Cover Sheet for Example Documentation
for PHAB Domain 11 Standard 1 Measure 4

The following documentation has been submitted to ASTHO for the Accreditation Library as a potential example of Health Department documentation that might meet the PHAB Standard and Measure **11.1.4.** This document is not intended to be a template, but is a reference as state health agencies develop and select accreditation documentation specific to the health department's activities.

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Document Title:	Cultural and Linguistic Competence Organizational Assessment for MSDH
Document Date:	August 2015

Version of Standards and Measures Used: V 1.5

Related PHAB Standard and Measure Number

Domain:	11	Standard:	1	Measure:	4	Required Documentation:	3

Short description of how this document meets the Standard and Measure's requirements:

This document is the executive summary of the Cultural and Linguistic Competence Organizational Assessment for the Mississippi State Department of Health (MSDH). OHDE partnered with Georgetown University's National Center for Cultural Competence to assess MSDH's social, cultural, and linguistic competence in providing public health programs to specific populations with higher health risks and poorer health outcomes. As indicated on pages 2 – 5, four data sources were used analyze MSDH processes: Administration of the Cultural and Linguistic Competence Policy Assessment (CLCPA), a policy review and analysis, structured interviews with MSDH staff, and patient/consumer focus groups. Findings of this assessment are on pages 6 – 9. Recommendations for improvement are on pages 9 – 13. This assessment was used to develop policies, develop language assessment plans for the agency, and conduct culturally and linguistically appropriate trainings.

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EXECUTIVE SUMMARY

Cultural and Linguistic Competence Organizational Assessment for Mississippi State Department of Health

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EXECUTIVE SUMMARY

OVERVIEW AND PURPOSE

The Georgetown University National Center for Cultural Competence (NCCC), Center for Child and Human Development, Georgetown University Medical Center executed a two-year contract with Mississippi State Department of Health (MSDH) to: (1) conduct an array of professional development forums (both web-based and onsite) for staff on cultural and linguistic competence; and (2) examine the *National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care*[1] and their relevance for public health. The MSDH received a grant from the Office of Minority Health, U.S. Department of Health and Human Services to partner with the Georgetown University NCCC to plan and conduct these professional development and training activities and to conduct the organizational assessment. Consistent with year two of the contract, the Georgetown University NCCC collaborated with MSDH to conduct an organizational assessment of cultural and linguistic competence for all of the health regions and central office.

This organizational assessment was conducted to meet the OMH grant goals and it fulfills the requirements of the Public Health Accreditation Board, Standards and Measures 1.5[2] which is delineated below:

"Standard: 11.1*. Develop and maintain an operational infrastructure to support performance of public health functions."*

"Measure: 11.1.4. Policies, processes, programs, and interventions provided that are socially, culturally, and linguistically appropriate to specific populations with higher health risks and poorer health outcomes."

"Purpose: The purpose of this measure is to assess the health department's social, cultural, and linguistic competence in providing public health programs to specific populations with higher health risks and poorer health outcomes."

"Significance: Public health departments are responsible for all residents in the health department's jurisdiction, and that usually includes people of various backgrounds, languages, and cultures. It is important for health departments to understand how values, norms, and traditions of the populations served affect how individuals perceive, think about, and make judgments about health, health behaviors, and public health services. Those values, norms, and traditions affect how populations interact with public health workers, how open they are to health information and health education, and how they can change health behaviors. Ensuring that the health department's policies, programs, services, materials, and processes address these social, cultural, and language differences (including low literacy, non-English speaking populations, and the visually or hearing impaired) will enhance the health department's ability to provide the most effective programs and services to meet the needs of the population. Ensuring that the health department's policies, programs, services, materials, and processes

intentionally address health disparities and health inequities will enhance the health department's ability to impact the health of the population."

The Public Health Accreditation Board Standards and Measures 1.5 recommend *the Cultural and Linguistic Competence Policy Assessment*,[3] developed by the Georgetown University NCCC, to meet:

> "Documentation Requirement 3. Assessment of the health department's cultural competence and knowledge of health equity; and
> Guidance 3.3. The health department must provide an assessment of cultural and linguistic competence."[1]

The designated lead MSDH staff for the cultural and linguistic competence self-assessment process was Dr. Tanya Funchess, Office of Health Promotion and Health Equity, Office of Health Disparity Elimination, MSDH.

ASSESSMENT METHODOLOGY

The cultural and linguistic competence self-assessment process involved the following four data sources.

