



Delaware Standards for Culturally and Linguistically Appropriate Services in Health Care (CLAS) Initiative

*The Delaware Healthy Mothers and Infants Consortium
Health Disparities Subcommittee*

Final Report



**Prepared by Sandra Silva, Sheryl Mathis, and Jamie Hart
Altarum Institute
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Introduction

In 2005, the state legislature created the Delaware Healthy Mother and Infant Consortium (DHMIC) to narrow and/or eliminate racial and ethnic prenatal care differences. DHMIC's mission is to provide statewide leadership and coordination of efforts to prevent infant mortality and improve the health of women of childbearing age in Delaware.

DHMIC's Health Disparities Subcommittee is charged with developing a plan for implementation of Culturally and Linguistically Appropriate Services (CLAS) standards in Delaware. It sought input from consumers and health care practitioners (nurses, nurse practitioners, physician assistants, and physicians) throughout the state to inform development of the plan and priority steps for implementation. With support from the State Division of Public Health, the subcommittee contracted with Altarum Institute, a non-profit research and consulting firm, to collect and synthesize the feedback. Altarum Institute staff met with the subcommittee in November to finalize the research questions and data collection plan.

Specifically, the subcommittee identified the topics listed below as key areas in which more information is needed from health services providers and consumers. This topic list was used to inform development of the data collection activities and protocols.

Topics to be explored with health services providers follow:

- Awareness of standards currently being implemented and how implementation is measured
- Participation in cultural competency training and perception of its importance
- Perceptions about barriers to implementation of cultural and linguistically appropriate care
- Incentives or resources they believe they need to support implementation

Topics to be explored with (adult female) health services consumers follow:

- What good provider service looks like
- Perceptions about how they are being treated by providers of care
- How this treatment affects their desire to return or continue their care
- Perceptions of what could be better
- Perceptions of empowerment (e.g., ability to negotiate the system, health literacy)
- How consumers access health-related information
- Awareness of messaging about preconception and interconception care, the importance of health and physical activity, the source of messages, and more
- Which criteria consumers use to select a health care provider

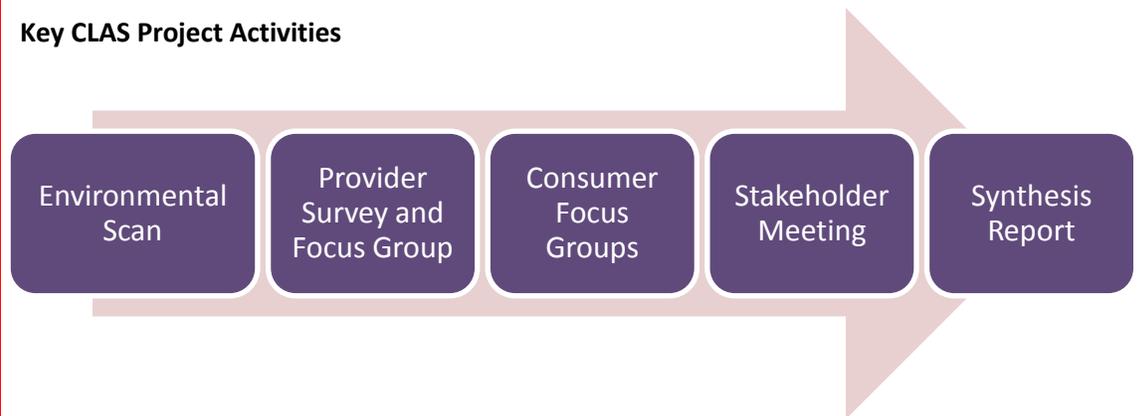
To this end, DHMIC contracted with Altarum to undertake the following activities:

- Conduct a limited environmental scan using key existing reports and recent data collection efforts related to cultural and linguistic competency, as identified by subcommittee members, to inform the data collection effort
- Administer a brief Web-based survey with providers serving the maternal and child health (MCH) population and conduct a focus group with providers to collect information about cultural and linguistic policies and practices within their organization or practice
- Conduct focus groups with consumers to learn more about the health care experiences of women throughout state and their perceptions about appropriate care

Following the data collection efforts, a meeting of MCH stakeholders was planned to develop a common understanding of the CLAS-related priority issues based on the findings from the data collection, to develop recommendations for adapting and implementing cultural competency standards; and to prioritize the recommendations.

This document presents the key findings of the data collection efforts and stakeholder meeting, which will be used by the subcommittee, to inform development of a plan for implementing standards for culturally and linguistically appropriate care for women, infants, and their families. The report is organized by the project activities listed below.

Key CLAS Project Activities



A Health Disparities Snapshot

Delaware is the second smallest state but has the fifth highest infant mortality rate in the nation at 8.8 deaths per 1,000 live births.¹ The infant mortality rate is significantly higher among African-American infants, ranging from twice to nearly thrice that of Caucasian infants.² Figure 1 presents these rates by race and county.

Figure 1. Infant Mortality Rates by Race and County for Delaware, 2002–2006

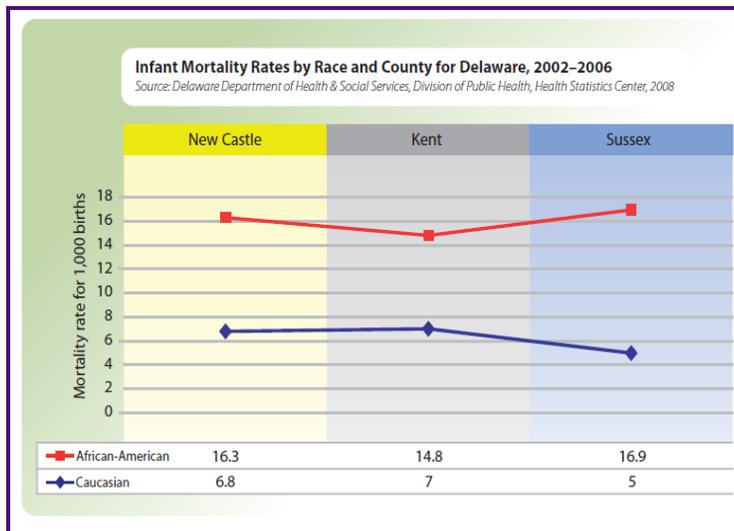
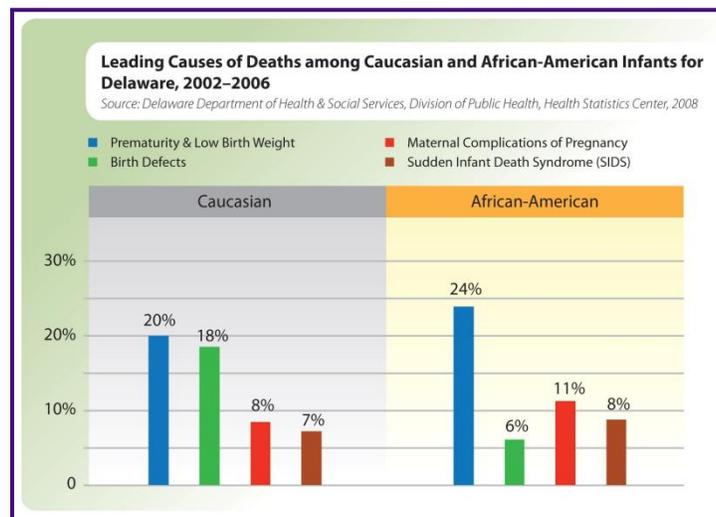


