also for providers on how to use interpreters, can increase the success of the interpretation services. Staff indicated the importance of ensuring that both the interpreter and the clinician are clear about positioning (where the patient, interpreter, and provider should all stand and how the conversation should be directed) and, in particular, about the interpreter’s role. Interpreters expressed feeling that they are often put in positions that exceed their responsibilities; rather than simply interpreting, word-for-word, what the clinician (or other staff member, depending on where in the program the interpretation takes place) or patient says, they are often put in the position of describing or embellishing on what either the provider or patient quotes. However, most programs valued their interpreter staff not only for their ability to support a more seamless provision of care void of a language barrier, but also for their ability to broker cultural gaps and establish trust with patients, a quality which often enables providers to achieve a deeper level of care provision.

Providing telephonic interpretation. Telephonic interpretation is appreciated by some program staff and patients, and seen as impersonal and a last resort for others. One of the more appealing methods of providing telephonic interpretation includes the use of dual headsets, so that both the provider and the patient have simultaneous access to the interpretation. One program described their reliance on telephonic interpretation as pervasive throughout their operations. They found it helpful to have access to a language line that could be called at any (unscheduled) time, in any part of their program (patient intake, financial screening, clinical examination, social services, or the exit portion of the patient visit), and for any language. This is particularly useful for programs that have patients from multiple linguistic backgrounds where it is impossible to hire staff members in each part of the program that speak every language their patients speak.

Even for the more linguistically-challenged programs, however, many staff and patients continue to prefer in-person interpretation, to have the ability to see each other, read body language, invite questions, and build trust.

Using signage or visual aides. At least one or two programs described the utility of descriptive signage, especially in the exam rooms. A calendar, for example, can be used between a patient and medical assistant or nurse to support a patient’s recall and description of their last menstrual period, with little

need for detailed verbal communication. Photographs of clinicians can be helpful during the patient intake in describing which provider the patient saw last. While certain visual aids still require adequate language-appropriate oral communication, aides that enhance a provider's description of birth control or body parts can enhance the patient learning experience, and when programs are able to overcome the financial barriers to securing those visual aids, they find them helpful.

Linguistically- and culturally-appropriate outreach using promotoras. By providing basic language-appropriate health information and going door-to-door in targeted neighborhoods, staff are able to reach patients in an environment familiar to the patient and provide the first entrée into care. Because of language and other barriers, patients may not previously have had knowledge of available services. Even if patients are familiar with services, they often need help scheduling appointments, or understanding and gaining access to services such as transportation, which can be additionally challenging for LEP populations. One program also equips promotoras with cell phones in order to help patients make appointments on the spot, since promotoras often visit homes without telephone service.

An example of one such program is “Habla con su Hermana” (Speak with your Sister), a home-based peer education program targeting adult women, which was started because of the high need for health education and limited education staff to do the work. This new program will train participants (*promotoras*) to provide health education in their homes to groups of women (i.e., friends and family members) interested in learning more about reproductive health. It provides a strong advantage in reaching out to LEP women in their own community and addressing more than language barriers at one time.

For a promotora program such as Habla con su Hermana to be successful, the program requires training, funds, and coordination, especially considering that non-professional staff/promotoras conduct work offsite, unsupervised, and are still required to report their activity back to the clinic. Also, because this is taking place offsite, there may be questions or situations that arise which have to be deferred until a clinician or other clinic staff member can be consulted.

EXEMPLARY PROGRAM EXAMPLE:

One highly linguistically-diverse program implements a patchwork of strategies that includes bilingual providers (beyond clinical providers), onsite interpretation, and telephonic interpretation. They have developed a “walkie talkie” system for scheduling patients and interpreters. One of the main strategies relies on assigning a specific frequency or channel to a specific language, so that only interpreters throughout the clinic who speak a particular language are called on when their language is needed. Interpreters or bilingual staff who speak other languages do not have their other responsibilities interrupted unless their specific language skill is needed. The following details how the system works, as well as what training is provided to interpreters and bilingual staff of this program:

Most providers at this clinic are bilingual, but may not speak the same language as their patients. Bilingual staff are available at each step (e.g. Front Desk, Financial Screening), depending on staff hired into those positions, but interpreters are available for patients who speak other languages. The clinic uses telephonic interpretation if an interpreter is not available or an interpreter in an additional language is needed.

- **Appointments:** Staff members fluent in three different languages staff the appointment line; if callers speak another language, they are transferred to an interpreter, who automatically schedules their appointment themselves.

- **Registration/patient intake:** Registration forms screen for preferred language and the need for an interpreter. The forms are only in English. The clinic tried having forms in multiple languages, but in order for all clinic staff to understand the forms, all content would need to be translated back to English anyway. When patients come to the clinic, sign in, and are given registration forms, an interpreter provides oral translation if the patient is unable to complete the English-language forms. If the patient requires an interpreter to complete the registration papers, the interpreter follows the patient to the financial screening.
- **Financial screening:** Financial screeners speak three different languages. If the patient’s language does not match those three languages, an interpreter is called.
- **Clinical portion of the visit:** After the financial screening, the patient returns to the waiting room to be called by a Medical Assistant in order to have their vitals. The Medical Assistants speak English and three other languages. Interpretation is not as essential at this point, considering often-familiarity of patients with the process for doing the weight and height. The clinic tries to use signage for some questions, such as “when was your last menstrual period” and there are calendars in every room so the patient and provider can point to the calendar. Once in the actual exam, they definitely need an interpreter.
- **Interpreter training:** Interpreters receive on- and offsite training, and have to participate in continuing education on an annual basis (at least one or two trainings or interpreter-focused forums) to keep up their interpreter skills. All interpreters and bilingual nurses attend a 5-day, 40-hour training provided at no cost to the clinic (provided by a health plan that serves individuals on Medicaid, Medicare, and SCHIP). The training includes cultural competency components and attendees receive a certificate of completion, but this State does not have an interpreter certification in place. There is national level organization that is trying to move in that direction. New interpreters are given a basic oral and written language test when they are hired. Experienced interpreters are involved in that process. Staff go through an orientation process where established interpreters do the orientation for new interpreters, and then the new ones do observed interpreting sessions and back observing (they observe the experienced interpreters and then the experienced interpreters will observe them interpreting).

C. Developing Materials, Policies, or Practices for Improving Access for LEP Individuals

As described in other sections, such as the Organizational Capacity section, it is important to provide a holistic approach to addressing LEP barriers. Having established clinic practices and written policies further underscores a program’s commitment to serving LEP individuals.

I. Introduction

Strategies focused on “community” are highly promoted in the literature as an important component of a culturally competent approach.⁶³ Community focused approaches have been described using a number of terms including community engagement, knowing your community, participatory approaches, and collaborative partnerships—concepts that are integrated throughout the CLAS standards. The rationale of focusing on community approaches is that health services can be improved with an increased understanding of the community needs and by involving community members in programming decisions. A key informant commented that the extent to which family planning programs have engaged communities in a participatory process—shaping policy, administrative practices, and service development, is an important indicator of cultural competence; and further adds that there are community engagement models that lend themselves to implementing these strategies and to evaluation.

Common to all community focused strategies was the general intent of Title X programs to increase their visibility in their communities and to be seen as community leaders and experts. In some cases, programs relied on key staff, such as the executive director or outreach coordinator, to establish and maintain important connections. In other examples, programs have disseminated materials they have developed to get their “program out there” and to be seen as an important referral source.

The Title X programs we visited played leadership roles or supported important community efforts, and not necessarily related to reproductive health. One of the clinics receiving Title X funding, has incorporated advocacy on behalf of its community into its mission, and views itself as an important community voice on a number of health and quality of life issues affecting residents in the surrounding community. This clinic prioritized its commitment to the community and considers its relationships with community organizations one of its greatest strengths. Their greatest achievement is the reputation they have established in the community for being compassionate and having staff who are respectful

⁶³ National Center for Cultural Competence. *Culturally Competent Guiding Values & Principles*. Washington: Georgetown University Press; 2005. Available at: <http://www11.georgetown.edu/research/gucchd/nccc/foundations/frameworks.html#ccprinciples>. Accessed January 21, 2008.

Corresponding CLAS Standards

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.

Standard 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.

Standard 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.

Standard 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 treat patients well. This was echoed during the focus group conducted with clinic patients, who stated the clinic has a good reputation that provides high quality services and is known to assist people who are low-income.

“We believe that the clinic in practice has demonstrated cultural sensitivity toward our community and we believe that we become strong because of the [community] support. The clinic is the voice for the community.”

Title X Program Director

Title X programs visited for this assessment have used multiple approaches to engage community members, such as partnering with community-based organization, relying on input from their Advisory Board, and implementing community health worker programs. This section will present strategies around three key approaches:

1. Improve Knowledge of Community,
2. Collaborate with Community Organizations and Community Leaders, and
3. Conduct Outreach Activities.

It is important to note that while these strategies are presented here as distinct, many are connected, build on one another, and are often implemented concurrently to maximize reach.

II. General Challenges

As important as community involvement is, this approach does not come without its challenges. The following were identified as the primary challenges:

- **Level of staff time.** Developing and maintaining meaningful relationships with partners and community members requires consistency and a level of commitment on behalf of the Title X program. Making decisions about how best to utilize staff was identified as a challenge by all Title X programs, and is further complicated if a program is successful in its community approaches and increases visibility. For example, establishing referral agreements with community organizations can increase demand for services, which then increases staff workload.
- **Managing community feedback.** Key informants also pointed out the general challenges that come with managing the community involvement and incorporating community feedback. Once community needs have been identified, there is an expectation that programs will enhance programs, which is not always feasible due to limited financial resources. And while there are benefits to collaboration, these community relationships can be difficult to manage if partners feel that the relationship is not mutually beneficial or if there are competing interests.

III. Improve Knowledge of Community

Key informants agreed that for a Title X program to serve a community well and make good programming decisions, “There has to be some understanding of the population, consumer, and community expectations.” It is important to understand the demographic, cultural, and epidemiological makeup of the geographic service area. Programs need to ask themselves, “To what extent do we understand the populations we are trying to serve?” Key informants listed types of information that should be familiar to Title X programs, including preferred language, primary communication channels, trends in health data and outcomes, and unmet community needs. One of the benefits to Title X

program of knowing a target population is that programs have information that allows tailoring of their educational approach, materials, and curricula.

Having a better understanding of communities is important because several Title X programs and key

“We believe that the clinic in practice has demonstrated cultural sensitivity towards our community and we believe that we become stronger because of the [community] support. The clinic is the voice for the community.”