1. Administration of the Cultural and Linguistic Competence Policy Assessment (CLCPA)[3]

The CLCPA was administered to a randomly selected cohort of MSHD employees. The CLCPA is intended to assist organizations concerned with health care and public health to: (1) improve health care access and utilization, (2) enhance the quality of services within culturally diverse and underserved communities, and (3) promote cultural competence and linguistic competence as essential approaches to reduce health and health care disparities. The CLCPA has seven subscales and include: (1) Knowledge of Diverse Communities, (2) Organizational Philosophy, (3) Personal Involvement in Diverse Communities, (4) Resources and Linkages, (5) Human Resources, (6) Clinical Practices, and (7) Engaging Diverse Communities.

The CLCPA was adapted to the unique organizational structure of the MSHD. Georgetown University NCCC faculty requested that MSDH staff review the CLCPA to determine which questions were relevant for the Department, to identify those questions that should be modified and/or deleted, and to adjust the demographic information form to meet the structure and employee categorization of the Department. The MSHD staff specified the following populations that reside in Mississippi for inclusion in the assessment − American Indian/Native American, Black/African American, Hispanic/Latino, Vietnamese, and White (non-Hispanic). Additionally the MSDH was interested in eliciting information on two unique groups - people with disabilities and those who self-identify as Lesbian, Gay, Bisexual, and Transgender (LGBT) − specifically how they are perceived and included as distinct populations both as employees and public health service patients/consumers. Within the context of this assessment process, people with disabilities and individuals who self-identify as LGBT are designated cultural groups and their members may be of any race or ethnicity.

A letter from the Dr. Mary Currier, MD, MPH was issued on March 21, 2015 which announced the CLC assessment, informed those employees that they were randomly selected to participate in the assessment process, and encouraged each employee to complete the CLCPA. The MSDH identified **783** employees to respond to the CLCPA.

Data analysis and interpretation of the CLCPA was completed by Suzanne Bronheim, Ph.D., a faculty member of the Georgetown University NCCC and a member of its consultation team.

2. A Policy Review and Analysis

A review was conducted which consisted of an analysis of policies that may contribute to or hinder the advancement of cultural and linguistic competence (CLC) and the *National Culturally and Linguistically Appropriate Standards in Health and Health Care* (*National CLAS Standards*). The review was conducted by Vivian H. Jackson, Ph.D., a faculty member of the Georgetown University NCCC and member of the consultation team.

Dr. Jackson met via conference call with Dr. Funchess' team which provided a brief overview of MSDH policies. A tentative decision was made regarding which policies Dr. Jackson would review in collaboration with Dr. Funchess' team. Rather than individual policies, Dr. Funchess' team sent bound volumes of MSDH programs, major functions, and key professional disciplines in which the identified policies were located. This offered Dr. Jackson the opportunity to see the specific policies within the larger context of the Department. It also offered Dr. Jackson an opportunity to peruse the materials for additional policies that may be of relevance for inclusion in the review and analysis.

The review and analysis addressed the following questions including but not limited to:

- Did the policy provide guidance relevant to cross-cultural practice?
- Did the policy provide guidance on capacity to conduct the practice in the preferred language of the client?
- Were relevant materials, including formal documents and educational materials, prepared in the appropriate language?
- Were mechanisms in place to assure awareness and understanding of MSDH programs, services, and entitlements to persons who may not be familiar with service delivery system (e.g., immigrants, individuals with limited English proficiency, individuals with low literacy and/or health literacy, individuals who lack understanding of the public health system)?
- Did the policy facilitate diversity of the workforce?
- Were any of the policies consistent with the intent and guidance of the CLAS Standards?

The policy review and analysis is presented in tables and organized in the following categories:

- Title of the manual or program;
- Section of the manual and the page(s) referenced;
- Excerpts - if there were short excerpts of relevance, the text is presented in the table;
- Comments – provides responses to the policy by the reviewer;

- Suggestions for Change - offers changes in the policy to be considered by MSDH;
- Suggestions for Implementation - offers suggestions for implementation of a policy that may or may not require language change and the manner of implementation would have implications for cultural and linguistic competence; and
- For each policy, relevant standards from *the National CLAS Standards* are noted.

It should be noted that a few of the originally identified policies were not relevant and do not appear in aforementioned tables, and other policies were reviewed that had not been originally discussed. Tables are presented in the final report.

3. Structured interviews

The structured interviews were conducted with senior leadership, district administrators, program managers, health officers, and selected staff to elicit their: (a) views on leadership for CLC within the Department and how CLC relates to their positions; (b) personal involvement in implementing CLC within the confines of their roles; (c) knowledge of Title VI of the Civil Rights Act of 1964, Section 601 that prohibits discrimination due to national origin and ensures access to services for populations with limited English proficiency; and (d) knowledge of the *National CLAS Standards* and the extent to which the Department supports their adoption and implementation. Refer to the interview questions in Box 1.