Figure 2. Leading Causes of Deaths among Caucasian and African-American Infants for Delaware, 2002–2006



The most common causes of infant mortality among Caucasians and African-Americans were prematurity and low infant birth weight. The following are other factors that impact infant mortality:

- Inadequate health care services
- Lack of health insurance coverage
- Lack of access to appropriate health care services
- Maternal attitudes
- Sociocultural variables
- Inadequate access to early prenatal care³

For African-Americans, the second leading cause was maternal complications in pregnancy, which can be prevented.⁴ Researchers have found that early

initiation of prenatal care can improve maternal outcomes by promoting healthy behaviors, identifying risk factors, treating complicating conditions, and making other needed referrals.⁵ Efforts to reduce racial and ethnic disparities have emphasized the provision of culturally and linguistically appropriate care, but the women most likely to benefit from early prenatal care are the least likely to receive it and have reported a range of barriers, including lack of insurance, difficulty in obtaining transportation, and difficulty in getting an appointment or finding a provider.⁶

A Health Capacity Snapshot

There are 83 practicing OB/GYNs in Delaware:

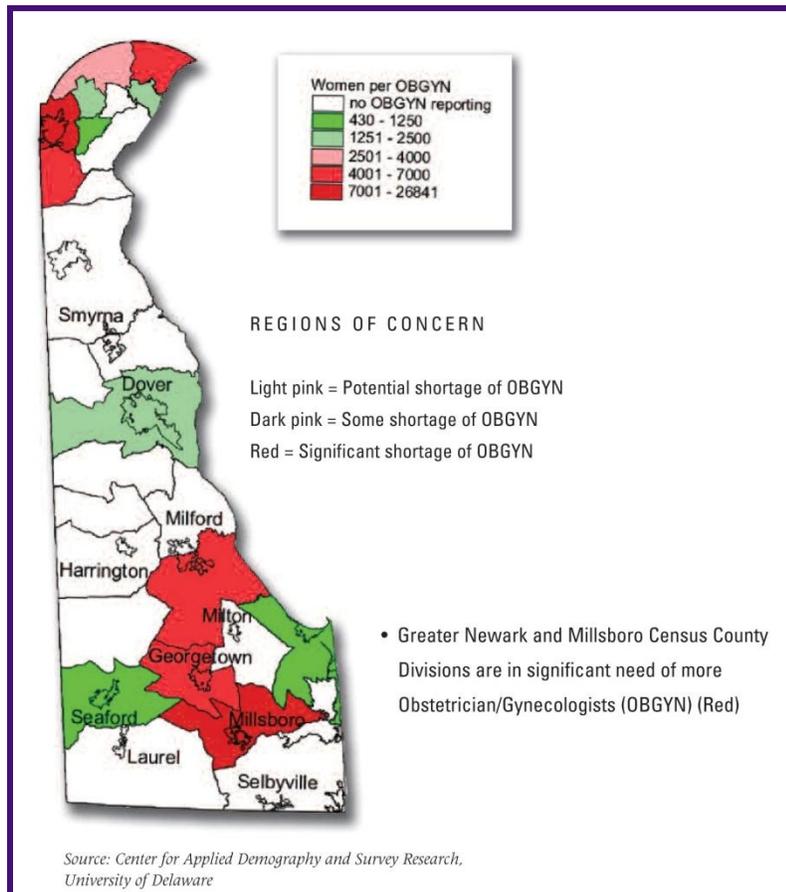
64% practice in New Castle

22% practice in Sussex

14% practice in Kent⁷

Delaware Health and Social Services' Division of Public Health/Bureau of Health Planning and Resources Management commissioned the University of Delaware/Center for Applied Demography and Survey Research to compile the Primary Care Physicians in Delaware 2008 capacity study. This report assessed the supply and distribution of primary care providers in Delaware. The report found that 7 out of 27 Census County Divisions (26%) have a potential shortage, some shortage, or significant shortage of primary care physicians.⁸ Of 737 full-time practicing primary care physicians, only 11% (83) are obstetricians/gynecologists (OB/GYNs).⁹ As Figure 3 illustrates, Kent and Sussex counties are the most underserved in OB-GYN practice sites, with many Census County Divisions having no OB/GYN practice to report. This is true for 14 of the 27 Census County Divisions in the state. The most overburdened practices are in the Millsboro and Greater Newark Census County Divisions, with a range of 7,001 to 26,841 women per OB/GYN.¹⁰

Figure 3. Regions of Concern for OB/GYN Shortage



The provider shortage creates a real barrier for women seeking OB/GYN services. Other barriers include limited provider Medicaid participation and travel distance. Pregnant and postpartum women reported using mobile clinic services or having to travel to access care at community clinics and hospitals. OB/GYNs tend to be located near hospitals, which mean longer travel distances for women seeking OB/GYN services.¹¹

Insurance coverage—or lack of it—limit care options, especially for women who are unable to find a provider that accepts Medicaid.^{12, 13} This is consistent with a finding from the Perceived Discrimination Study, which found that lack of coverage delayed initiation of prenatal care by 4.3 weeks.¹⁴

34% of primary care physicians were not accepting new Medicaid patients.¹⁵

27% of OB/GYN physicians were not accepting new Medicaid patients.¹⁶

Cultural Competency and Providers in Delaware

Cultural and linguistic competence is defined as a set of behaviors, attitudes, and policies that enables effective work in cross-cultural situations. "Culture" refers to 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 the Office of Minority Health Web site)

The Delaware Department of Health and Social Services (DHSS) commissioned focus groups with health care providers in 2008 to assess their perception of the growth of diverse populations, including the effect of that growth on the delivery of care, and to identify strategies for meeting the demands of a growing diverse population. Providers are seeing an increasingly diverse caseload and, despite limited resources, are challenged to meet the needs of their most vulnerable populations.