Title X Program Director

informants pointed out cultural differences in how family planning is viewed. Family and the role of family can vary across cultures.⁶⁴

Knowing how a specific population views family planning services and how these concepts are communicated can be very helpful to providers and educators. Title X programs shared that they approach topics like HIV and birth control differently based on the population group, as

they have learned about some of the cultural norms and how to more readily translate concepts. For example, a clinic working with the Somali population uses educational materials that refer to the concept of “child spacing” instead of family planning and explained that it’s about finding appropriate terms within a culture. Another example that was shared is the experience of learning about immigrant and refugee populations during a stakeholders meeting. The Title X program posed a question to a number of immigrant serving organizations, asking them about the unmet needs regarding reproductive health, and used information from this meeting, to implement a health navigator within their program.

A. Conduct Regular Needs Assessment

New Title X grant applicants are required to conduct an assessment of the need for family planning services prior to applying for a competitive grant award, and existing grantees are required to perform periodic reassessments of service needs. The breadth and depth of this assessment process varies across programs sometimes dependent on available resources. Some programs undertake one comprehensive assessment annually, while others have smaller assessments occurring throughout the year. The process used to undertake a needs assessment and the level of involvement among staff also varies. In some programs, there is a designated staff person responsible for overseeing needs assessment activities; in other programs, these responsibilities may be distributed across several individuals. One program mentioned that they have assembled a “data committee” responsible for these type of activities. Often, a needs assessment involves analyzing and reviewing available secondary data, such as that collected by the Census, CDC, and local and State health departments (e.g., poverty rates, racial/ethnic percentages, HIV/STD rates, health behaviors). In addition to using available secondary data, Title X programs reported collecting primary data, most often through focus groups with community members and community organizations. A number of Title X programs use focus groups as a means to gather community input to learn about beliefs, family planning needs, and barriers to care. Although OFP does require that Title X programs conduct an annual focus group, some have maximized the utility of this information. One approach is to begin by reviewing the available secondary data and then identifying gaps and determining what additional information would be useful. One program has used this approach and focuses its qualitative data collection in HIV and STDs within the Latino communities, based on HIV and STD rates among these populations.

⁶⁴ NCCC, 2005.

Another program also holds focus groups with community gatekeepers and stakeholders that are connected to populations, as a means of identifying unmet needs. In addition to focus groups, a few programs have also used surveys to collect information directly from community members. A Title X clinic that has a promotora program also uses the promotoras to collect demographic information (e.g., income, insurance status, referrals needs) during their outreach work.

“Being out in the community gives [the promotora] a different perspective about community needs...even working in various colonias, they notice the level of need may differ in the areas they visit. The communities they are targeting are some of the most impoverished communities in the State.”

Title X Program Director

B. Utilize Informal Knowledge Gathering

In conjunction with a more structured needs assessment process, a number of programs also reported using more informal methods to learn about a community. In most cases, this involved soliciting feedback and opinions from staff—providers, educators, outreach. As staff members have regular contact with clients, they were considered an important source of information, and a perspective that management sought out regularly. This was particularly true of staff who could relate to client population or considered themselves members of the community. For instance, the basis of the promotora model is building the capacity of community members to conduct education and make referrals in community settings. As members of the target community, the clinic director and education coordinator, feel they benefit from their perspective. Another program mentioned conducting a number of informal assessments throughout the year, in the form of seeking information from “the providers...the medical and nursing providers, the family planning counselors...around who they are seeing...what their needs are” and combine this information with the annual survey data they collect.

C. Maximize Input of an Advisory Group

OFP requires that Title X clinics have an advisory committee comprised of community members to help inform program decisions. How programs utilize this committee varies. One program relies on input from their advisory board, which participates on a volunteer basis and meets every few months, to learn about community needs. They have been strategic in recruiting members (includes clients, parents, and community members) and have identified individuals with strong community connections. This is a method that other Title X programs have also employed as a means to gather information about their community.

Another approach is to form an advisory group around a priority population. Identifying, recruiting, and selecting members that are reflective of the population of focus was recommended in the literature (including informal and formal cultural leaders, faith-based communities, youth representatives, and family members).^{65, 66} One Title X program has successfully used this approach and formed a youth advisory board. This program has prioritized efforts to reach adolescents and developed a peer educator model that also offers STD testing, and relies on input from its youth advisory board to drive programming decisions.

⁶⁵ Bustamante-Forest and Giarratano, 2004.

⁶⁶ HHS, 2000.

D. Develop Community Profiles

Once community data has been collected, programs can use this to develop a community profile. Collecting a broad range of quantitative and qualitative data directly from the community is essential to creating a complete picture of the potential client population. A community profile will help determine relevant factors about the client population, as well as the community's resources, assets, and needs related to family planning services. In addition, members of the community could help play an active role in this process. Findings from the community profile can be used to do the following:

- Determine whether there are new groups moving into the service area,
- Forecast changes in the patient population,
- Estimate how well the clinic is serving the community's population groups, and
- Determine to what extent clinic staff represent the cultures of the communities served.⁶⁷

Example of Topics Covered in Factsheet or Community Profile

- History of U.S. immigration
- Current population size in community
- Languages spoken
- Traditional religions
- Views of family and social relationships
- Roles of family and partners in decision making
- General health care issues
- Perceptions and experiences of U.S. health care system
- Reproductive health care beliefs (e.g., potential unfamiliarity with family planning care, cultural norms that may inhibit discussion about sexuality and reproduction)

Developing a community profile has been recognized by the Title X program as an important component of service delivery and is integrated into the Title X application as part of the needs assessment process. One Title X grantee prepared several factsheets on immigrant groups and distributed to the clinics it oversees. These factsheets aimed to educate clinic staff on the historical context of a population's immigration to the area; as well as provide the clinic staff with important information that can impact clinical encounters. The grantee prepared factsheets on West African, Southeast Asian, and Latino populations, which generally covered a range of topics listed in the text box.

While community profiles can be useful to provide a "big picture" of a population, some key informants cautioned about *how* this information is communicated to staff. It is important to be aware of the factors that may influence an encounter but understand that they may not apply. Ignoring the variation in knowledge, beliefs, and perceptions that exist among any group could reduce specific population groups to stereotypes.

E. Challenges in Improving Knowledge and Lessons Learned

One of the challenges involved in improving knowledge of a community relates to managing the process and the limitations of the information. It requires someone to oversee various aspects of the process—collect data, solicit feedback from staff,

"And we have a real problem because we have a lot of transgender clients...but in terms of documentation, these questions are not included in any of our data collection. And we can't collect the data on transgender because...our State data goes through our federal collection system."

Title X Program Director

⁶⁷ Alliance of Community Health Plans Foundation, 2007.

analyze information, organize advisory groups, prepare community profiles. The use of data is helpful but there are inherent limitations as well. For example, a program interested in identifying needs of transgender population does not have reliable data sources, because the systems in place only collect information based on two gender classifications—male or female.

Once community needs have been identified, an even greater challenge mentioned by Title X programs is their ability to address the identified needs. By seeking community input and suggestions, there is the expectation that programs will act on these suggestions, which is not always feasible. Some of the factors that make it difficult to respond to community needs relate to insufficient staff and resources. Another director stated that with additional financial resources, they would be able to provide the level of services requested. This clinic felt confident about what the needs are, but challenged about the financial constraints. Their board and staff have identified a need for a new clinic site but the director expressed “We need to find resources to be able to expand the services we provide...it’s just not possible today.”

In addition to the financial resources, there are informational resources and support that are needed as well. Based on their data, one Title X program wanted to improve their ability to provide services to populations that have traditionally not been serviced by Title X—males and LGBTQ clients, but had difficulty accessing appropriate training materials for their staff. Additionally, Title X programs face similar challenges to other health care programs. For example, a need commonly identified is having bilingual providers on staff, yet recruiting bilingual providers was identified as challenge by a number of programs.

Important lessons learned include:

- **Utilize various data sources to inform decisions.** Using various data sources, from secondary data, interviews with community members and staff, focus groups with clients, can provide a more complete picture of needs.
- **Remember that no group is homogenous.** Balance the need to identify important cultural information with the potential of reducing cultural groups to stereotypical profiles.
- **Capitalize on all opportunities to improve knowledge.** While a structured knowledge gathering process like a needs assessment can provide important information, informal interactions can prove to be informative as well.

IV. Collaborate with Community Organizations and Community Leaders

Creating and sustaining partnerships within the broader community can help engage well-respected leaders and groups towards common goals of improving access to care for underserved populations and eliminating health disparities. Collaboration strategies are dependent on building and maintaining trust with the community and ensuring that the contributions from community members are valued and respected (Bustamante-Forest and Giarratano, 2004; HHS, 2000; Goode, 2001). The Title X programs we visited praised the benefits of developing partnerships and have collaborated with a broad range of community organizations, including schools, traditional providers,

“[We] have also held meetings with partner organizations to get feedback on community needs, including WIC, the Community Health Representative (CHR) program, social hygiene programs, and local schools. This feedback has been used to help tailor community education.”

Title X Program Director

faith-based organizations, immigrant serving organizations, social service, and other governmental agencies.

A. Develop Formal Partnerships

Partnerships can be formal and informal. Formally developed partnerships typically have a written agreement in place such as a memorandum of understanding (MOU) that defines the nature of the agreement and relationship. This can outline referral agreements, shared resources for training and education, and in-kind contributions. Programs have sought relationships that are mutually beneficial, such as agreeing to mutual referrals. One program has referral agreements with a number of health and social organizations, including local hospitals, WIC, a Special Needs program, and domestic violence programs. Family planning counselors are able to refer clients to these other organizations for services they do not provide and receive referrals from these organizations. Another program has developed a relationship with a major Spanish language publication in their community, and writes a monthly column on reproductive health.

Title X programs have established agreements with a range of organizations:

- School districts;
- Colleges and universities;
- Child and Youth-focused programs (e.g., WIC, HS, teen centers);
- Resource centers;
- Language centers;
- Community centers;
- Food banks;
- Faith-based institutions (e.g., churches, temples);
- Community collaborative; and
- Media—newspapers, television.

One clinic described its partnership development as strategic. Management worked with their staff to identify the community organizations that are important to those in their target populations—Thai, Filipino, and Cambodian communities, and then worked over the years to build strong relationships. Their outreach staff has spent much of their time earning the trust of community leaders in the community churches and temples and organizations that provide consulate services to these populations. They have referral agreements in place, have co-sponsored events, and have received letters of support when applying for grant funding.

One Title X Partnership Network Targeting Adolescents has partnered with local school district and other community organizations to support the following:

- **Youth Program Coordinators and Educators** facilitate a 21 week sexuality education curriculum in grades 6 & 8 across 12 schools, which reaches about 2,000 children annually (funded by a grant from Pew).
- **Health Resource Center Program** housed in 3 high schools, where staff can offer more intimate, one on one counseling to students and distribute condoms.
- Staff the **Achieving Independence Center** (in partnership with other organizations), which provides one on one counseling and annual training to peer educators to facilitate a 9 class curriculum.