The MSDH State Health Officer informed prospective respondents about the overall CLC assessment process and requested their participation in the structured interviews. MSDH provided a listing of contact information including email addresses and telephone numbers for each of the prospective interviewees. The Georgetown University NCCC issued individualized invitations on March 24, 2015. Eleven interviews were scheduled and conducted during the first two weeks of April 2015. Follow-up reminders were issued in mid- and late April 2015 to MSDH staff who had not responded to requests for interviews. A total of 19 interviews were completed by April 30, 2015 and five additional were scheduled. During the first week of May, the five scheduled interviews were completed. A total of **24 of 31** MSDH staff participated in the interview process. Refer to the final report for results and a detailed discussion of the structured interviews.

The structured interviews were conducted by Wendy Jones, M.Ed., MSW, a faculty member of the Georgetown University NCCC and a member of its consultation team.

BOX 1.
Structured Interview Questions

1. Briefly describe your position/responsibilities within the Department.
2. What do you see as the function of cultural and linguistic competence in your role/position?
3. Describe the environment within the Department that supports cultural and linguistic competence.
4. In what ways are you involved in the Department's efforts to advance and sustain cultural and linguistic competence?
5. How familiar are you with:
   A. Title VI of the Civil Rights Act of 1964?
   B. The *National Standards for Culturally and Linguistically Appropriate Services in Health and Healthcare*?
6. How do the *National CLAS Standards* relate to your role in public health?
7. To what extent does the Department support adoption of the *National CLAS Standards*?
   A. Please provide examples of policies.
   B. Please provide examples of structures.
   C. Please provide examples of practices.

4. Patient/Consumer Focus Groups

Focus groups were convened by Georgetown University NCCC faculty in three geographic areas in Mississippi including the Delta (Indianola), Central (Jackson), and Gulf Coast (Biloxi) regions. MSDH staff and consultants in each region selected prospective focus group participants from a pool of patients or consumers of Department services.

The focus group questions were designed to correspond with the seven subscales of the CLCPA and elicit the experiences of MSDH patients/consumers and to determine the extent to which they believe Department services and supports are responsive to their cultures and languages. Focus group questions elicited the extent to which MSDH staff:

1. have knowledge of diverse communities,
2. involve consumers and community members in planning, conducting and assessing health education health interventions and/or health initiatives,
3. are visible in communities,
4. partner with community organizations to improve health,
5. respond to cultural differences in the services they provide,
6. provide health care and services that demonstrate understanding of cultural beliefs and practices, and communicate and provide health information that is easy to understand, and
7. tailor health initiatives for diverse racial and ethnic groups.

Lastly focus group participants were asked to offer recommendations for service enhancement.

MSDH staff identified and contacted consumers/patients consistent with the racial and ethnic groups selected for inclusion in the CLCPA for each geographic locale. African American/Black and Hispanic/Latino participants were recruited in Indianola; Asian and White (non-Hispanic) participants were recruited in Biloxi; and African American/Black, Hispanic/Latino, White (non-Hispanic), and Native American participants were recruited for Jackson. Each participant received and signed consent forms several days in advance of the focus group. Refer to the final report for a detailed discussion of focus group findings.

Dr. Jackson and Wendy Jones, M.Ed., MSW, faculty members of the Georgetown University NCCC conducted five focus groups with a total of **24 of 36** individuals in attendance .

SUMMARY OF ASSESSMENT FINDINGS

Findings from the CLCPA

The MSDH identified **783** employees to respond to the CLCPA. A total of **729** MSDH employees logged on to respond to the CLCPA from April 7 through May 1, 2015. Of these, **170** completed the demographics form and failed to complete the questionnaire itself.

The Georgetown University NCCC's data analysis protocol and assignment of responses includes the category of strength (i.e., 75% or more of respondent endorse the item). Only one item in this administration of the CLCPA rose to this level. Georgetown University NCCC uses a category of relative strength in which 75% of most levels of respondents chose the top two categories for an item. In addition, items on which 50% up to 75% of most levels of respondents chose the top two categories are considered as current areas for growth, because they are emerging areas of relative strength. Items on which fewer than 50% chose the top two categories are described as areas in need of intentional focus from MSDH. Responses on most subscales reflected current areas for growth as well as areas of intentional focus. Refer to the final report for a detailed explanation of data analysis and results.