To gather additional information from a larger sample of health care providers, Altarum administered a Web-based survey. The survey link was forwarded to members of the Delaware American Academy of Pediatrics and Delaware Medical Society, as well as the following provider groups:

- Federally Qualified Health Centers
- Title X programs within the state
- Conrad-30/J-1 visa providers
- School-based wellness providers
- Infant mortality contract providers
- Hospitals

The survey was distributed in February 2010 and completed by 100 providers. The respondents were primarily physicians and nurses as shown below in Figure 4. Information was collected about training received, barriers and facilitators to improving cultural and linguistic competency and the policies implemented around it. There were no major differences in the responses from physicians versus nurses (survey instrument and data tables are included in Appendices A and B, respectively).

Figure 4. Provider Survey Demographics (N = 100)

Profession

Physicians	48%
Nurse practitioners and nurse specialists	46%
Other	6%

Practice Setting

Community-based settings and health centers	37%
Hospitals and universities	35%
Private practice	23%
Other settings	10%

Providers in Delaware define “diversity” broadly—in terms of religion, race, ethnicity, language, age, health beliefs, socioeconomic status, gender, and gender dynamics.^{17, 18}



In all, 89% of respondents felt it was very or somewhat important for health providers to receive training in cultural diversity and/or multicultural health care.²²

Following completion of the survey and a preliminary analysis of the data, Altarum conducted a focus group with health care providers to explore findings of the survey in more depth (Protocol included in Appendix C). The provider focus group included five participants who represented a range of practice settings, including private practice, hospital, and public health settings. The summary below reflects data from both the survey and the focus group.

Policies and Practices

Providers identified language access policies and practices (approaches taken to provide services for individuals with limited English proficiency) as the CLAS-related policy most commonly developed in their practices. This corroborates statements made by providers that participated in the Altarum-led focus group and findings in the 2008 DHSS Cultural Competency Training Report, in which providers identified linguistic competency as an important policy for their practices.¹⁹ In that report, physicians reported that they wanted to have bilingual staff, and some practices and centers even offered Spanish classes for staff. In the Altarum provider focus group, all health care providers reported using language lines for interpretation by phone.²⁰

Policies and practices in place related to the following domains²¹:

Language access policies and practices

Defined as approaches taken to provide services for individuals with limited English proficiency **91%**

Provider and staff policies and practices

Defined as implementing approaches to develop the knowledge, skills, and ability of all staff members to understand and address the needs of diverse populations **75%**

Organizational policies and practices

Defined as incorporating cultural competence into the organizational mission, planning, policymaking, and infrastructure activities within the health care organization or practice **74%**

Community-focused policies and practices

Defined as engaging community members and community partners, and using knowledge of a community to inform decisions within your health care organization or practice **67%**

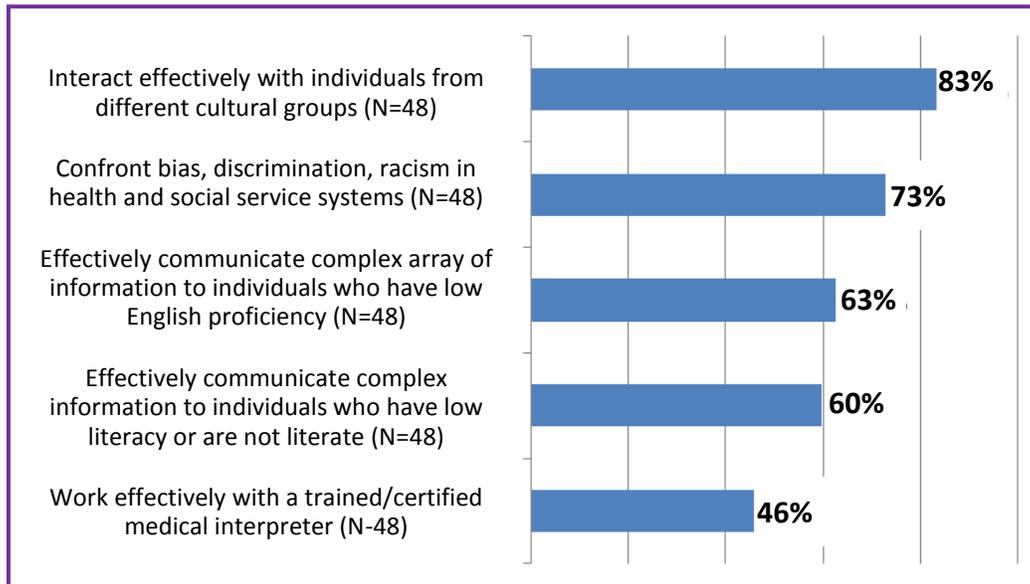
Providers were also asked about the extent to which these policies and practices are monitored or evaluated. Few (9%) reported that policies and practices were monitored and evaluated to “a great extent”, while 37% of respondents were unaware if any monitoring or evaluation was taking place in their practice.²³

When asked about the best format for training, providers felt that multiple formats (e.g., Web-based modules, in-person group sessions, video conferencing) should be used and stressed the benefit of having opportunities to learn from their peers.²⁶

Cultural Competency Training

Health care providers who participated in the 2008 focus groups recommended provider education and suggested that education on cultural and linguistic competency would be most beneficial if provided during medical residency.²⁴ Half the survey respondents (51%) reported participating in cultural competency trainings or educational opportunities within the past 12 months.²⁵ Respondents reported the following benefits (Figure 5) of participating in cultural competence training and professional development activities.

Figure 5. Benefits of Cultural Competency Training and Education



Source: Altarum Provider Survey, 2010

“We have a functional language line 24 hours a day and 7 days a week; however, there are times when the language line is grossly inadequate and a real person is needed to help convey information.”