Another program developed agreements with other health and social service providers. These agreements address Title X priorities, including intimate partner violence and STI prevention. Family planning counselors have educated their partners about available services through Title X and identified appropriate referral mechanisms.

A. Participate in Informal Networks and Community Collaboratives

Some of the Title X programs rely more informal networks and partnerships, which may be less strategic and tend to develop more organically. This was a common approach for Title X programs selected for site visits. They were active in community networks, which included:

- Community health fairs,
- Local professional associations,
- Local clinical collaborative,
- Local community health coalition,
- Neighborhood development associations, and
- Economic councils.

The reported benefits of participating in these events included increased visibility for Title X programs and an opportunity for programs to learn about available community resources. Attending public meetings was an important responsibility for one Title X education director who felt it raised their clinic's visibility in the community and she developed a network of contacts that have resulted in partnerships. After years of consistent networking efforts, the program is now well-known in the community and regularly invited to participate in community events.

B. Engage Community Leaders

Several programs mentioned that building good working relationships with key community leaders has been effective. These community leaders are viewed as cultural brokers that serve as a link to a specific population. This is a concept that has been embraced and promoted as a way to improve services to traditionally underserved populations.⁶⁸

The NCCC has identified a number of benefits in working with cultural brokers.

- Health care settings can create a reputation for being committed and inclusive community partners, which improves access and use.
- Health care settings can increase the use of preventive services to minimize the use of cost-prohibitive emergency care.

⁶⁸ NCCC, 2004.

- Health care settings can increase cost effectiveness in service delivery by decreasing return visits from patients who did not clearly understand treatment protocols.
- Health care settings can engender mutual respect and trust within the communities they serve, which assures sustainability.⁶⁹

In a Title X program that prioritized health access for immigrant and refugee populations, they approached local immigrant and refugee service organizations to participate in a stakeholders meeting, to identify actions that the Title X program could take to improve access to reproductive health services. The program was able to implement a few suggestions that were made during this meeting:

“A couple of us are non drivers and we take lots of cabs. And talking with a Sudanese taxi driver and giving him one of our cards resulted in a couple of meetings with local Sudanese community leaders. So this is sometimes how things...new partnerships just happen.”

Title X Program Director

- Development of a referral manual for the community agencies, that describes their services, sites, how to access services, and primary contacts; and
- Development of a new position—a health navigator for the Somali clients, that can help orient new clients to the program or to receiving health services in this country.

C. Collaboration Challenges and Lessons Learned

Developing high-quality relationships and partners requires significant investment of time. As programs gain visibility, demand for their services increases. One program mentioned that their greatest challenge is not being able to meet requests for educational presentations. Some program leaders believe that community partnership efforts may be limited based on available funding, especially in rural areas where significant travel is required.

Another program also mentioned that while there are benefits to working with other organizations, that sometimes territorial or ‘turf’ issue can create barriers to effective relationships when there are competing interests.

Important Lessons Learned:

- **Relationships are best cultivated in-person.** This is particularly important in some cultures or organizations that are relationship-driven.
- **Building and maintaining a quality relationship takes time and requires follow-up.** Program staff must be consistent in their communication and deliver on what they promise.
- **The benefits of a relationship do not come quickly.** Trust needs to be developed before a Title X program can reap the rewards.
- **Good partnerships serve multiple needs.** Partnering with organizations can strengthen political voice around health issues, can maximize limited resources, and can be a good source of information and connection to important populations.

⁶⁹ NCCC, 2004.

V. Conduct Outreach to Underserved Populations

The NCCC promoted the value of working in conjunction with natural, informal support, helping networks within culturally diverse communities, and involving community members as full partners in decision making.⁷⁰

The Title X clinics shared that outreach programs should hire workers from the community that represent their target audience. Most of the outreach workers interviewed during site visits agreed that being fluent in a language and being able to relate to a particular culture, improved their ability to connect with individuals and seemed to make clients feel more at ease. One clinic that started a teen outreach program has hired teen educators and recognizes that their ability to relate to their fellow teens will make them better educators.

“The staff tries to tell family member that discussion sexual health is important because their teens may be coerced into sexual activity when they are not ready. Also, the staff informs family members that the family planning program can serve as an important resource for them when they lack knowledge about some sexual health topics.”

--Title X Program Director

A. Conduct Targeted Community Outreach

For Title X programs that described having a strong community presence, they mentioned the importance of being flexible in outreach approaches and supporting grassroots efforts. All Title X programs described the importance of targeted outreach to key populations—adolescents, immigrant communities and have worked closely with program staff and partnerships to identify outreach locations and events.

Key informants believe that understanding a target population supports outreach efforts that are more effective. For example, a program interested in engaging Somali women learned that approaching a group of women—such as a needle work group—is a good opportunity to educate on domestic violence and family planning and more welcomed that one-on-one sessions.

Another outreach strategy is hosting community forums and sessions. One program uses this strategy in areas that are more rural and the sessions cover both male and female family planning topics. This program has noticed that these types of events have created a greater awareness among adolescents, who have been more receptive to seeking family planning. They use evaluation forms to collect feedback on the community sessions.

B. Implement a Community Health Worker Program

Another approach to improving access to underserved populations is the implementation of a community health worker (CHW) program that engages a community member to provide education in community settings and facilitate access to health care programs. Serving a similar role are promotora programs, targeting Spanish speaking populations. During site visits, one Title X clinic serving a predominantly Spanish-speaking population has implemented two promotora programs. Currently, the

⁷⁰ NCCC, 2005.

clinic employs two full-time Spanish speaking staff who spend their week conducting door-to-door outreach as well as visiting community locations—such as day labor center, teen centers, schools, stores—to distribute health information and assist individuals in making appointments at the family planning clinic or providing other referrals. The director remarked that the program has been empowering for the women receiving information and learning about available services, but it has also been empowering for the promotoras themselves. The clinic staff have worked to improve this program over the past 10 years and have seen what an important role it serves in the community.

C. Outreach Challenges and Lessons Learned

A consistent challenge for Title X programs is managing requests and opportunities for outreach and making decisions about how best to use their staff time and resources. All programs have identified outreach activities as a priority but levels of investment vary across programs. One program mentioned that their level of outreach is dependent on patient volume. In their higher volume sites, staff conduct less outreach and focus more on internal operations while the lower traffic sites will conduct more visits to area schools, colleges, and social service agencies.

Other programs have mentioned challenges when encountering community groups or individuals that are not interested in family planning services or disapprove of the programs outreach activities. For the promotora program that does a lot of individual education in the community, they have encountered some cultural barriers to care such as when women express that they need their husband's approval before seeking services. In a few instances, the promotoras have been prevented from even speaking with women by a husband that was present at the time of the visit. In these situations, they have offered to educate both the women and men on services that both can access at the family planning clinic. Their approach is also to inform women of their rights and leave contact information, should they want to follow-up.

Important lessons learned include:

- **Hire from the community.** Having outreach workers that reflect the community can improve their ability to reach individuals, which can make for a more effective education encounter.
- **Be willing to adapt.** By collecting feedback from community members and outreach and education staff, Title X program can create outreach models that are able to adapt to community needs.

Chapter 8 | Key Lessons Learned and Recommendations

Through the conduct of a literature review, key informant interviews, and site visits to Title X Programs and Regional Training Centers, the Altarum Project Team has been able to assist OFP in:

- Documenting the current strategies implemented – as well as the barriers, challenges, and gaps – by Title X family planning clinics to provide culturally competent care;
- Defining cultural competency within the Title X context;
- Identifying existing activities and highlighting innovative and successful strategies;
- Informing the development of strategies to support Title X providers in addressing culturally competent service delivery and reducing health disparities.

The following chapter outlines the key findings of the study gained from all data collection activities and concludes with some recommendations.

I. Key Lessons Learned

As highlighted throughout the report, the study respondents have numerous lessons learned to share as a result of their efforts to build their capacity to provide culturally and linguistically competent care. Table 4 and the narrative that follows summarize these lessons and provide insight into implementation strategies that may be replicated by other Title X Programs.

Table 4: Lessons Learned by Title X Programs and Implementation Strategies

Lessons Learned	Implementation Strategies
Understand that developing cultural and linguistic competency is an ongoing process	<ul style="list-style-type: none"> • Practice “cultural humility” • Confront the “isms” • Keep it real and relevant
Institutionalize your commitment to cultural and linguistic competency	<ul style="list-style-type: none"> • Make cultural competence a legitimate policy initiative with financial support • Conduct an organizational assessment and develop a plan to move forward • Understand the importance of leadership and buy-in • Involve all levels of the staff • Connect policies to practice • Integrate language access strategies
Build provider and staff capacity	<ul style="list-style-type: none"> • Recruit and retain diverse staff • Provide training to build staff capacity to deliver culturally and linguistically competent care
Know your community	<ul style="list-style-type: none"> • Improve knowledge of the community • Collaborate with community organizations and community leaders • Conduct outreach to underserved populations

A. Understand that Developing Cultural and Linguistic Competency is an Ongoing Process

All respondents felt that developing the capacity to provide culturally and linguistically competent care is an ongoing, time-consuming process. They stressed that staff, programs, and systems needed the support to be able to:

- **Practice “cultural humility”**- by incorporating a lifelong commitment to self-evaluation and self-critique, addressing the power imbalances in the client-provider dynamic, and developing mutually beneficial and non-paternalistic clinical and advocacy partnerships with communities on behalf of individuals and defined populations;⁷¹
- **Confront the “isms”**- by creating supportive climates and actively discussing and addressing stereotyping, bias, prejudice, and the “isms” (i.e., racism, sexism, homophobia, classism, genderism, etc.) that exists amongst themselves and others; and
- **Keep it real and relevant** – by tailoring efforts to address the realities of clients and providers, and the communities and programs within which they operate.

B. Institutionalize Your Commitment to Cultural and Linguistic Competency

Respondents provided a number of strategies for institutionalizing a commitment to cultural and linguistic competency that focused on policy, planning, organizational assessment, infrastructure support activities, and quality improvement. Their key lessons learned focused on the following:

- **Make cultural competence a legitimate policy initiative with a financial commitment**, rather than treating it as an add-on initiative. Programs had the most success when they were able to integrate the concepts into their organizational mission and vision and develop and implement policies guiding activities related to, for example, staff performance evaluations or for ensuring access for individuals with LEP. Above all, policy must be connected to practice, which means including community and providers voices in planning, programming, and policy decisions
- **Conduct an organizational assessment and develop a plan to move forward** that includes lines of authority and responsibility and implementation and monitoring processes. Respondents stressed the need to build in time for strategic planning and the importance of engaging staff at all levels in workgroups and committees.
- **Understand the importance of leadership and buy-in** and that any effort to address cultural and linguistic competency must be backed and prioritized by top-level senior staff who are in a position to allocate staff time and resources.
- **Involve all levels** of the staff to infuse cultural competency throughout the organization and create a sense of shared ownership and commitment. This also includes attention to intercultural issues between professionals on the team so that cultural and linguistic competency is more than what the clients bring to the table.