There are four themes in the findings from the CLCPA. The ***first*** is a lack of knowledge among respondents related to MSDH's policies on CLC. Across all subscales the majority of respondents indicated they were unaware if policy existed. While senior and middle management were more likely to report knowledge of policy status, they too were largely unaware of policies related to CLC. The ***second finding*** is that there is differential knowledge and practice within MSDH by population. Throughout the subscales, respondents typically reported greater knowledge of and more likelihood to adapt practices and engage with Black/African American and White (non-Hispanic) populations, and to a somewhat lesser extent Latino/Hispanic populations than with American Indian/Native American or Vietnamese populations. When asked with which populations respondents felt least proficient, the most mentioned group was Asians, particularly Vietnamese. The ***third finding*** is that MSDH may have some degree of insularity from the communities that it serves. On the subscale *Organizational Philosophy*, respondents reported very limited consumer and community participation. At the same time, based on responses to the subscale on *Personal Involvement in Diverse*

Communities, MSDH is not viewed as providing opportunities for its personnel to leave the boundaries of the Department to engage on a personal level within the communities served in the state. On the subscale *Resources and Linkages*, relatively few respondents viewed MSDH as having linkages to members of informal and culturally specific community networks of support such as traditional healers, cultural brokers, and key community informants and leaders. The *fourth finding* is that perceptions of MSDH in relation to CLC were relatively consistent across the levels of MSDH staff affiliation on most items.

Findings from the Policy Review and Analysis

The major finding from the policy review and analysis is that MSDH does not have an overarching policy that is designed to advance and sustain CLC within its core public health functions. There is no department-wide MSDH policy specifically focusing on Title VI of the Civil Rights Act of 1964, Section 601, barring discrimination against individuals with limited English proficiency. Moreover, as currently written very little of the Department policy comports with the *National CLAS Standards.*

With a few exceptions, most of the text in the policy manuals was silent on matters relating to culture, language access, health literacy, and CLC. There was some variability of how the different policy manuals were structured. Some delineated detailed procedures, process requirements, documentation requirements, reporting authority, and time lines with minimal discussion of the content of the practice. Other manuals provided great detail of both the process requirements and the practice expectations. In most of the manuals there were just a few items that referenced culture, diversity, and/or language. However, there were two notable exceptions in this review – the MSDH Family Planning Manual and Public Health Nursing Manual. The Family Planning Manual included language that addresses aspects of cultural and linguistic competence throughout its various components, and the Public Health Nursing Manual included a section on the use of foreign language interpreters.

Findings from the Structured Interviews

The structured interviews yielded a wealth of information from the 24 respondents. The primary findings are listed as follows.

- Among the respondents, there is a wide array of perspectives about and knowledge of the function of CLC within their respective roles and responsibilities .
- Respondents believe in CLC and its role in public health and are able to describe a positive environment within the Department that supports CLC. Respondents provided many examples of culturally and linguistically competent practices that are employed within the Department's programs and services.
- Respondents identified policy development that directly addresses the adoption and implementation of CLC and the *National CLAS Standards* as a critical need within the Department. Staff indicate that such Departmental policy would provide "a clear mandate" and guidelines, define practices and procedures, and offer tools to support implementation and evaluation of CLC efforts across all public health regions in the State.
- There is a perception among many respondents that implementation of CLC and the *National CLAS Standards* at the local county level is impeded due to factors such as lack of

buy-in and understanding of CLC, biases, indifference, and other negative attitudes among MSDH staff.

- A number of respondents are actively engaged in efforts to advance and sustain CLC at the program and office levels. There is also an almost equal number of respondents who indicated that their involvement in CLC has been limited to participation in the webinars and professional development activities and the organizational assessment process conducted by the Georgetown University NCCC. Opportunities to increase knowledge and skills related to CLC are viewed as a priority within the Department; however the lack of policies and internal structures hinders systemic and consistent deployment of CLC practices.
- A significant number of respondents are unfamiliar with or have minimal knowledge of Title VI of the Civil Rights Act of 1964, Section 601 and its provisions against non-discrimination due to national origin and ensuring language access for individuals with limited English proficiency.
- Respondents' familiarity with and knowledge of the *National CLAS Standards* varied considerably. Less than half of the respondents were unable to describe how the Standards relate to their role in public health.
- Few respondents were able to provide examples of Department policies that support adoption of the *National CLAS Standards*. Half of respondents were able to identify current practices and structures that support adoption of the Standards.

Findings from the Focus Groups

Focus group respondents in three regions of Mississippi (The Delta-Indianola, Central-Jackson, and the Gulf Coast-Bilioxi/Gulfport) reported an array of experiences and perceptions associated with MSDH service delivery. Regional variations were noted in the issues raised including perceived inequities described in racial, cultural, and linguistic terms in Indianola and among and between cities (Indianola vs. Greenville, and Greenlee). In Jackson respondents described differences between large and small counties (Meridian vs. Hinds); and in Biloxi, differences were attributed to language and culture.