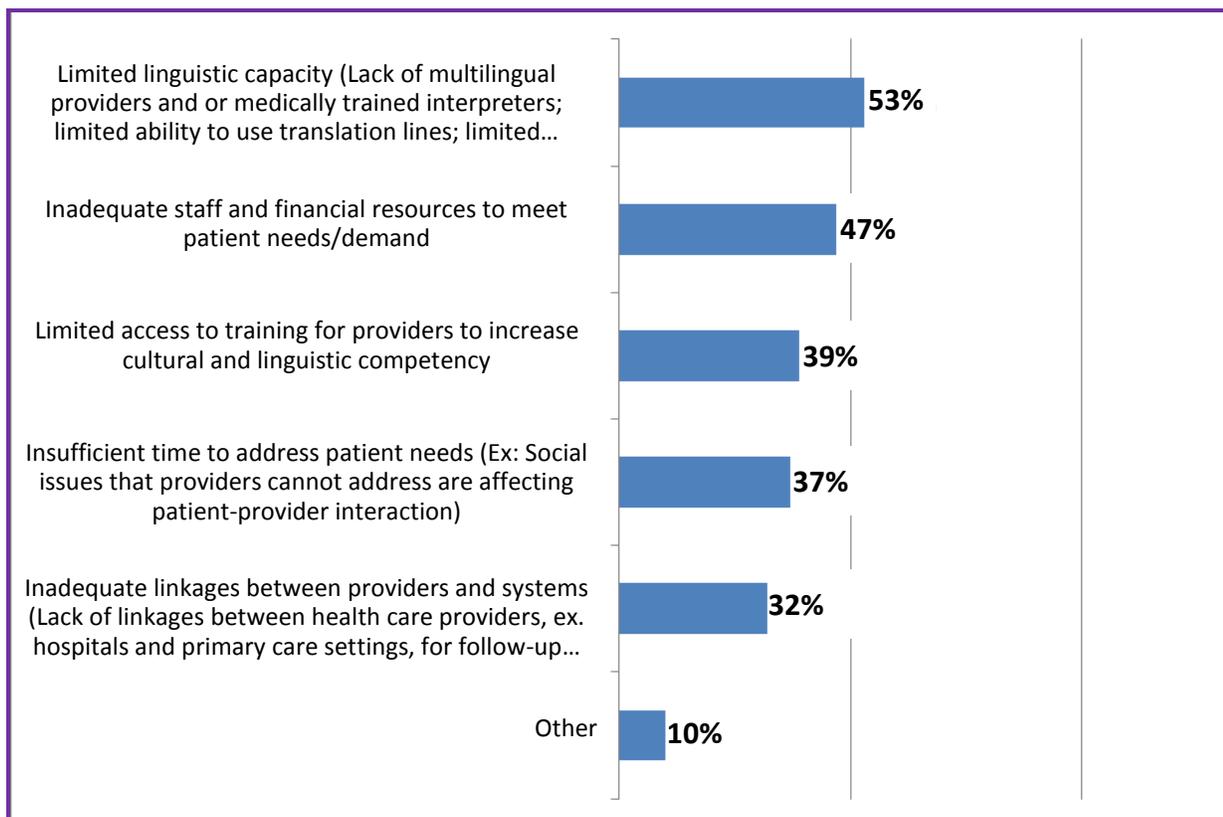
—Provider survey respondent

Barriers to Improving Cultural Competency

When asked about barriers to improving cultural and linguistic competence within their health care organization or practice, survey respondents identified limited linguistic capacity as their greatest obstacle (53%).²⁷ This was also cited as a common barrier in the 2008 DHSS report.²⁸ In that study, as in the Altarum survey, providers felt that expanded staff and staff capacity would be useful to help address patient demand and linguistic barriers. In the 2008 DHSS report, health care providers reported relying on patients’ family members or friends to interpret information in the absence of sufficient interpreter services.²⁹

In the Altarum survey, inadequate staff and resources was the second most common barrier to effective cultural and linguistic competency, identified by almost half of respondents (47%).³⁰ In the Altarum provider focus group, providers also identified the barriers identified below. They described the limited duration during appointments to address all of a patient’s questions and concerns as the “nature of the business” and a challenge that all providers must address. They also described inadequate linkages, instances when referrals were made to another agency, having limited opportunity to share information, and not knowing the extent to which any action was taken.³¹

Figure 6. Barriers to Improving Cultural and Linguistic Competency



Source: Altarum Provider Survey, 2010

Incentives or Resources



In addition to describing barriers to access and care, survey respondents were asked about the types of incentives or resources that would help them improve their ability to be culturally and linguistically competent. Most respondents indicated that additional information about referral resources to local social services would be the most helpful

Regarding incentives or resources that would help organizations or practices improve cultural and linguistic competence, 74% of providers selected easy access to centralized information about local social services and resources to which vulnerable clients can be connected, and 58% of providers selected making cultural competency tools and resources more widely available.

resource. This finding is consistent with the barrier of “inadequate linkages between providers and systems,” identified by almost one-third of survey respondents.³² Providers that participated in the Altarum focus group felt that referrals to dental and mental health providers were less available.³³

More than half of survey respondents (58%) noted that wider availability of cultural competency training, tools, and resources would be the best incentive (e.g., part of the support available to providers participating in

the Community Healthcare Access Program and the Voluntary Initiative Program). This finding was consistent with one of the recommendations resulting from the 2008 DHSS report, in which providers felt that the state could play a larger role in gathering resources for providers and funding classes to train health interpreters. Another needed resource identified by providers is guidance on the types of cultural and linguistic policies that should be in place in their practices and examples of training that should be conducted with their staff. This is a particular need among smaller practices that may not have the resources to develop policies, practices, and training and are looking to larger organizations or the state for guidance.³⁴ Providers also noted that mandates without some type of incentive (e.g., discount on malpractice insurance, translation line use) would not be well received.³⁵

Perceptions of Female Health Care Consumers in Delaware

Altarum Institute conducted focus groups with female health care consumers (ages 18–49) and also reviewed other consumer information previously collected by DHMIC, which included a focus group study (Perceived Discrimination Study) conducted in Wilmington and a study led by the chair of DHMIC’s Health Care Disparities Committee which surveyed women who accessed prenatal care at an urban health center to determine barriers to early initiation of services.