“One [lesson learned] is that commitment needs to start from the top and you have got to have buy-in from management and from your top-level senior staff. And then it will trickle down. If this is something that is being just pushed on to people then please know that it will never work.”

--Title X Program Director

⁷¹ Tervalon M, Murray-García J. *J Health Care Poor Underserved*. 1998 May;9(2):117-25.

- **Integrate language access strategies** by assessing clients’ language needs; building the capacity of staff to meet needs through language skills and interpretations; and developing specific materials, policies and practices for improving access.

C. Build Provider and Staff Capacity

Most respondents felt that their program’s staff was very representative of the clients they serve in regard to race/ethnicity, languages spoken, age, and gender. However, several Program Directors and other types of staff members indicated they would like to address some key deficiencies regarding the diversity of their staff, including lack of diversity in senior-level staff, disparity in bilingual staff, and few male staff. Staff differed in their perception of whether the background of staff has a significant impact on the quality of care provided to clients. Some felt having good communication skills helps bridge cultural differences that may exist between staff and clients. Others stressed that matching background of staff and client leads to in-depth cultural knowledge, trust, ability to attract diverse patients, and ability to combat stereotypes.

“My advice is make sure that your staff is representative of the culture you are serving. And I think more than anything it is just to be open. Be open minded, learn from your patients, listen to your patients, design your services around patient needs in their community, be in their community.”

--Title X Program Director

Their key lessons learned focused on the following:

- **Recruit diverse staff** by making desired characteristics (e.g., residence in the geographic area) explicit in job announcement; supporting a variety of job positions, including community health workers (CHWs) and promotoras; emphasizing non-salary perks of employment; and strategically advertising for vacant positions through local sources and internal referral programs.
- **Recruit and retain diverse staff** by implementing staff-friendly practices like time for breaks and flexible working hours; promoting a staff culture that embraces diversity by developing and setting core values and communication norms; providing mechanisms for staff input on program improvements through annual performance reviews and staff meetings; offering professional development and career advancement opportunities by tying additional education and training to defined career paths and promotions; and tracking and rewarding culturally competent practices through incentives such as salary increases and “employee of the month” awards.
- **Provide training** to build staff capacity to deliver culturally and linguistically competent care by providing opportunities for ongoing skill development through conferences, webinars, and tailored technical assistance; providing training for all staff, from the front line to the program administrators; incorporating cultural competence into orientation, staff meetings, and training related to existing program initiatives; working with external experts as needed to provide guidance and training, including the Regional Training Centers; and using performance assessment issues or incidents related to cultural issues as “teachable moments” for provider training.

D. Know Your Community

Respondents clearly felt that family planning services could be improved through an increased understanding of community needs, engagement of community members in policy and programming

decisions, and tailored community outreach strategies. Despite challenges related to the level of staff time required to support community involvement and managing community feedback, they suggested the following strategies:

- Improve knowledge of the community by:
 - **Using various data sources** from secondary data, interviews with community members and staff, focus groups with clients, to provide a more complete picture of needs and inform decisions.
 - **Remembering that no group is homogenous and** balance the need to identify important cultural information with the potential of reducing cultural groups to stereotypical profiles.
 - **Capitalizing on all opportunities to improve knowledge** through structured knowledge gathering process like a needs assessment as well as advisory groups and informal interactions.
- Collaborate with community organizations and community leaders by:
 - **Cultivating relationships in-person**, particularly for some cultures or organizations that are relationship-driven.
 - **Building and maintaining a quality relationship takes time and requires follow-up**, as trust needs to be developed with the community and program staff must be consistent in their communication and deliver on what they promise.
 - **Developing good partnerships to serve multiple needs**, such as strengthening political voice around health issues, maximizing limited resources, and providing information and connection to important populations.
- Conduct outreach to underserved populations by:
 - **Hiring from the community** to reflect the client population and improve a program’s ability to reach individuals, which can make for a more effective education encounter.
 - **Being willing to adapt** and use feedback from community members and outreach and education staff to create outreach models that are able to adapt to community needs.

II. Recommendations

As highlighted throughout the report, the study respondents have numerous lessons learned to share as a result of their efforts to build their capacity to provide culturally and linguistically competent care. Table 5 and the narrative that follows summarize these lessons and provide insight into implementation strategies that may be replicated by other Title X Programs.

Table 5: Recommendations for OFP and Implementation Strategies

Recommendations for OFP	Implementation Strategies
Define culture and cultural competency broadly	<ul style="list-style-type: none"> • Broaden the OMH definition to include more than race and ethnicity and why family planning values cultural differences • Provide specific strategies, policies, standards, practices, and metrics to help programs and providers implement and measure efforts to provide culturally and linguistically competent care
Develop and share evidence and resources related to cultural and linguistic competence	<ul style="list-style-type: none"> • Continue to build the evidence base by stressing reporting and documentation and conducting longitudinal studies and demonstration projects • Tap into new technology and stay connected to larger discussions of cultural competence
Make cultural competency a priority at the Federal level	<ul style="list-style-type: none"> • Continue to prioritize cultural competence • Dedicate funding • Share training materials, best practices, and data

A. Define Culture and Cultural Competency Broadly

When asked how culture and language influence clients’ ability to access and utilize family planning services, respondents stressed two key points: (1) the critical roles of beliefs, values, and ideas related to family and relationship dynamics; and (2) the impact of culture and language on individuals ability to seek access care and on client-provider interactions. Many had success when linking cultural and linguistic competence to broader concepts such client centered care, quality, patient safety, client satisfaction, and customer service. Within this context, respondents felt that the OMH definitions of culture and cultural competency were widely accepted and applicable to family planning. However, most felt that it the OMH definitions should be broadened to include:

- References to socio-economic status, sexual orientation, gender, age, and disability; and
- Information about why family planning values cultural differences.

Respondents also felt that OFP could play a critical role in helping Title X programs and providers implement culturally and linguistically competent care by:

- **Helping clinic staff understand how cultural and linguistic competence pertains to their day-to-day work** by developing self- and organizational-assessments tailored to family planning settings and offering ongoing technical assistance to help individuals and programs use the assessments to guide the development of strategic plans, programs, and policies;

“Just provide quality service, respectful quality services because your patients will tell other people. If they are treated right and they get good care they are going to tell their sisters, their mothers, their cousins, their daughters.”

--Title X Program Director

- **Sharing examples of strategies and how culturally and linguistically appropriate strategies were implemented** by posting study findings on the OPA Web site and developing webinars and communities of practice; and
- **Developing operational definitions** in terms of standards, policies, and practices that a clinic would have to undertake to provide culturally and linguistically appropriate care within the Title X program;
- **Providing specific targets** that clinics can use to measure their progress in planning and implementing effective strategies, which can be supported by reviewing and adapting OPA program evaluation tools and continuing to support RTCs efforts to improve their capacity to measure outcomes.

B. Develop and Share Evidence and Resources Related to Cultural and Linguistic Competency

When asked how Title X can further support their efforts to implement strategies to build cultural and linguistic competency, many respondents felt that OFP could:

- **Continue to build the evidence base and make the case** by stressing reporting and documentation among Title X grantees, conducting longitudinal studies to provide more accurate evidence about effectiveness, and conducting demonstration projects to allow programs to adapt and test strategies; and
- **Share knowledge and build community** by tapping into new technology (e.g., learning collaboratives and virtual communities) and helping staff stay connected to larger discussions of cultural competence (e.g., through Diversity Rx).

C. Make Cultural Competency a Priority at the Federal Level

Finally, many respondents strongly recommended that OFP make cultural and linguistic competency an explicit priority at the Federal level. Specific strategies were for OFP to:

- **Continue to prioritize cultural competence**, by integrating specific language in the Title X Program Guidelines and identifying it as one of OFP priorities;
- **Dedicate funding for specific initiatives**, such as service delivery improvement grants, demonstration projects, and potentially an RTC devoted to addressing cultural competency (similar to HRSA's Minority AIDS Education and Training Center); and
- **Share training materials, best practices, and data**, using the Regional Training Centers as a resource for data collection and analysis, distribution, technical support.

Appendix A. Clinic Overview

	Name, City, State	Services provided	Facility Characteristics	Funding sources	Number of staff	Number of Clients	Client demographics	Community Characteristics /Additional Information
Clinic A	Navajo Family Resource Center Window Rock, AZ	<ul style="list-style-type: none"> Family Planning One-on-one obstetrical counseling Sexual health education Community outreach Referrals to other services 	8 service units. Some offer only ambulatory care while others have an OB ward and specialty care clinic for women.	Title X, Indian Health Services (HIS), private funding	10 Family Planning Counselors	Approx. 6,000	<ul style="list-style-type: none"> <i>Race/Ethnicity:</i> 95% Native America <i>Gender:</i> 60% Female, 40% Male <i>Age Range:</i> 12 to 80 years old (majority are between the ages 20 to 24) <i>Language(s) Spoken:</i> English is the primary language and Navajo is the second most frequent language spoken 	Members of the surrounding community are not very knowledgeable about family planning. The subject itself is still taboo within the Navajo community. Traditionally, clients “stumble across” family planning services.
Clinic B	Planned Parenthood Brownsville, TX	<ul style="list-style-type: none"> Family Planning Breast exams OB/GYN services Diagnosis and treatment for STDs Cancer screenings Educational services 	3 clinic sites	Title X, Title XX, Title V, CDC funds	Info not available	Info not available	<ul style="list-style-type: none"> <i>Race/Ethnicity:</i> 99% Hispanic/Latino <i>Gender:</i> 98% Female; 2% Male <i>Age Range:</i> 18 to 29 years old <i>Language(s) Spoken:</i> Spanish 	This area has some of the highest teen pregnancies in the State. This community struggles with high unemployment and high numbers of uninsured residents.
Clinic C	Asian Pacific Health Care Venture Los Angeles, CA	<ul style="list-style-type: none"> Family planning Dental Mental health Pediatric Perinatal Senior health 	2 clinic sites, one of which is school based	Title X, State and county funds, private grants	130 staff	10,000 (in 2008)	<i>Race/Ethnicity:</i> 28% Filipino, 33% Thai 10%, Hispanic, 29% other	More than 75% of the clinic’s clients are uninsured.