According to the respondents, customer service is reported as a problem in general and its impact varied across racial, ethnic, and cultural groups and by geographic region. For example, respondents reported that interactions and communication were particularly poor when MSDH staff interfaced with those who were culturally different from themselves. Respondents with limited English proficiency described the worse experiences, and at least in Indianola, African Americans/Blacks had worse experiences when compared to Whites (non-Hispanic). Language barriers and limited availability of interpretation services were cited in Jackson and Indianola. In some localities, consumers/patients have to "wait in the cue" for their turn with the interpreter; in others, patients/consumers are told to bring their own interpreter (a clear violation of Title VI of the Civil Rights Act of 1964, Section 601). In Biloxi, Vietnamese respondents indicated that there is one individual who has the multiple roles of interpreter, cultural broker, and system navigator and whose services are spread across all Vietnamese-speaking and other Asian patients that require her assistance.

Finally, all focus groups respondents reported limited, if any, MSDH activities and initiatives focused on tailoring health messages to meet the cultural and linguistic preferences and needs of the diverse communities served. Yet in Jackson, respondents affirmed that the community believes in the important, essential nature of public health services provided by the MSDH and recognizes the Department as a known entity upon which multiple communities rely. Refer to the final report for results and detailed analysis of the focus groups.

RECOMMENDATIONS

The following recommendations are offered by the Georgetown University NCCC based on findings from the CLC organizational assessment process. These recommendations take into consideration that a total of **559** MSDH staff who participated in the assessment process by completing the CLCPA and **24** staff who consented to structured interviews. It should be noted that there may be overlap among the staff who participated in these two components of the CLC assessment process. While MSDH selected the sample pool to be representative of the Department's workforce, assessment results were compromised by the **170** staff who only completed the CLCPA demographic form and failed to complete the remainder of the questionnaire. Moreover, the respondent pool may not be inclusive of some voices and views of those employees that were not selected to participate in the process. The recommendations also take into consideration the analysis of Department policy and data from the patient/consumer focus groups.

This final report provides a significant amount of information that the Department can use to solidify its commitment to CLC, to galvanize staff and reach a shared vision of the essential role of CLC in public health across regions and all positions, and to begin the ongoing process of formalizing its commitment to CLC by developing and implementing supporting policy. The fact that the Department sought and was awarded a grant from the Office of Minority Health, U.S. Department of Health and Human Services is a strong indication of its desire to bring about systemic change to advance and sustain CLC, including adoption of the *National CLAS Standards*. The Department should establish priorities, identify the necessary resources and expertise to achieve short-term and long-term goals, and determine which organizational change frameworks and processes will be effective in moving the CLC agenda forward. The Georgetown University NCCC encourages the Department to build upon relative strengths and current areas of growth identified in this report, and commends the Department for taking action and using the CLC organizational assessment a vehicle to improve public health services for all residents in Mississippi, particularly most affected by health disparities.

Recommendations for Immediate Next Steps

Consider the following strategies for immediate next steps.

1. MSDH leadership should plan a process to share this report of CLC assessment results with all public health regions and staff. Engaging staff in disseminating and discussing results can be the impetus for and provide a forum to reinforce the importance of CLC in public health, reach consensus on a shared definition of cultural competence and linguistic competence for the Department, and create a shared vision for achieving CLC within the Department.

Cross-reference to the National CLAS Standards

Engagement, Continuous Improvement, and Accountability

Standard 10. Conduct ongoing assessments of the organization's CLAS-related activities and integrate CLAS-related measures into measurement and continuous quality improvement activities.

Standard 15. Communicate the organization's progress in implementing and sustaining CLAS to all stakeholders, constituents, and the general public.

2. Create a structure to begin the ongoing work of planning and implementing CLC within the Department. This structure should be authorized at the highest level of the Department, comprised of MSDH staff that have policy and decision-making authority as well as those from various levels of the Department, and supported with necessary *resources and time* to accomplish its short-term and longer-term goals.

Cross-reference to the National CLAS Standards

Governance, Leadership, and Workforce

Standard 2. Advance and sustain organizational governance and leadership that promotes CLAS and health equity through policy, practices, and allocated resources.

3. Customer service and staff professionalism, as described by focus group participants, appear to be areas of concern that require immediate attention. It is recommended that the Department invest resources to convene additional focus groups or other forums to elicit the experiences of its patients/consumers across the State. The number of focus group participants in this CLC assessment was quite small and may not represent the experiences of the overall populations served by MSDH. It should be noted though that the small sample size in no way lessens the significant concerns expressed by focus group participants about the quality of services they received, the way in which they are treated by MSDH staff, and the variation between service experiences by geographic locale. In order to yield the most forthright results, the recommended forums should be independently conducted by experienced professionals that have no affiliation with the Department. Implementing this recommendation will enable the Department to have better understanding of the dynamics impacting the people and communities it serves throughout the State.