Figure 7. Consumer Focus Groups Demographics (N = 21)

Race	
Hispanic/Latino	50%
Black/African American	28%
White	11%
Other/multiracial/multiethnic	11%
Age	
18–21 years	50%
22–29 years	6%
30–39 years	33%
40–49 years	11%
Education	
Some high school	33%
High school/GED	33%
Some college	17%
Bachelor’s degree	11%
Other	6%
Primary language	
English	56%
Spanish	44%

Source: Altarum Consumer Focus Groups, 2010

Health Messages

During medical appointments, focus group participants reported receiving information about fitness, general nutrition, smoking cessation, HIV and other sexually transmitted infections, the importance of regular medical care and infant immunizations, and postpartum depression.^{36, 37}

When asked about their sources of health information, focus group Participants reported multiple sources:

- Television and public service announcements (PSAs)
- Print ads and billboards
- Parents and family members
- Peers
- Doctors and health professionals (e.g., school clinics)^{38, 39}

In the focus group of adolescent girls, Participants mentioned the Internet as an important source of information. They use it to search for sensitive health information on topics, such as sex or HIV. In the 2008 Wilmington study, participants emphasized the role of peers in transmitting health messages; however, this is a questionable source, as other teenagers are likely to be uninformed about parenting skills. Focus group participants in

several groups commented that physicians seemed most concerned about their health during pregnancy or postpartum.⁴⁰



Defining Quality in Health Care

When asked about how they defined “high-quality health care”, similar themes emerged across multiple focus groups:

- Feeling welcomed by front-office staff and providers
- Feeling that they are treated with respect
- Feeling that staff and providers take the time to provide information and answer questions

Focus group participants talked at length about the importance of a provider’s attitude and treatment on their health care experience. They were especially pleased when they felt that the provider was concerned about their health, as when the provider asked questions (about both health and the patient’s life in general), was responsive to pain or discomfort, and explained upcoming procedures. Participants were interested in having a dialogue with their health providers. One respondent was impressed by a doctor who had already read her chart and medical history and came to the meeting with personal information: *“She remembered me from the last appointment.... Some doctors don’t even remember who you are.”* Smiling, joking, happy front-office staff also put participants at ease. Participants cited other positive factors such as having a nice waiting area with magazines and toys for children, minimal waiting time, and flexibility when an appointment is missed or has to be rescheduled.⁴¹

When asked to describe their negative experiences, focus group participants again focused on interactions with providers. Poor communication and listening skills were most often cited as a barrier to care.^{42, 43} Problems included lack of follow-up from doctor’s offices regarding test results or medications and unanswered questions about billing. Participants were especially aggrieved when they felt that doctors did not listen to their complaints or symptoms and used “medical jargon” instead of using simpler terms. One respondent said, *“I want to know what’s going on with my body.... Don’t just say, ‘Don’t worry about it; get out of here.’”*⁴⁴

Poor treatment was another commonly cited barrier, with participants recounting incidents of incompetent blood draws, doctors who did not provide enough care, botched medical procedures, misdiagnoses, and hurried exams. Participants also described having to endure long wait times. The adolescent focus group participants complained about seeing patients that had arrived after them receive care first, and the African-American women complained about sitting in the doctor’s office for hours.

For the focus group with primary Spanish speakers, language and immigrant status were cited as common barriers or issues during medical appointments. The women described discrepancies in the quality of interpreter services available in Sussex County. In the Wilmington Consortium study, participants identified barriers such as lack of insurance coverage.⁴⁵

Many participants noted that these experiences have affected where they seek medical care; they are willing to travel farther to avoid hospitals or doctors who give them poor care.

“Some doctors have the patience with you and sit and really talk to you and really spend that time with you and let you know, and they’ll listen to you.”

—Consumer

“We don’t want them to talk to us like we’re medical students...but we don’t want them to talk down to us. There is a fine line between the two of them. It’s kind of hard to find that, but if you’re a doctor and you find that line, then I would go back to you. That would be a doctor that I would go to forever.”

—Consumer



Perceived Differences in Treatment

Consumers identified situations in which they perceived differences in treatment, for which they cited different reasons. All groups mentioned that having public insurance could cause differences in treatment, with doctors not accepting public insurance, delaying appointments, and generally being less receptive to patients who have public insurance. The 2008 Wilmington Consortium study confirms this concern, with respondents believing that people are treated differently based on the type of insurance they have or their social class and that those who have Medicaid are treated less favorably.⁴⁶

In the adolescent female group, participants discussed their perception that physicians are more dismissive of younger patients and less likely to take them seriously. The women in the Spanish-language group felt that they were treated differently by front-line staff and providers because they could not communicate in English. Women who were not legal immigrants or whose children were not legal immigrants described receiving a different level of care from what other patients received.⁴⁷ African-American women who participated in the Wilmington Consortium study felt that their race was a factor in treatment and that providers view them negatively when they have multiple children or are single mothers.⁴⁸ This is consistent with the findings from the Perceived Discrimination Study, which suggested a connection between racial bias and seeking care. The study found that prenatal care was initiated later among racial and ethnic minority patients who thought doctors and nurses were biased against minorities or felt that they discriminated based on race. Participants who perceived that they were treated unfairly because of their race delayed prenatal care 4.2 weeks on average compared to participants who did not have that perception. The perception of bias also can affect nonminority patients. Study participants who perceived that doctors and nurses treated others unfairly due to race delayed prenatal care 2.4 weeks on average compared to their counterparts.⁴⁹

Consumer Empowerment

Several themes emerged regarding ways in which consumers feel empowered in their health care experiences. First, focus group participants felt empowered when they could make informed choices about their health care—able to understand the benefits that they could access through insurance, make healthy food choices and exercise, and keep track of their appointments and checkups. They felt that it was important to not play the blame game and to take care of themselves. The African-American women in particular felt that taking control of their diets and taking steps to end bad habits such as smoking helped them to feel empowered. Conversely, the Spanish-language participants generally felt disempowered about improving their health. They know what to do—maintain a healthy weight and reduce their risk of diabetes—but struggle with incorporating these practices into their lives. They also mentioned that stress is a major contributor to feeling a loss of control and a challenge to making healthy choices. The adolescent group emphasized research and education as a form of empowerment, including double-checking information from the Internet because it might not be valid, and making phone calls to find out about needed services.

The second major theme to consumer empowerment was the ability to partner with their providers in navigating their health care, which was contingent on open communication. Participants felt more comfortable with doctors who were willing to answer patient questions and engage in a dialogue with patients. In contrast, poor communication discouraged consumers from pursuing their own care. Participants felt that they did not have control over their health when they could not afford doctor's visits, when they did not know how to fix a health problem, and when they could not get answers to their health questions from doctors. One participant noted, "If [health care providers] don't have the answer where they can fix it or anything they can do about it...that really puts a damper on me. That makes me feel like, 'Oh, what I'm going to do now?' There's no control."⁵⁰

Recommendations from Survey and Focus Group Participants

Consumers and providers shared their recommendations for improving the quality and provision of culturally and linguistically competent health care.