	Name, City, State	Services provided	Facility Characteristics	Funding sources	Number of staff	Number of Clients	Client demographics	Community Characteristics /Additional Information
Clinic D	Oscar Romero Clinic Los Angeles, CA	<ul style="list-style-type: none"> Family planning STD/ HIV screening and treatment GYN Services Dental Counseling and Advocacy 	3 clinic sites - only provide service in 2 of the sites	Title X.	18 Staff	Info not available	<ul style="list-style-type: none"> <i>Race/Ethnicity:</i>94% Latino and White, 4% Unreported, 2% other <i>Gender:</i> 69% Female, 31% Male <i>Age Range:</i> Clients span across all age groups. Majority of the clients are between the ages 20 to 64 years. <i>Language(s) spoken:</i> Spanish, Mayan dialect(small percentage) 	
Clinic E	NYC Planned Parenthood New York, NY	<ul style="list-style-type: none"> Family Planning Sexual Health services Counseling, Educational and training services GYN care Surgical abortion and medication abortion Male reproductive health 	3 health centers	Title X	Approx. 150 staff	More than 45,000 (in 2008)	<ul style="list-style-type: none"> <i>Race/Ethnicity:</i> 31% African-American, 23% Latino, 21% Caucasian, 3% Asian, and 22% other <i>Gender:</i> Majority females <i>Age Range:</i> Over 49% were under the age of 25 	
Clinic F	Variety Health Center Oklahoma City , OK	<ul style="list-style-type: none"> Family Planning Women health services Pediatric services services 	3 clinic sites	Title X, additional grants and donations	100 staff	19,230 (in 2008)	<i>Race/Ethnicity:</i> 90% Hispanic	This clinic does not offer STD testing for males
Clinic G	Planned Parenthood of Southeastern Pennsylvania Philadelphia PA	<ul style="list-style-type: none"> Family planning Sexual health services GYN exams Sterilization Education and training services to deaf and hearing challenged Programs for incarcerated women 	18 health centers	Title X funding, grant funds, prison funding sources, and STD finding sources	Info not available	More than 62,000	<ul style="list-style-type: none"> <i>Race/Ethnicity:</i> 43% African American, 7% Latino, 43% White, 3% Asian, 4% other <i>Age Range:</i> Clients span across all age groups. Majority of the clients are between the ages 18 to 29 years <i>Gender:</i> 94% Female, 6% Male <i>Language(s) Spoken:</i> English, Spanish 	

	Name, City, State	Services provided	Facility Characteristics	Funding sources	Number of staff	Number of Clients	Client demographics	Community Characteristics /Additional Information
Clinic H	ABCD/ Boston Family Planning Boston, MA	<ul style="list-style-type: none"> • Prenatal programs • Behavioral health • Internal medicine • Pediatrics • Women's health • Dental care • Domestic violence advocacy 	24 agencies	Title X, the MA Department of Public Health's Family Planning Program	Info not available	30,000 clients/year	<ul style="list-style-type: none"> • <i>Race/ethnicity</i>: 36% African American, 17% Asian, 30% Latino, 37% White, 9% more than one race • <i>Gender</i>: 92% Female, 8% Male • <i>Age</i>: 26% of clients are under age 20 • <i>Language(s) Spoken</i>: Spanish, Brazilian Portuguese, Chinese, Haitian Creole, Cape Verdean Portuguese, and Vietnamese • Over 50% of the clients speak a language other than English at home 	

Appendix B. Key Informant Protocol

An Assessment of Strategies for Providing Culturally Competent Care in Title X-Supported Family Planning Clinics Key Informant Interview Guide

I. OVERVIEW AND BACKGROUND ON STUDY

Thank you for agreeing to participate in this interview. My name is _____ and I work for Altarum Institute. Our firm was selected by the Office of Population Affairs (OPA) Office of Family Planning (OFP) to conduct an evaluation of strategies for providing culturally competent care in Title X-supported family planning clinics. This assessment is critical for OFP, as it directly addresses the OFP's priority to eliminate disparities in health status, health care access, and quality as well as to promote preventive health practices to improve the overall health outcomes.

As part of this project, we conducted a literature review on cultural and linguistic competence in family planning and other health care areas. We are now in the process of conducting key informant interviews with Federal and regional staff, researchers, and experts in the field of cultural competency. We will also be conducting in-depth site visits with OFP regional training centers and Title X clinics. The information gathered will be used to assist OFP in the following:

- Defining cultural competency within the Title X context
- Documenting the current strategies implemented – as well as the barriers, challenges, and gaps – by Title X family planning clinics to provide culturally competent care
- Highlighting innovative strategies and defining best practices for the development of training curricula
- Informing the development of a national strategy to support Title X providers in addressing culturally competent service delivery and reducing health disparities.

Before we begin, I would like to review a few details about our discussion:

- The interview will last about 60 minutes. If you need to discontinue the interview please let me know.
- The information you share is confidential. Your name will not be attached to any comments you share today.

II. KEY INFORMANT INFORMATION

Interviewer:

Interviewee:

Title/Position:

Organization or Agency:

Area(s) of expertise:

III. INTERVIEW QUESTIONS

In the first few sections of the interview, I will be asking you about the role of culture and how cultural competence impacts the health care setting.

A. Role of Culture

1. How do culture and language influence clients' ability to access and utilize family planning services?
2. Are there additional cultural considerations that are specific to family planning settings and OFP's goals of reducing the incidence and prevalence of unintended pregnancies, STDs, and HIV?

B. Defining Cultural Competence in Health Care and Family Planning Settings

3. Although various definitions exist for cultural and linguistic competence, the Office of Minority Health (OMH) definition is most commonly accepted among federal agencies within HHS and is included in the CLAS Standards:

“Cultural and linguistic competence is a set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among professionals that enables effective work in cross-cultural situations. ‘Culture’ refers to integrated patterns of human behavior that include the language, thoughts, communications, actions, customs, beliefs, values, and institutions of racial, ethnic, religious, or social groups. ‘Competence’ implies having the capacity to function effectively as an individual and an organization within the context of the cultural beliefs, behaviors, and needs presented by consumers and their communities.”
(Adapted from Cross, 1989).

- Are there important components you think are relevant and missing?
 - Do you feel the OMH definition is applicable in family planning settings?
4. What factors are most important in the delivery of culturally and linguistically competent services?
 - At the community level? (e.g. work with community groups to develop a community profile and conduct needs assessment)
 - At the organizational and clinic level? (e.g. clinical protocols, provision of ongoing training for staff; signage and materials in primary languages)
 - At the provider and staff level? (e.g. familiarity with alternative contraceptive measures; provision of patient instructions both orally and in written form)

C. Assessing Cultural Competence within Health Care Settings

This section will discuss how cultural competence can be assessed within a health care setting.

5. What measures specific to cultural competency can be assessed within a health care setting?
 - At the community level? (e.g. mechanisms in place to community and consumer involvement in designing and implementing cultural competency activities)
 - At the organizational and clinic level? (e.g. written strategic plan that outlines clear goals, policies, and plans to provide culturally and linguistically appropriate services; hours of operation that are convenient for clients; process in place to assess the training and competency of individuals who will deliver language services)
 - At the provider and staff level? (e.g. availability of language assistance services for individuals with limited English proficiency; staff that are broadly representative)
6. What frameworks or tools have been developed to assess organizational cultural competency?
 - How are these helpful?
 - Which are most relevant in family planning settings?
7. What is the evidence supporting the need to address cultural competence (e.g. improved quality of care, increased access to and use of services, improved health outcomes)?
 - In your experience, what evidence is most compelling?

D. Implementing and Assessing Strategies for Cultural Competence in Health Care Settings

In the next set of questions, please think about your professional experience with different types of health care settings, especially family planning. We are interested in learning about specific strategies to improve cultural competence in these settings.

[NOTE TO INTERVIEWER: Probe for strategies specific to family planning settings when appropriate, based on interviewee background and expertise.]

8. What guidelines and strategies have health care settings used to improve cultural and linguistic competency?
 - What about in family planning settings?
 - Of the ones you mentioned, which strategies have been most successful?
 - How do you know these strategies have been effective?
 - What have been the major barriers to implementation?
9. What approaches and strategies have health care settings implemented for recruiting and retaining a diverse staff?
 - Which strategies have been successful in family planning programs?
 - How have these strategies been assessed?
 - What are the major barriers to implementation?

10. How are health care programs ensuring culturally competent encounters and providing meaningful access for individuals with limited English proficiency (e.g. materials are available and signage is posted in commonly encountered languages)?
 - What strategies are family planning centers using to ensure that written materials are responsive to clients with limited literacy or proficiency in English?
 - What are the major barriers to implementation?

11. How have health care programs strengthened their ability to respond to community and client needs (e.g. conduct regular self-assessments and community needs assessments, track demographic data of service area, develop community partnerships and engage community members in planning activities)
 - Which strategies have been successful in family planning programs?
 - How have these strategies been assessed?
 - What are the major barriers to implementation?

12. Do you have other examples of specific efforts undertaken by family planning clinics that have been effective in improving cultural competency?
 - How do you know these strategies have been effective?
 - What factors have contributed to the success of these efforts?
 - Which of these programs would you consider a best practice or promising model? Why?

13. What are the biggest training needs in health care settings related to cultural competency?
 - What are the greatest gaps?
 - How do training needs differ for family planning programs?

14. What are the important lessons that you have learned about attempts to improve cultural competence?

IV. CLOSING AND ADDITIONAL COMMENTS

I have a few more closing questions. My colleagues and I at Altarum very much appreciate your participation in this interview. You have contributed valuable information about how culturally competent care is defined and implemented within health care settings and family planning clinics.

15. Before we close, is there anything I have not asked you that you would like to tell me about your experience with or opinions of the development and implementation of culturally competent care in the Title X Family Planning Program specifically or in family planning programs overall?

16. Are there any specific Title X programs that you would suggest we visit?

Thank you for your time.

Appendix C. Site Visit Protocols

Interview Protocol for Director

Title X-Funded Clinics

I. Background

Thank you for agreeing to participate in this interview to assist us in our examination of cultural competence in Title X-funded programs. My name is _____ and I am here with my colleague _____ and we work for Altarum Institute and are based in Washington, DC. Our company was selected by the Office of Population Affairs, Office of Family Planning (OFP) to conduct an assessment of strategies for providing culturally competent care in family planning clinics. This information will be used to assist OFP in:

- Defining cultural competency within the Title X context
- Documenting the current strategies implemented – as well as the barriers, challenges, and gaps – by Title X family planning clinics to provide culturally competent care
- Highlighting innovative strategies and defining best practices for the development of training curricula
- Informing the development of a national strategy to support Title X providers in addressing culturally competent service delivery and reducing health disparities.

The information collected during the site visits will be used to prepare a summary report.