Recommendations for Immediate Next Steps (continued)

Cross-reference to the National CLAS Standards

Engagement, Continuous Improvement, and Accountability

Standard 12. Conduct regular assessments of community health assets and needs and use the results to plan and implement services that respond to the cultural and linguistic diversity of populations in the service area.

4. Revisit the current or develop new policy to ensure compliance with Title VI of the Civil Rights Act of 1964, Section 601 barring national origin discrimination and ensuring language access for limited English proficient populations. Violation of Title VI can result in liability, investigation by the Office for Civil Rights of the U.S. Justice Department, and costly penalties and consent decrees. Begin a process to ensure that all staff understand this MSDH policy, what their responsibilities are related to the policy, and how to access resources to implement this policy. Ensuring staff knowledge and adherence may include but is not limited to: (a) factors to assist in determining the scope and types of language access services to address the needs of linguistically diverse populations within the State; (b) the parameters of the Department's language access plan and how they apply to every office, program, clinic or other setting in MSDH; (c) procedures and practices based on public health function; (d) how to access trained and qualified MSDH or contract staff who perform interpretation and translation services; and (e) how the general public is notified of the Department's legal obligation to provide language access and how such services can be obtained.

Cross-reference to the National CLAS Standards

Governance, Leadership, and Workforce

Standard 4. Educate and train governance, leadership, and workforce in culturally and linguistically appropriate policies and practices on an ongoing basis.

Communication and Language Assistance (All Standards in this CLAS theme apply)

Standard 5. Offer language assistance to individuals who have limited English proficiency and/or other communication needs, at no cost to them, to facilitate timely access to all health care and services.

Standard 6. Inform all individuals of the availability of language assistance services clearly and in their preferred language, verbally and in writing.

Standard 7. Ensure the competence of individuals providing language assistance, recognizing that the use of untrained individuals and/or minors as interpreters should be avoided.

Standard 8. Provide easy-to-understand print and multimedia materials and signage in the languages commonly used by the populations in the service area.

Intermediate and Longer-Term Recommendations

The following recommendations are divided into the categories of policy development, clinical practice/service delivery, and professional development and training.

Policy Development

1. The Department should develop an overarching policy that clearly articulates that CLC is an integral and required aspect of its public health functions and practices. Formalizing this policy, and allocating requisite resources, will allay the ambiguity among some MSDH staff who think CLC only applies to some programs or that they do not have to support CLC as a practice.

Cross-reference to the National CLAS Standards

Principle Standard 1.
Provide effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs.
Governance, Leadership, and Workforce
Standard 4. Educate and train governance, leadership, and workforce in culturally appropriate policies and practices on an ongoing basis.
Engagement, Continuous Improvement, and Accountability
Standard 9. Establish culturally and linguistically appropriate goals, policies, and management accountability, and infuse them throughout the organization's planning and operations.

2. The Department should perform an analysis (crosswalk) between areas where staff reported either lack of policy or no knowledge of policy related to items on the CLCPA. This should include not only high level departmental policy, but program-level formal, written guidelines and procedures. Where policy exists that is supportive of CLC, staff should be apprised of such. Where no policy exists, the Department should consider developing policies to support culturally and linguistically competent practices and to align with the *National CLAS Standards*.

Cross-reference to the National CLAS Standards

Governance, Leadership, and Workforce
Standard 2. Advance and sustain organizational governance and leadership that promotes CLAS and health equity through policy, practices, and allocated resources.
Standard 4. Educate and train governance, leadership, and workforce in culturally and linguistically appropriate policies and practices on an ongoing basis.
Engagement, Continuous Improvement, and Accountability
Standard 9. Establish culturally and linguistically appropriate goals, policies, and management accountability, and infuse them throughout the organization's planning and operations.

Intermediate and Longer-Term Recommendations – Policy Development (continued)

3. The Department's policy manuals need to be revisited with a goal of integrating CLC in appropriate sections. In each manual, there should be language that:
   - Describes the cultural implications of the specific public health services, functions, or tasks.
   - Provides rationale, guidance, and procedures on how to address language access services as they relate to specific public health services, functions, or tasks.
   - Provides rationale, guidance, procedures to be responsive to literacy and health literacy of patient/consumer populations within the context of each public health service, function, or task.
   - Promotes the need to adapt public health services for specific communities, populations, and cultural groups including but not limited to immigrants, persons with limited English proficiency, individuals with disabilities, individuals who self-identify as LGBT, and individuals who are deaf or hard of hearing.