Consumer Recommendations:

- Offer training to providers to improve their ability to explain medical information using terms that are clear and easy to understand
- Provide training on good customer service to all staff in health care facilities. Be friendly, treat patients respectfully, take time to answer questions and explain procedures, maintain confidentiality
- Expand services that will increase access to patients (e.g., interpreter services, office hours)

Provider Recommendations:

- Develop a resource guide for providers that describes available local referral resources for patients
- Develop educational materials and strategies (e.g., health navigator) to help patients navigate the health care system
- Support the implementation of innovative strategies (e.g., interpreter cost-sharing) to address needs of the most vulnerable populations
- Provide examples of written policies promoting cultural and linguistic competence that should be implemented in health care practices
- Offer incentives and training (for providers and interpreters) to support the implementation of cultural and linguistic policies and practices



Stakeholder Forum on Delaware CLAS Standards

A stakeholder forum was held on March 23, 2010, to engage key public and private providers, administrators, and consumers from the maternal and child health community in making recommendations on priority standards for culturally and linguistically information from the CLAS Initiative data collection efforts, facilitate dialogue about current activities related to provision of culturally and linguistically appropriate care for women and infants, gather input on priority standards, and generate recommendations for implementation. Personal vignettes about the impact of culturally and linguistic diversity on the health care experience were presented by a local physician operating a private practice and a health care consumer who also serves as a promotor⁵¹ in a local health center.

Figure 8. Programs and Organizations Represented at the Stakeholder Forum

- Bayhealth
- Christiana Care
- Delaware Commission for Women
- Delaware State University
- Department of Health and Human Services Division of Public Health County Administrators
- Department of Services for Children, Youth, and Families Division of Child Mental Health
- Head Start
- Henrietta Johnson Medical Center
- LaRed Health Center
- Nanticoke Memorial Hospital
- Nemours Health and Prevention Services
- Office of Minority Health
- Private-practice physicians and nurse practitioners
- WIC programs

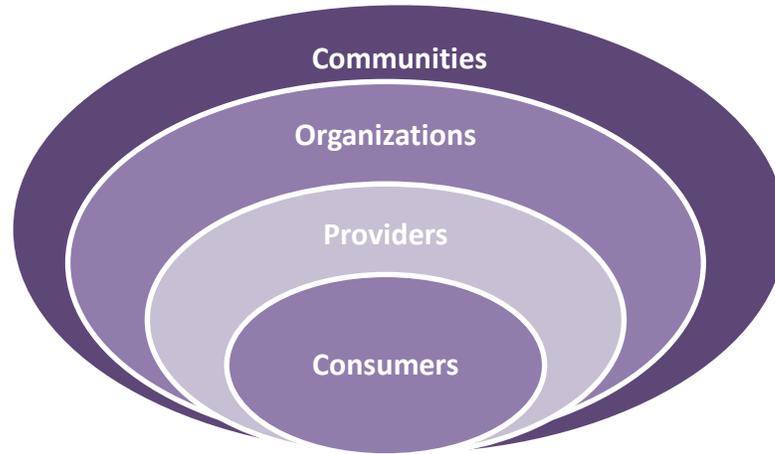
Twenty-five individuals representing state agencies, Federally Qualified Health Centers, private health care practices, hospitals, nonprofit health education and research organizations, universities, and health professional membership organizations participated in the 1-day forum. A summary of the CLAS Initiative and data collection findings was presented to participants, followed by a discussion in which key questions were raised about engaging additional key stakeholders (e.g., administrators of other large health centers) in the CLAS Initiative and gathering more information about how such facilities are currently implementing the federal CLAS standards.

Participants were then divided into roundtable discussion groups organized by the four levels of influence targeted by the CLAS standards as illustrated in Figure 8. The objectives of the roundtable discussions were to: (1) provide participants with an opportunity to learn what other organizations are currently doing to address health disparities and support provision of culturally and linguistically appropriate health services, (2) generate ideas about strategies for ensuring provision of culturally and linguistically appropriate health services in Delaware focused on one of the four target audiences addressed in the federal CLAS standards, and (3) identify priority strategies for implementation of CLAS standards focused on one target audience.

To this end, each group was asked to address the following questions:

- What is your organization currently doing to impact health disparities?
- Are there other activities currently addressing health disparities for this target audience?
- Given the data presented, what strategies should be targeted for this audience?
- Which strategies are priorities and what would it take to get started on them?

Figure 9. CLAS Standards Levels of Influence



Following a period of discussion and brainstorming, each group presented two recommended strategies for their assigned target audience. In total, 8 strategies were recommended to the Health Disparities Subcommittee for consideration and prioritization, as summarized in Figure 10 below. Overall, the stakeholders’ strategies focused on education, empowerment, and maximizing existing resources. In addition to suggesting the strategy, each workgroup identified priority action steps needed to initiate the strategy and stakeholders that will need to be involved to successfully implement the strategy. A draft action planning grid showing the recommended strategies, action steps, and stakeholders is provided in Appendix G.

Figure 10. Stakeholder Forum CLAS Implementation Strategies

Stakeholder Forum Strategies	
Consumer-Focused Strategies	
<ul style="list-style-type: none"> ▪ Develop a statewide consumer workgroup to advocate for the inclusion of a consumer perspective in the development of provider guidelines and consumer-oriented materials. ▪ Develop a consumer train-the-trainer health navigation program. 	
Provider-Focused Strategies	
<ul style="list-style-type: none"> ▪ Enhance provider education and awareness of cultural and linguistic competence. ▪ Develop provider buy-in for state CLAS standards implementation. 	
Organization-Focused Strategies	
<ul style="list-style-type: none"> ▪ Conduct a gap analysis of implementation of the CLAS standards among Delaware health care organizations and practices. ▪ Develop an expanded statewide medical interpreter pool. 	
Community-Focused Strategies	
<ul style="list-style-type: none"> ▪ Engage youth as change agents to address health disparities. ▪ Partner with academic institutions to conduct community-based participatory research focused on health disparities. 	

Consumer- and Provider-Level Strategies

The consumer focused strategies were aimed at addressing what stakeholders perceived to be confusion or lack of awareness among consumers of how to access existing services and how to ensure that consumer perspectives are considered and incorporated in efforts to address health disparities in the state.