Before we begin, I would like to review a few details about our discussion:

- The interview will last approximately 1.5 hours. If you need to discontinue the interview, please let me know.
- The information you share is confidential. After we conduct all of the site visits, a summary report will be submitted to Office of Family Planning. Your name will not appear anywhere in the report and what you say today will not be attached to your name at any point. Nothing you say will affect your current position or eligibility for Title X funding and your clinic will not be identified.
- Please tell me your opinions. I work for an independent contractor and don't have a vested interest in anything that is said during the interview.
- The interview is being audiotaped so that we don't miss anything important you tell us. Therefore, please speak loudly. (can opt out)

II. Introductions

I would like to start by asking you some questions about your role at this clinic/program.

1. Please tell me your job title and how many years you have served in this role.
2. How would you describe your training or experience relevant to your current role?

III. Clinic Overview

Before we talk specifically about cultural competence, we would like to learn a bit more about the overall clinic setting and services offered here.

3. Please tell me about the range of services offered by this clinic program.
4. What are the funding sources for the overall clinic/program?
5. Can you please provide us with a demographic profile of your staff and client population?
 - Racial/ethnic breakdown
 - Gender
 - Age
 - language
6. What information can you share about the surrounding community?
 - What are important community characteristics (e.g. emerging populations)?
7. What else about this clinic is important for us to understand?
 - Its history?

IV. Role of Culture and Defining Cultural Competence

8. How do culture and language influence clients' ability to access and utilize family planning services?
 - Are there additional cultural considerations that are specific to family planning settings and OFP's goals of reducing the incidence and prevalence of unintended pregnancies, STDs, and HIV?

Various definitions exist for cultural and linguistic competence. The Office of Minority Health (OMH) definition is most commonly accepted among federal agencies within HHS and is included in the CLAS Standards. *[provide copy of definition]*

- How applicable is the OMH definition in family planning settings?
- Are there important components you think are relevant and missing?

V. Assessing Cultural Competence

9. What organizational factors influenced your decision to prioritize cultural competence?

VI. Implementing Strategies: Knowledge of and Engagement with Community

Addressing Community Needs

10. What are the challenges associated with identifying and addressing community needs?

11. What approaches and strategies has your program used to identify and address community needs?
- What were strategies based on (e.g. research, another program, EBP)? What led you to believe they would be effective?
 - Which staff were most involved in implementing this strategy?
 - What information and resources did you use to implement this strategy?
 - What positive outcomes have you seen as a result of this approach/strategy?
 - What factors have made it successful?
 - How do you know? How was it assessed?
 - What were the barriers to implementation?
 - How will your program be able to sustain this strategy?
 - How has this strategy been fully integrated into your program?
 - How easily can another program replicate your approach?

12. What are the challenges associated with collaboration with community partners and engaging community members in program development?

Collaborating with Community Partners

13. What approaches and strategies has your program used to develop collaborative community partnerships and promote community participation in service development?
- Which staff were most involved in implementing this strategy?
 - What information and resources did you use to implement this strategy?
 - What positive outcomes have you seen as a result of this approach/strategy?
 - What factors have made it successful?
 - How do you know? How was it assessed?
 - What were the barriers to implementation?
 - How will your program be able to sustain this strategy?
 - How has this strategy been fully integrated into your program?
 - How easily can another program replicate your approach?

VII. Implementing Strategies: Organizational Capacity

Clinical Environment

14. Have you made any physical changes to the clinical office to provide a more welcoming space to clients of diverse backgrounds?
- Are the pictures and art on the walls reflective of the client population?

- Are written materials on the walls and information boxes translated into multiple languages?
- Are there adequate provisions in the clinical offices to ensure patient privacy?

Policy Development

15. What are the challenges associated with developing policies that support culturally competent encounters?

16. What approaches and strategies has your program used to develop policies that support culturally competent encounters?
 - Which staff were most involved in implementing this strategy?
 - What information and resources did you use to implement this strategy?
 - What positive outcomes have you seen as a result of this approach/strategy?
 - What factors have made it successful?
 - How do you know? How was it assessed?
 - What were the barriers to implementation?
 - How will your program be able to sustain this strategy?
 - How has this strategy been fully integrated into your program?
 - How easily can another program replicate your approach?

Strategic Planning

17. What are the challenges associated with developing a written strategic plan that addresses the provision of culturally and linguistically appropriate services?

18. Has your program prepared a written strategic plan that addresses the provision of culturally competence services?
 - Which staff were most involved in implementing this strategy?
 - What information and resources did you use to implement this strategy?
 - What positive outcomes have you seen as a result of this approach/strategy?
 - What factors have made it successful?
 - How do you know? How was it assessed?
 - What were the barriers to implementation?
 - How will your program be able to sustain this strategy?
 - How has this strategy been fully integrated into your program?
 - How easily can another program replicate your approach?

Self Assessment

19. What are the challenges associated with conducting a cultural competency assessment?

20. Related to cultural competence, has your program conducted a self-assessment?
 - What specific measures did you assess?
 - At the community level?
 - At the organizational level?
 - At the provider and staff level?

- What information and resources did you use to implement this strategy?
 - Did you use any frameworks or tools during the process? Please describe.
- What was worked well about the process? Would you recommend any modifications?
- Did you receive any type of assistance with the self assessment?
- Who participated in the process? In what ways? How receptive were they to the process?
- In what ways, if any, has the assessment been useful to you?
- What factors have made it successful?
- How do you know? How was it assessed?
- In what ways, if any, have you followed up on the assessment?
- What were the barriers to implementation?
- How easily can another program replicate your approach?

Data Collection

21. What are the challenges associated with collecting and using client demographic data?
22. What approaches and strategies has your program used to collect and use demographic data on your client population?
- Which staff were most involved in implementing this strategy?
 - What information and resources did you use to implement this strategy?
 - What positive outcomes have you seen as a result of this approach/strategy?
 - What factors have made it successful?
 - How do you know? How was it assessed?
 - What were the barriers to implementation?
 - How will your program be able to sustain this strategy?
 - How has this strategy been fully integrated into your program?
 - How easily can another program replicate your approach?

Recruiting and Retaining Diverse Staff

23. What are the challenges associated with recruiting and retaining a diverse staff?
24. What are your perceptions of the diversity of the staff?
25. What approaches and strategies has your program used to recruit and retain a diverse staff?
- Which staff were most involved in implementing this strategy?
 - What information and resources did you use to implement this strategy?
 - What positive outcomes have you seen as a result of this approach/strategy?
 - What factors have made it successful?
 - How do you know? How was it assessed?
 - What were the barriers to implementation?
 - How will your program be able to sustain this strategy?
 - How has this strategy been fully integrated into your program?
 - How easily can another program replicate your approach?

26. What are the challenges associated with training and educating Title X staff on the delivery of culturally competent services?
27. What approaches and strategies has your program used to train and educate staff on the delivery of culturally competent services?
- Which staff were most involved in implementing this strategy?
 - What positive outcomes have you seen as a result of this approach/strategy?
 - What factors have made it successful?
 - How do you know? How was it assessed?
 - What were the barriers to implementation?
 - How will your program be able to sustain this strategy?
 - How has this strategy been fully integrated into your program?
 - How easily can another program replicate your approach?
28. Do you have other examples of specific efforts your program has undertaken that have been effective in addressing cultural competency?

IX. Implementing Strategies: Improving Access for Individuals with Limited English Proficiency (LEP)

29. What are the challenges associated with improving access for individuals with limited English proficiency?
30. What approaches and strategies has your program used to improve access for individuals with limited English proficiency?
- Process in place for providing language services?
 - Providing training and ensuring the competency of interpreters?
 - Having materials and signage available in the most commonly encountered languages?
 - Which staff were most involved in implementing this strategy?
 - What positive outcomes have you seen as a result of this approach/strategy?
 - What factors have made it successful?
 - How do you know? How was it assessed?
 - What were the barriers to implementation?
 - How will your program be able to sustain this strategy?
 - How has this strategy been fully integrated into your program?
 - How easily can another program replicate your approach?

X. Challenges, Barriers, and Gaps in Implementing Strategies for Cultural Competence

31. Overall, what would you identify as the greatest challenges to your programs trying to improve the delivery of culturally competent services?
32. Related to cultural competency, in what areas would you like additional training?
33. In what ways can the regional and Federal Title X administrators support your efforts?

XI. Innovative Strategies, Promising Strategies, Lessons Learned

34. What lessons have you learned from your efforts?
 - How can these lessons be shared with other Title X-funded programs?
35. Thinking about the strategies you discussed today, which would you identify as most promising and innovative?
 - Why?
36. Before we end today, is there anything I have not asked that you feel is important to understand about the implementation of culturally competent care?

Thank you again for your time and insights.

Interview Protocol for Staff/Providers

Title X-Funded Clinics

I. Background

Thank you for agreeing to participate in this interview to assist us in our examination of cultural competence in Title X-funded programs. My name is _____ and I am here with my colleague _____ and we work for Altarum Institute and are based in Washington, DC. Our company was selected by the Office of Population Affairs, Office of Family Planning (OFP) to conduct an assessment of strategies for providing culturally competent care in family planning clinics. This information will be used to assist OFP in:

- Defining cultural competency within the Title X context
- Documenting the current strategies implemented – as well as the barriers, challenges, and gaps – by Title X family planning clinics to provide culturally competent care
- Highlighting innovative strategies and defining best practices for the development of training curricula
- Informing the development of a national strategy to support Title X providers in addressing culturally competent service delivery and reducing health disparities.

The information collected during the site visits will be used to prepare a summary report.

Before we begin, I would like to review a few details about our discussion:

- The interview will last approximately one hour. If you need to discontinue the interview before the end of the hour, let me know.
- The information you share is confidential. After we conduct all of the site visits, a summary report will be submitted to Office of Family Planning. Your name will not appear anywhere in the report and what you say today will not be attached to your name at any point. Nothing you say will affect your current position or eligibility for Title X funding and your clinic will not be identified.
- Please tell me your opinions. I work for an independent contractor and don't have a vested interest in anything that is said during the interview.
- The interview is being audiotaped so that we don't miss anything important you tell us. Therefore, please speak loudly. (can opt out)

II. Introductions

I would like to start by asking you some questions about your role at this clinic/program.

1. Please tell me your job title and how many years you have served in this role.
2. How would you describe your training or experience relevant to your current role?

III. Role of Culture and Defining Cultural Competence

3. How do culture and language influence clients' ability to access and utilize family planning services?

- Are there additional cultural considerations that are specific to family planning settings and OFP's goals of reducing the incidence and prevalence of unintended pregnancies, STDs, and HIV?

IV. Implementing Strategies: Organizational Capacity

Policy Development

4. What are the challenges associated with developing policies that support culturally competent encounters?

5. What approaches and strategies has your program used to develop policies that support culturally competent encounters?