Cross-reference to the National CLAS Standards

Governance, Leadership, and Workforce

Standard 2. Advance and sustain organizational governance and leadership that promotes CLAS and health equity through policy, practices, and allocated resources.

Engagement, Continuous Improvement, and Accountability

Standard 9. Establish culturally and linguistically appropriate goals, policies, and management accountability, and infuse them throughout the organization's planning and operations.

4. The Department should revisit and/or develop new policy that clearly delineates the role of communities in its core public health functions and services (i.e., design, implementation, and evaluation). The policy should place emphasis on the need to involve and have representation from diverse populations in the state (i.e., age, gender, race, ethnicity, languages spoken, geographic locale, sexual orientation, and other relevant factors). The policy should address identifying community partners, providing resources to support their involvement, providing training for meaningful participation, and responding to the language and literacy needs of community members.

Cross-reference to the National CLAS Standards

Governance, Leadership, and Workforce

Standard 2. Advance and sustain organizational governance and leadership that promotes CLAS and health equity through policy, practices, and allocated resources.

Standard 4. Educate and train governance, leadership, and workforce in culturally and linguistically appropriate policies and practices on an ongoing basis.

Engagement, Continuous Improvement, and Accountability

Standard 9. Establish culturally and linguistically appropriate goals, policies, and management accountability, and infuse them throughout the organization's planning and operations.

Standard 13. *Partner with the community to design, implement, and evaluate policies, practices, and services to ensure cultural and linguistic appropriateness.*

Clinical Practice/Service Delivery

1. It is important for MSDH to address the issues of customer service and professionalism across the board. There is a need to understand the dynamics that seem to make one facility more professional than another. It is necessary to explore and address the racial, ethnic, and cultural factors that are contributing to disparate patient/consumer experiences as well as possible tension among staff attributed to racial and ethnic differences.

2. Focus group respondents' report suggests that there are regional and county level differences in customer service and operational efficiency, openness to cross-cultural interactions, and availability of language access services. It is important to understand the factors that might explain the differences.

Cross-reference to the National CLAS Standards

(Recommendations 1-2 above)

Governance, Leadership, and Workforce

Standard 3. Recruit, promote, and support a culturally and linguistically diverse governance, leadership, and workforce that are responsive to the population in the service area.

Standard 4. Educate and train governance, leadership, and workforce in culturally and linguistically appropriate policies and practices on an ongoing basis.

Engagement, Continuous Improvement, and Accountability

Standard 9. Establish culturally and linguistically appropriate goals, policies, and management accountability, and infuse them throughout the organization's planning and operations.

Standard 11. Collect and maintain accurate and reliable demographic data to monitor and evaluate the impact of CLAS on health equity and outcomes and to inform service delivery.

Standard 15. Create conflict and grievance resolution processes that are culturally and linguistically appropriate to identify, prevent, and resolve conflicts or complaints.

3. While the Department needs to improve access to language assistance services to populations with limited English proficiency in all regions, Biloxi is an area that requires immediate attention. Currently Biloxi has a high level of dependency on one individual who performs the multiple roles of interpreter, cultural broker, and system navigator, and which renders the patients/consumers, community, and the MSDH vulnerable.

Cross-reference to the National CLAS Standards

Communication and Language Assistance (All Standards in this CLAS theme apply)

Standard 5. Offer language assistance to individuals who have limited English proficiency and/or other communication needs, at no cost to them, to facilitate timely access to all health care and services.

Standard 6. Inform all individuals of the availability of language assistance services clearly and in their preferred language, verbally and in writing.

Standard 7. Ensure the competence of individuals providing language assistance, recognizing that the use of untrained individuals and/or minors as interpreters should be avoided.

Standard 8. Provide easy-to-understand print and multimedia materials and signage in the languages commonly used by the populations in the service area.

Intermediate and Longer-Term Recommendations – Clinical Practice/Service Delivery (continued)

4. Develop approaches to engage members of the diverse communities served in the Department's core public health functions in an active manner. Such approaches may include but are not limited to: (a) establishing community advisory boards and committees for each region; (b) community involvement in planning, implementing, and evaluating projects and health education initiatives; (c) creating and implementing cultural brokering programs; (d) reviewing and making recommendations to address the literacy and health literacy of diverse communities; and (e) developing posters and video narratives about the quality and effectiveness of Department services for public dissemination (e.g., the MSDH website, public service announcements on ethnic media, displays in commercial areas where the populations served frequent most.

5. The Department should convene a work group with the goal of involving members of the populations of focus in approaches to adapt or tailor service delivery to the cultures of the diverse populations served. For example addressing dietary preferences in nutrition and nutrition education programs, having the capacity to respond to culturally-defined beliefs of parents related to child development/developmental norms, and being knowledgeable of and responding to cultural beliefs and practices of families in services designed for children with special health care needs and disabilities.