Education and resources were identified by stakeholders as priority areas for providers. Priority provider-focused strategies were aimed at clarifying definitions and expectations for providers as well as identifying resources to support increased cultural competence among providers (informational and financial resources).

Organization- and Community-Level Strategies

The organization-focused strategies identified two areas of need: (1) the very specific and targeted need for additional medical interpreter services throughout the state to supplement the use of telephone interpreter lines and (2) a lack of information on how various organizations and medical practices are currently implementing the federal CLAS standards. An in-depth assessment of the current practices related to CLAS standards could yield promising practices upon which to build and clearly illuminate areas in need of strengthening, which will allow for more targeted allocation of effort and resources to support implementation of statewide CLAS standards.

At the community level, stakeholders were in agreement that to effectively address infant mortality and health disparities in perinatal outcomes, youth must be engaged early and effectively in helping to define the problem and the solutions. Strategies that the stakeholders identified focused on ways to engage the community in identifying why the disparities exist and how best to address them.

When asked about overall priority areas for implementation of CLAS standards, stakeholders were in agreement on establishing mechanisms for ongoing engagement of consumers (youth and families in communities most affected) and the need to gather more targeted information about current CLAS-related practices.

Next Steps for the Health Disparities Subcommittee

The next step for the Health Disparities Subcommittee is to craft the plan for statewide implementation of CLAS standards based on the existing information available, the new data collected, and input from the stakeholders.

To develop the plan, it is critical to articulate the goals for statewide implementation of CLAS standards and measurable objectives that will allow for tracking progress toward those goals. What are the actions to be taken by Delaware health care organizations and providers? What are the desired outcomes as a result of having the implementation plan (e.g., all health services facilities demonstrate clear evidence of engaging in CLAS-related self-assessment and planning on an annual basis)? Answers to these questions should be clearly articulated as part of the plan.

Based on the review, collection, and analysis of data for the CLAS initiative, the following are recommended components of the plan:

- Information sharing and dissemination
- Education
- Resource development
- Incentives and recognition

Dissemination

Inform key health services stakeholders (public and private administrators, providers, academics, advocates, and consumers) about the goals and implementation plan in development. Engage them as the plan is constructed. Persons who are responsible for ensuring their organization's adherence to federal CLAS standards are particularly important to engage directly and on board as supporters of the state plan. Existing partnerships with medical professionals associations can be leveraged to gain assistance with sharing the plan and rationale for its development. It may be useful to organize workgroups dedicated to CLAS-related tasks such as development of CLAS resource materials or guides and provider outreach and education.

Education

Provider education on culturally and linguistically appropriate care was cited as an area of need by providers, consumers, and stakeholders. If CLAS standards are to be implemented more uniformly throughout the state, additional opportunities for education are needed for health care providers and administrators. Delaware has already made strides in this area with the launch of the Cultural Competency Education Series, sponsored by the Delaware Division of Public Health in partnership with the National Medical Association First State Chapter. This series, designed to increase the cultural competence of health care professionals and organizations by raising awareness of cultural issues that impact the delivery of health services and providing strategies that improve health outcomes, is an important resource that can be used to educate providers throughout the state. Currently, the scope is limited to three or four annual trainings spread across the

three counties of the state. The success of this series can be built on to address additional CLAS-related issues, challenges, and strategies. Workshops providing suggested strategies to address challenges related to implementation-specific CLAS standards may be particularly useful for some organizations.

Providers suggested that online resources can be quite effective when coupled with face-to-face learning opportunities. Since time limitations are always a consideration for health care providers and it can be challenging to schedule time away from the clinical setting, online training resources can be a valuable tool for increasing access to educational opportunities for this population. Online educational resources such as video-based (and DVD accessible) CME- or CNE-eligible training sponsored by a state agency or office (Department of Health or Office of Minority Health) could be used alone or in conjunction with face-to-face trainings to educate health care providers (public health providers, community-based providers, and all direct medical and social service providers) on

- Addressing the cultural and linguistic barriers to health care delivery
- Increasing access to health care for limited English-proficiency patients and clients
- Understanding health risk factors and successful prevention and intervention strategies
- Implementing strategies to comply with the CLAS Standards

Other states and organizations have developed educational programs for this purpose that may serve as a model for the Delaware training. For example, the New Mexico Department of Health, Division of Policy and Performance, Office of Health Equity offers a free online 3-hour CLAS standards course, funded by a grant from the National Office of Minority Health, through which providers may earn CME or CNE credits. The New Mexico course is aimed at increasing health care providers' understanding of why culturally competent health care is important and increase their understanding of the CLAS standards mandated for provision of health care to limited-English-proficiency patients. In addition, it offers participants exposure to new strategies for implementing the CLAS standards in their clinic or service unit.

Additional online CLAS-related resources for physicians, nurses, and health care administrators are available at <https://www.thinkculturalhealth.org/>. They include a set of free courses that provide up to 9 hours of online interactive CME-eligible training for health care professionals.

Another area of need cited by providers and other stakeholders is training for medical interpreters. The Delaware Division of Public Health currently offers the Bridging the Gap Medical Interpreter program each year through the Cross-Cultural Health Care Program to establish an effective interpreter pool. Informants of the CLAS Initiative indicate that while this resource is well received, the number of people trained is small and therefore the pool of trained interpreters remains limited. To address this issue, additional sources of support and expanded outreach to engage and train additional interpreters are needed.

Resource Development and Sharing

Providers and stakeholders discussed the need for greater access to resources to support increased cultural competence and implementation of CLAS standards. Below are recommendations for specific resources to address this need:

- Share tips for how organizations can use the HHS Office of Minority Health Guide for Implementation of CLAS Standards.⁵²
- Develop a Delaware guide to implementation of CLAS standards with tailored resources and supports for implementation. Similar guides have been developed by other organizations (e.g., *Underserved Quality Improvement Organization Support Center CLAS Standards Implementation Tip Sheet*⁵³; *Massachusetts Department of Public Health—Office of Health Equity: A Guide to Providing Culturally and Linguistically Appropriate Services (CLAS) in a Variety of Public Health Settings*⁵⁴) and can be modified for use in Delaware.
- Provide a position-specific guide on the implementation of CLAS standards, such as a clinic manager’s guide to the provision of culturally and linguistically appropriate care (e.g., Oregon Guide: <http://www.dhs.state.or.us/tools/diversity/tools/cctools-managers.pdf>).
- Crosswalk data from the Delaware Racial and Ethnic Disparities Health Status Report Card with suggested steps that organizations can take to affect key indicators of concern (indicators rated “D” or “F”) to help organizations and practices prioritize CLAS-related priority areas for the populations whom they serve.
- Compile a directory of CLAS-related resources available to Delaware health care providers to facilitate their access to education and training. Include online training such as Aetna Quality Interactions,⁵⁵ a series of interactive online courses that teach health care professionals participating in Aetna’s network how to identify cross-cultural issues, conduct a culturally competent patient history and medical exam, work effectively with interpreter services, increase patients’ understanding of diagnosis and treatment options, and elicit greater patient cooperation and compliance with the prescribed treatment plan. The directory may include assessment tools and templates for CLAS-related strategic planning. An example resource guide and strategic planning tool are included in Appendix H. Tools and processes for organizational and individual self-assessments of cultural and linguistic competence are available through the National Center for Cultural Competence.