- What positive outcomes have you seen as a result of this approach/strategy?
- What factors have made it successful?
- How do you know? How was it assessed?
- What were the barriers to implementation?
- How were you involved in implementation?
- Did you feel well equipped to participate? Why?

Strategic Planning

6. What are the challenges associated with developing a written strategic plan that addresses the provision of culturally and linguistically appropriate services?

7. Has your program prepared a written strategic plan that addresses the provision of culturally competence services?

- What positive outcomes have you seen as a result of this approach/strategy?
- What factors have made it successful?
- How do you know? How was it assessed?
- What were the barriers to implementation?
- How were you involved in implementation?
- Did you feel well equipped to participate? Why?

Self Assessment

8. What are the challenges associated with conducting a cultural competency assessment?

9. Related to cultural competence, has your program conducted a self-assessment?

- In what ways, if any, has the assessment been useful to you?
- What factors have made it successful?
- What were the barriers to implementation?

- How were you involved in the assessment?
- Did you feel well equipped to participate? Why?

Data Collection

10. What are the challenges associated with collecting and using client demographic data?
11. What approaches and strategies has your program used to collect and use demographic data on your client population?
- What positive outcomes have you seen as a result of this approach/strategy?
 - What factors have made it successful?
 - How do you know? How was it assessed?
 - What were the barriers to implementation?
 - How were you involved in implementation?
 - Did you feel well equipped to participate? Why?

Recruiting and Retaining a Diverse Staff

12. What are the challenges associated with recruiting and retaining a diverse staff?
13. What are your perceptions of the diversity of the staff?
14. What approaches and strategies has your program used to recruit and retain a diverse staff?
- What positive outcomes have you seen as a result of this approach/strategy?
 - What factors have made it successful?
 - How do you know? How was it assessed?
 - What were the barriers to implementation?
 - How were you involved in implementation?
 - Did you feel well equipped to participate? Why?

V. Implementing Strategies: Improving Provider and Staff Capacity

Overview of Provider and Staff Training

15. What are the challenges associated with training and educating Title X staff on the delivery of culturally competent services?
16. What approaches and strategies has your program used to provide culturally competent training?
- What positive outcomes have you seen as a result of this training?
 - What factors have made them successful?
 - How do you know? How was it assessed?
 - What were the barriers to implementation?
 - How were you involved in implementation?
 - Did you feel well equipped to participate? Why?

- What are you doing differently as a result of the training you received?

VI. Implementing Strategies: Outreach to Community Partners and Prospective Clients

QUESTIONS FOR OUTREACH STAFF

Identifying Community Needs

17. How important do you feel it is for the outreach staff to be representative of the client populations served? Do you think that outreach staff at your facility are representative of the client population?

Probe for the following areas:

- Race/ethnicity
- Language Spoken
- Country of origin
- Gender

18. What are the challenges associated with identifying and addressing community needs?

19. What approaches and strategies has your program used to identify community needs (e.g. collect community data, community forums) related to family planning services?

- Were you able to collect an adequate and accurate level of information to assess community needs?
- What were the community's major needs for family planning services? Do these needs differ by population group?
 - What positive outcomes have you seen as a result of this approach/strategy?
- What factors have made it successful?
- How do you know? How was it assessed?
- What were the challenges associated with identifying community needs? How have you overcome these challenges?
- How were you involved in implementation?
- Did you feel well equipped to participate? Why?

Collaborating with Community Partners

20. What approaches and strategies has your program used to reach out to community partners?

- What types of community partners have you reached out to? Which populations do these partners represent?
- What role have community partners played in helping to deliver more culturally competent family planning services at your clinics?
- How have you maintained communication and engagement with community partners?
- What positive outcomes have you seen as a result of this approach/strategy?
- What factors have made it successful?
- How do you know? How was it assessed?
- How were you involved in implementation?
- Did you feel well equipped to participate? Why?
- What were the challenges of collaborating with community partners and engaging community members in delivering culturally competent care?

Population Outreach

21. How have you instituted any strategies to identify and reach out to diverse prospective family planning clients in a culturally competent manner?

- Have outreach staff receiving training on culturally competent outreach?
- Is cultural competence training provided as part of orientation for new outreach staff?
- Is ongoing cultural competence training provided to existing outreach staff?
- How successful have culturally competent outreach efforts been? How do you know this?

22. What are the challenges associated with identifying and reaching out to diverse prospective clients? Have the challenges been greater for some population groups than others?

23. Overall, what would you describe as the biggest barriers to delivering culturally competent education services?

Training for Outreach Staff

24. Have outreach staff received training on conducting culturally competent community outreach?

- Is cultural competence training provided as part of orientation for new outreach staff?
- Is ongoing cultural competence training provided to existing outreach staff?
- Has communication between outreach staff and clients improved? Do prospective clients feel more comfortable asking staff questions about available family planning services? How do you know this?
- Have outreach staff become more comfortable conducting outreach to diverse populations? How do you know this?
- How effective has cultural competence training for outreach staff been? In what ways has the cultural competency training improved outreach services?
- Have community members reported greater satisfaction with outreach staff?
- Have there been any challenges to providing training? How have you overcome these challenges?

VII. Implementing Strategies: Client Education

QUESTIONS FOR EDUCATION STAFF

Overview of Client Education

25. How important do you feel it is for the outreach and education staff to be representative of the client populations served? Do you think that outreach and education staff at your facility are representative of the client population?

Probe for the following areas:

- Race/ethnicity
- Language Spoken
- Country of origin
- Gender

26. Have strategies been implemented to make client education more culturally competent?

- What changes were made to client education?
- What topics were covered? What curricula were used?
- Why were these changes made?
- Do these curricula and materials address the needs of patients with low literacy and visual impairments?
- Have these curricula and materials been tailored to specific population groups?
- How have these curricula and materials been received by patients?

Training for Education Staff

27. Have education staff received training on culturally competent client education?

- Is cultural competence training provided as part of orientation for new education staff?
- Is ongoing cultural competence training provided to existing outreach/education staff?
- Has communication between outreach/education staff and clients improved? Do clients feel more comfortable asking staff questions about the education they receive? How do you know this?
- Have outreach/education staff become more comfortable delivering education to diverse populations? How do you know this?
- How effective has cultural competence training for education staff been? In what ways has the cultural competency training improved education services?
- Have clients and community members reported greater satisfaction with outreach/education staff?
- Have there been any challenges to providing training? How have you overcome these challenges?

VII. Implementing Strategies: Clinical Care

QUESTIONS FOR CLINICAL PROVIDERS

Overview of Clinical Care

28. How important do you feel it is for the clinical staff to be representative of the client populations served? Do you think that clinical staff at your facility are representative of the client population?

- Race/ethnicity
- Language Spoken
- Country of origin
- Gender

29. Overall, what would you describe as the biggest barriers to effective interactions between clinical providers and family planning clients at your clinics?

Training for Clinical Providers

30. Have clinical staff received training on culturally competent interactions with patients? Is this training offered to all clinical staff (e.g. doctors, nurses, nurses' assistance, lab technicians)?

Probe for the following areas:

- What topics were covered? What curricula was used?

- Is cultural competence training provided as part of orientation for new clinical staff?
- Is ongoing cultural competence training provided to existing clinical staff?
- Have there been any challenges to providing training? How have you overcome these challenges?

31. In what ways has the cultural competency training impacted clinical encounters?

Probe for the following areas:

- Has communication between clinical providers and clients improved? Do clients feel more comfortable asking providers questions about clinical care? How do you know this?
- Have clinical providers become more comfortable interacting with diverse populations? How do you know this?
- Has the quality of family planning care improved for clients (compliance with contraception, more frequent STI testing, all necessary services provided)? How do you know this?
- Have clients reported greater satisfaction with clinical providers?

32. Has this training led to other changes to improve clinical encounters?

- Have you instituted new clinical encounter assessment forms or made changes to existing forms to help improve the quality of communication with diverse patients?

Additional probes

What types of information do these form(s) collect?

Have clinical staff received training on how to use these forms?

Has this training improved communication with clients? Has this training improved the quality of family planning care for clients? How do you know this?

Have there been any challenges to integrating these new forms into clinical encounters? How have you overcome these challenges?

33. Have you created new patient education materials for use specifically during clinical encounters?

Additional probes

- What types of materials have been created?
- Have clinical staff been briefed about these new materials and how to integrate them into clinical encounters?
- Do these materials address the needs of patients with low literacy and visual impairments?
- How have these materials been received by patients?

VIII. Implementing Strategies: Improving Access for Clients with Limited English Proficiency (LEP)

Questions for ALL Staff

34. What are the challenges associated with improving access for individuals with limited English proficiency?

35. What approaches and strategies has your program used to improve access for individuals with limited English proficiency?

Probe for the following areas:

- Process in place for providing language services?
- Providing training and ensuring the competency of interpreters?
- Having materials and signage available in the most commonly encountered languages?
- What positive outcomes have you seen as a result of these approaches and strategies?
- What factors have made them successful?
- How do you know? How was it assessed?
- What were the barriers to implementation?
- How were you involved in implementation?
- Did you feel well equipped to participate? Why?

Questions for Outreach Staff

36. What are the challenges associated with conducting outreach to prospective clients with limited English proficiency?

37. What approaches and strategies has your program used to improve outreach to clients with limited English proficiency?

- Language assistance services (access to bilingual staff, certified interpreters, language banks)?
- Translation of written outreach materials?
- Training for outreach staff to ensure effective utilization of language assistance services?
- What positive outcomes have you seen as a result of these approaches and strategies?
- What factors have made them successful?
- How do you know? How was it assessed?
- What were the barriers to implementation?
- How were you involved in implementation?
- Did you feel well equipped to participate? Why?

Questions for Outreach Staff

38. What are the challenges associated with delivering education to clients with limited English proficiency?

39. What approaches and strategies has your program used to improve delivery of education to clients with limited English proficiency?

- Language assistance services (access to bilingual staff, certified interpreters, language banks)?
- Translation of written outreach materials?
- Training for outreach staff to ensure effective utilization of language assistance services?
- What positive outcomes have you seen as a result of these approaches and strategies?
- What factors have made them successful?
- How do you know? How was it assessed?
- What were the barriers to implementation?
- How were you involved in implementation?

- Did you feel well equipped to participate? Why?

Questions for Clinical Staff

40. What are the challenges associated with interactions between clinical staff and clients with limited English proficiency?

41. What approaches and strategies has your program used to improve clinical encounters with individuals with limited English proficiency?

- Language assistance services (access to bilingual staff, certified interpreters, language banks)?
- Training for clinical staff to ensure effective utilization of language assistance services?
- What positive outcomes have you seen as a result of these approaches and strategies?
- What factors have made them successful?
- How do you know? How was it assessed?
- What were the barriers to implementation?
- How were you involved in implementation?
- Did you feel well equipped to participate? Why?