6. Provide formal mechanisms, which are sanctioned by MSDH leadership, for staff to have opportunities for personal engagement in the diverse communities within the state. Time for these activities should be seen as essential to effective performance of job responsibilities.

Cross-reference to the National CLAS Standards

(Recommendations 4-6 above)

Principle Standard 1. *Provide effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs.*

Standard 3. Recruit, promote, and support a culturally and linguistically diverse governance, leadership, and workforce that are responsive to the population in the service area.

Engagement, Continuous Improvement, and Accountability

Standard 11. Collect and maintain accurate and reliable demographic data to monitor and evaluate the impact of CLAS on health equity and outcomes and to inform service delivery.

Standard 13. *Partner with the community to design, implement, and evaluate policies, practices, and services to ensure cultural and linguistic appropriateness.*

Professional Development and Training

1. The Department should take steps to ensure that professional development is available on a continuous basis and that all personnel have access to needed training, resources, and tools necessary to fulfill public health functions for the diverse populations residing in the state.

2. Avoid one size fits all training and tailor professional development opportunities to staff positions and responsibilities. Consider the following examples:
    - Staff who are the first point of contact with the public (e.g. reception, front desk, responsible for answering the telephone in clinics, labs, and other offices) will require content that enhances their knowledge and skills in cross-cultural communication, operating language access lines for telephonic interpretation services or when and how to refer to bilingual staff, and other areas of professional courtesy.
    - Staff who are assigned to public health laboratories could benefit from a focus on: how to review standards forms/documents used by the public for health literacy and make appropriate changes; cross-cultural interactions (when obtaining specimens); and cultural appropriateness when fielding complaints.
    - Staff responsible for emergency planning and response could benefit from: culturally and linguistically competent approaches to disseminate information about disaster preparedness; and establishing partnerships with community-based, ethnic-based, and faith-based organizations to disseminate emergency and disaster information.
    - Staff across Department offices and who are responsible for writing grants may require support to develop budgets that accurately estimate the costs of community engagement activities or the provision of interpretation and translation services for populations with limited English proficiency.
    - Pharmacy staff may need professional development on addressing literacy and health literacy of populations, working with interpreters and interacting with patients/consumers with limited English proficiency, and issuing medication instructions in languages other than English.
    - Staff may be able to benefit from professional development on the role of culture and language in health policy development and planning including meaningful ways to involve the diverse populations served by MSDH in planning the services that impact them and their communities.

    Consideration should be given by MSDH to offer coaching, mentoring, and shadowing which are proven professional development/training methods.

3. The Department should consider conducting a survey or other inquiry to ascertain what are the professional development and training interests and needs of MSDH staff. While some staff may be reticent to raise issues of conscious and unconscious, stereotypes, discrimination, and other "ISMs" – such issues are indeed indispensable to CLC and addressing health disparities experienced by specific populations in the State and raised by patients/consumers across the state who participated in focus groups.

4. The Department needs to revisit or create new values that underpin service delivery (e.g., courtesy, professionalism, respect, cultural adaptation of services). These values should be considered within the context of staff professional development/training with a focus on: (a) responding to cross cultural differences in health care, health education, and other public health services; (b) cross-cultural communication; and (c) recognizing and addressing conscious and unconscious biases. Accountability measures to assess the quality of interactions with the public, patients, and consumers should be a strong component of the Department's efforts.

Cross-reference to the National CLAS Standards

(Recommendations for 1-3 above)

Governance, Leadership, and Workforce

Standard 2. Advance and sustain organizational governance and leadership that promotes CLAS and health equity through policy, practices, and allocated resources.

Standard 4. Educate and train governance, leadership, and workforce in culturally and linguistically appropriate policies and practices on an ongoing basis.

Engagement, Continuous Improvement, and Accountability

Standard 9. Establish culturally and linguistically appropriate goals, policies, and management accountability, and infuse them throughout the organization's planning and operations.

REFERENCES

[1]*National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care.* Office of Minority Health, U.S. Department of Health and Human Services. Retrieved on 8/3/15 from *https://www.thinkculturalhealth.hhs.gov/content/clas.asp*

[2] Public Health Accreditation Board Standards and Measures 1.5. pp 238-239. Retrieved on 8/3/15 from http://www.phaboard.org/wp-content/uploads/SM-Version-1.5-Board-adopted-FINAL-01-24-2014.docx.pdf

[3]National Center for Cultural Competence (2006). Cultural and Linguistic Policy Assessment. Washington, DC: Georgetown University Center for Child and Human Development. Retrieved on 8/3/15 from http://www.clcpa.info/