Recognition

Community-based initiatives have long acknowledged the power of recognizing and honoring those who champion their cause. Providers participating in the survey and the focus group indicated the importance of rewarding and recognizing those who are making strides in the implementation of CLAS standards. Providers and organizations demonstrating exemplary or innovative strategies for the implementation of CLAS standards could be showcased at the annual MCH summit and have vignettes posted on a partner Web site (e.g., Office of Minority Health).

Some states have used small pilot programs to encourage and reward organizations for targeted work on the implementation of CLAS standards. Utah, for example, is offering technical assistance and financial support for cultural competency training to organizational teams participating in its *CLAS Standards at Local Health Departments Clinics Project*.⁵⁶

If an assessment of current strategies for implementation of CLAS standards is undertaken, as suggested by the stakeholder forum participants, the results can be used to identify early achievers for recognition—those providers and organizations that are already frontrunners in implementation of the standards. These providers and organizations can be formally recognized for their efforts and highlighted as demonstrating the implementation of CLAS standards in ways that are soon to be encouraged and supported through the statewide CLAS implementation plan.

Summary

Altarum Institute is pleased to present this information for consideration by the Health Disparities Subcommittee as it prepares to make recommendations to DHMIC. We strongly recommend the establishment of the CLAS implementation workgroup, including some constituents groups that were represented at the stakeholder forum as an initial next step. Once the subcommittee and DHMIC have agreed on the priority areas for implementation using the draft action planning grid provided in Appendix G, the workgroup will be very valuable in helping the subcommittee move forward in implementing the action plan in a timely manner.

Endnotes

- ¹ Delaware Department of Health and Social Services, Division of Public Health (DPH), Delaware Healthy Mother and Infant Consortium (DHMIC). (2008). *The birth of change: 2008 annual report*. Dover, DE: DHMIC.
- ² Ibid.
- ³ Richardson, A.M., Rhodes, W.A., & Singleton, E.G. (2009, October 13). *Perceived discrimination, anti-minority bias, and delayed prenatal care study*. Poster session presented at the Delaware State University Annual Health Services Research Conference, Dover, DE.
- ⁴ DHMIC, 2008.
- ⁵ Researchers at the National Center for Health Statistics analyzed birth certificate data in the [National Vital Statistics System](#) (Martin et al., 2005, 2006).
- ⁶ Ibid.
- ⁷ DHMIC, 2008.
- ⁸ Primary Care Physicians in Delaware Capacity Study, 2008.
- ⁹ Ibid.
- ¹⁰ DHMIC, 2008.
- ¹¹ Ibid.
- ¹² Wilmington Consortium. (2008). *Final report: Wilmington Consortium infant mortality focus group study*. Wilmington, DE: Goeins-Williams Associates, Inc.
- ¹³ Altarum Institute. (2010). *Delaware health care consumer focus groups*. Washington, DC: Altarum.
- ¹⁴ Richardson, Rhodes, & Singleton, 2009.
- ¹⁵ Ibid.
- ¹⁶ Primary Care Physicians in Delaware Capacity Study, 2008.
- ¹⁷ Delaware Department of Health and Social Services, Division of Public Health. (2008). Development of a cultural competency provider training final reports. *Quality Insights of Delaware*. Dover, DE: DPH.
- ¹⁸ Altarum Provider Focus Group, 2010.
- ¹⁹ DHSS, DPH, 2008.
- ²⁰ Altarum Provider Focus Group, 2010.
- ²¹ Ibid.
- ²² Altarum Institute. (2010). *Delaware health care provider survey*. Washington, DC: Author.
- ²³ Ibid.
- ²⁴ DPH, 2008.
- ²⁵ Altarum Provider Survey, 2010.
- ²⁶ Altarum Provider Focus Group, 2010.
- ²⁷ Ibid.
- ²⁸ DPH, 2008.
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- ³⁰ Altarum Provider Survey, 2010.
- ³¹ Altarum Provider Focus Group, 2010.
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- ³³ Altarum Provider Focus Group, 2010.
- ³⁴ Ibid.
- ³⁵ DHSS, DPH, 2008.
- ³⁶ Altarum Consumer Focus Groups, 2010.
- ³⁷ Wilmington Consortium, 2008.
- ³⁸ Ibid.
- ³⁹ Altarum Consumer Focus Groups, 2010.
- ⁴⁰ Ibid.
- ⁴¹ Ibid.
- ⁴² Ibid.
- ⁴³ Wilmington Consortium, 2008.
- ⁴⁴ Ibid.
- ⁴⁵ Ibid.
- ⁴⁶ Ibid.
- ⁴⁷ Altarum Consumer Focus Groups, 2010.
- ⁴⁸ Wilmington Consortium, 2008.
- ⁴⁹ Richardson, Rhodes, & Singleton, 2009.
- ⁵⁰ Altarum Consumer Focus Groups, 2010.

⁵¹ Arizona State University. (2004, spring). Chicana and Chicano studies. *Latino Health Issues Collection*. Tempe, AZ: Arizona State University.

⁵² Salimbene, S. (2001). *CLAS A-Z: A practical guide for implementing the National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health Care*. Rockford, IL: Inter-Face International.

⁵³ <http://www.qsource.org/uqiosc/CLAS%20Standards%20Strategies%5B7AUG-2005%5D.pdf>.

⁵⁴ http://www.mass.gov/Eeohhs2/docs/dph/health_equity/clas_intro.doc.

⁵⁵ The Aetna online course is available at www.aetna.com/provider.

⁵⁶ <http://health.utah.gov/cmh/lhd/CLAS%20announcement%202010.pdf>.