VIII. Achievements and Challenges in Implementing Strategies for Cultural Competence

42. What would you describe as your program's greatest achievements related to cultural competence?

- In improving clinical providers' ability to deliver culturally competent care to clients?

43. Overall, what would you identify as the greatest challenges to the provision of culturally competent clinical care?

IX. Opportunities to Enhance Strategies for Cultural Competence

44. Related to cultural competency, in what areas would you like additional training?

45. In what ways can the regional and Federal Title X administrators support your efforts?

X. Closing

46. Before we end today, is there anything I have not asked that you feel is important to understand about the implementation of culturally competent care?

Thank you again for your time and insights.

Focus Group Protocol for Clients

Title X-Funded Clinics

I. Background

Welcome to our group discussion. Thank you for taking the time to participate in today's discussion about family planning services. My name is _____ and I am here with my co-worker _____ and we work for Altarum. We are from Washington, DC and our company is helping the Office of Family Planning to learn more about your experience receiving services, here at _____ clinic.

This discussion is called a "focus group". The purpose of focus groups is to get the honest opinions of small groups of people about a specific topic. We want to hear your experiences and opinions about the services you have received in this program (either alone or with your partner) and how you think the services can be improved. Your comments will be used to help improve the types and kinds of services that are available.

- FOR CLINICS FOCUSED ON HIV RISK REDUCTION-- Just because we are discussing the topic of HIV does not mean that we are assuming anyone here is HIV positive or at-risk for becoming HIV positive. However, if anyone here is HIV positive, please do not feel like you have to reveal this information during the discussion. Everything you say today will be kept private.

Before we begin, I would like to review a few details about our discussion:

- There are no right and wrong answers. Remember that I don't work for the clinic or for the Office of Family Planning, so please feel free to share your thoughts, whether they are positive or negative.
- It is ok to disagree with one another. We want to hear everyone's point of view. If you disagree, please do so respectfully.
- Your participation in tonight's focus group is voluntary. You are free to leave at any time.
- Only one person should talk at a time. We are tape recording this session so that we don't miss anything important. If two people talk at once, we can't understand what anyone is saying. I may remind you of this during the group.
- I would like everyone to participate. But, you each don't have to answer every question. You don't have to raise your hand either. If, however, some of you are shy or I really want to know what you think about a particular question, I may call on you.
- I have a lot that I want to talk about today. So, don't be surprised if at some point I interrupt the discussion and move to another topic. But, don't let me cut you off. If there is something important you want to say, let me know and you can add your thoughts before we change subjects.

- We will be using first names only today. Everything you say is private. After we conduct several of these group discussions across the country, we will write a report for the Office of Family Planning. Your name will not appear anywhere in the report. We also ask that you don't tell other people what was said by anyone during the group. What you say today will not be attached to your name at any point. *Nothing that you say will affect your eligibility for the services you may receive at the clinic.*
- Don't worry about offending me. I work for an independent contractor and don't have a vested interest in anything that is said during the interview. I really want to learn from you and find out what you think about the issues we talk about tonight. Therefore, I encourage you to please tell me all of your opinions.

Read consent form aloud and ask participants if they have any questions. Ask them to sign the forms.

The group will last an hour. We will finish by _____. If you need to leave for a restroom break, the bathrooms are _____.

Do you have any questions before we start?

II. Introductions

Let's get started. I'd like to start out by going around the table and having each of you tell us a little about yourself. Please share your first name and what your favorite television show is. I'll start.

1. My name is_____.
2. My favorite t.v. show is _____.

III. Interview Questions

A. Perceptions of Title X Clinic: General

1. How did you hear about this clinic?
 - What did you hear about this program?
2. Why did you choose this clinic?
3. How easy is it to get services here?
4. Are there any things that make it difficult to use services offered at this clinic?
5. How comfortable are you coming to this clinic for services?
 - What about this clinic setting makes you feel comfortable?

- What might make you feel uncomfortable?
- What changes would make you feel more comfortable about coming here for health services?

B. Perceptions of Title X Staff: General

6. How would you describe your experiences with the clinic staff?

Probe for:

- Receptionist?
- Medical staff (e.g. doctors, nurses)?
- Education and counseling staff?
- Other staff?

7. What made it a good experience?

8. What made it a bad experience?

9. How well do you think the clinic staff understands you and your health care needs?

- How do they show you that they understand your health concerns (verbal and nonverbal)?
- What makes you feel they don't understand your health concerns?
- Are you able to talk with them about your health concerns?

C. Implementing Strategies for Cultural Competence: Impact of Culture

[Refer to the culture wheel]

11. Do you feel your culture influences your health needs or concerns?

- If so, in what ways?
- If not, why?
- How does your culture impact the family planning/reproductive health services you use at this clinic?

12. How well do the staff here at the clinic represent your cultural background?

- Is this important to you?
- How does it impact the services they provide?

13. How well do you think the staff at this clinic understands your culture?

- How do you know?
- How important is this to you?

14. Do you feel your cultural beliefs are considered during your visits?

- If so, in what ways?
- If not, why?
- How do you know?
- Do you feel your cultural beliefs are valued?

15. Has anyone here at this clinic ever asked you about your cultural beliefs during a visit?

- If so, please describe

C. Implementing Strategies for Cultural Competence: Literacy and Language

16. Is there health information that is available to you (e.g. posted in the clinic or in the waiting room)?

- Can you relate to the people or stories?
- Is it written in a way that you can understand it?
- Is it available in your preferred language?
- Is there someone available to answer any questions you might have?

17. Do you feel you can communicate well during your appointments?

- What makes it difficult?
- What would make it easier to communicate with the staff?

[Ask for show of hands]

18. How many of you prefer to receive services in a language other than English?

19. Has anyone here ever needed an interpreter at this clinic?

- Did you make a request to a staff member?
- How did the process work?
- What was your experience using the interpreter?

20. For those of you that needed an interpreter but did not have one, how did you communicate during your visit?

- Did you have difficulty communicating with staff?
- Were you able to ask questions?
- How well did you understand what the nurses or doctors were telling you?
- Was there information provided to you in your preferred language?

21. Have you ever used a family member or friend to interpret during a visit at this clinic?

- What was that experience?
- How comfortable are you using family members or friends to interpret during clinic visits?

IV. Closing

Thank you very much for participating in this focus group. We have learned a lot about the services that are provided at the clinic and some of the key issues or concerns you have.

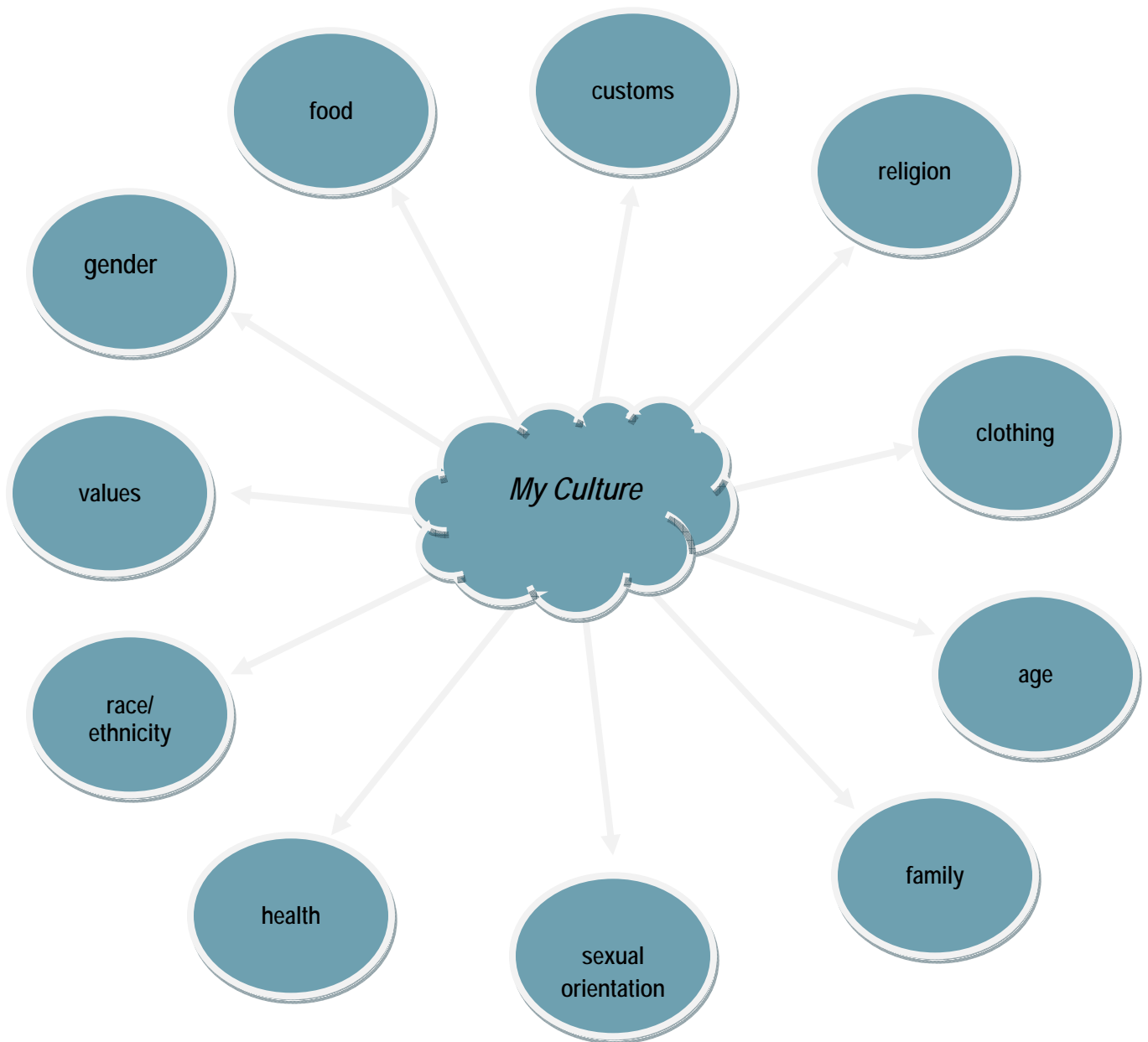
22. This clinic is very interested in providing services that are culturally appropriate and culturally competent.

- Are these terms familiar to you? Where have you heard them?
- What do these terms mean to you?
- How would you make services at this clinic more culturally competent?

23. Before we end today, is there anything you'd like to share about your experience receiving services at this clinic?

Thank you again for your time and the information you provided.

Culture Wheel



Adapted from Global Citizenship & Youth Philanthropy:
http://www.globalkidsconnect.org/activities/culture_lesson.doc

Appendix D. Annual Grantee Conference Presentation

<<insert PowerPoint presentation from Grantee Meeting>