Maryland Health Quality and Cost Council

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Cultural Competency Workgroup Report

Maryland Cultural, Linguistic and Health Literacy Competency Strategies: A Policy Framework for 2013-2020

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Maryland Cultural Competency Strategies and Policy Framework 2013-2020

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Executive Summary

Maryland is a State on the move in 2013. Building on hospital rate setting in the 1970s and Medicaid expansion during the intervening years, the State has established the Maryland Health Quality and Cost Council (MHQCC), the Maryland Health Care Reform Coordinating Council (MHCRCC), and passed several pieces of legislation to reform and modernize the health system. Maryland's health vision for the next decade includes a population health approach; improved patient outcomes and experience; reformed payment and incentives that lead to cost-effective operations; reaching all populations with services they need and can use; and accountability to tax payers and citizens.

The State's population of about 6 million residents includes over 2.6 million minorities and 800,000 immigrants from many counties. This population mix of 45.3% minorities in 2010, and a projected 51% in 2020, calls for special attention to enable health care, behavioral health and social services to be most cost-effective for a diverse population. Recognizing the importance of positive and effective patient-provider encounters in health interactions, Maryland along with other states have passed legislation and enacted requirements to ensure that the health care workforce is culturally, linguistically and health literacy competent and prepared to be effective.

The Maryland Health Improvement and Disparities Reduction Act of 2012 required the Maryland Health Quality and Cost Council (MHQCC) to form the Cultural Competency Workgroup to explore and make recommendations on how the State could increase the cultural, linguistic, and health literacy competency of health providers and health care delivery organizations throughout Maryland. Forty-seven persons were appointed to serve on the Workgroup. There were three legislative charges: 1) develop recommendations for cultural competency standards and tiered reimbursement for medical and behavioral service settings; 2) recommend standards for multicultural health in Patient Centered Medical Homes (and other health care settings); and 3) propose standards for continuing education in cultural competency for health care providers.

The Workgroup process involved three meetings of the full membership. At the November 2012 meeting, the three charges from the MHQCC were defined. Members divided themselves into three subcommittees, each to address a respective charge. Ongoing work took place at the subcommittee level. At the January 2013 meeting, a presentation on cultural competency was conducted by Ms. Darci Graves from SRA International. At the May 2013 meeting, the Subcommittees discussed their work progress and their expected deliverables. Throughout this period, Subcommittee Co-chairs coordinated ongoing work via teleconferences, electronic communication and in-person meetings and produced Subcommittee final reports by July 2013. Workgroup Co-Chairs Dr. Lisa Cooper and Mr. Marcos Pesquera provided updated reports to the MHQCC in December 2012 and March and September of 2013.

A team of 10 volunteers in the Staff Support Group representing academic institutions and diverse health equity experts, worked with State staff and Workgroup members to research and develop recommendations for the charges. Oversight was provided by the Office of Minority Health and Health Disparities in partnership with the Maryland Health Care

Commission. Together, these staff and volunteers conducted widespread research of cultural, linguistic and health literacy competency and related practices and publications throughout the nation. As a result, a total of 19 dedicated professional staff and 44 health equity experts spent time on this project from the fall of 2012 through October 2013. This final report is a composite of their research, experience and review of a wide array of information. A noteworthy observation is that around the nation, cultural, linguistic and health literacy competency is developing into a central measure for identifying the commitment of organizations and initiatives to the achievement of quality health equity in service delivery as systems seek reform and cost-effectiveness.

The findings and recommendations are summarized below by each of the three legislative charges to the workgroup.

Charge 1: *"Examine appropriate standards for cultural and linguistic competency for medical and behavioral health treatment and the feasibility and desirability of incorporating these standards into reporting by health care providers and tiering of reimbursement rates by payors;"*

- Cultural and Linguistic Competency assessment and reporting were found to be both feasible and desirable.
- Standards for the cultural and linguistic competency performance assessment of medical and behavioral health care providers were found to be currently applied in some settings.
- Linking tiered reimbursement rates by payors to medical and behavioral health care providers' cultural and linguistic competency performance assessment results was found to be desirable, but the feasibility will require a more broad experience with assessment and reporting.
- At least 14 states and the District of Columba reimburse language services on a per service basis in their Medicaid programs, either for their Fee –For-Service enrollees or for all enrollees.

Recommendations:

- Integrate the *Maryland RELICC Assessment* quality measurement tool for addressing disparities to the metrics reported in the Maryland *Health Benefit Plan Quality and Performance Report* and in the metrics used to assess the quality of the qualified health plans participating in the State's Health Benefit Exchange, the *Maryland Health Connection.*
- Adapt the concepts in AHRQ's CAHPS *Cultural Competence Item Set* (CCIS) for use in plan assessment for the Maryland *Health Benefit Plan Quality and Performance Report*. This item set broadly covers cultural, linguistic and health literacy competency of providers as reported by their patients.
- Adapt the concepts in AHRQ's CAHPS *Cultural Competence Item Set* (CCIS) for use in assessment of the quality of the State Medicaid MCOs.
- Adapt the concepts in AHRQ's CAHPS *Cultural Competence Item Set* (CCIS) for use in the State's program for assessing hospital quality.
- Ensure that third party payors reimburse healthcare organizations and private physician practices for provision of appropriate language services, including qualified bilingual staff and contractual foreign language and sign language interpreters per encounter, rather than as a bundled payment.

- Assess annually whether the maturity of cultural, linguistic and health literacy competency assessment and reporting in the State is sufficient to begin to link some portion of reimbursement to performance in those competencies.

Charge 2: *"Assess the feasibility of and develop recommendations for criteria and standards establishing multicultural health care equity and assessment programs for the Maryland Patient Centered Medical Home (PCMH) program and other health care settings."*

- Incorporation of cultural and linguistic competency standards into PCMH assessment programs is feasible: NCQA PCMH recognition standards already incorporate cultural and linguistic competency elements, and several states require this recognition in their PCMH programs.

Recommendations:

- Maryland's PCMH programs should require or incentivize participating practices to meet the cultural competency standards contained in national PCMH recognition products.
- Maryland's PCMH programs should examine the feasibility of using the AHRQ's CAHPS Cultural Competence Item Set for provider-level and practice-level assessment of cultural and linguistic competency. This item set broadly covers cultural, linguistic and health literacy competency of providers as reported by their patients.
- Maryland's PCMH programs should require or incentivize participating practices to meet the NCQA Multicultural Health Care Standards or a similar standard.
- Maryland's PCMH programs should assess annually whether the maturity of cultural, linguistic and health literacy competency assessment and reporting in the programs is sufficient to begin to link some portion of reimbursement to performance in those competencies.

Charge 3: *"Recommend criteria for health care providers in the State to receive continuing education in multicultural health care, including cultural competency/health literacy training.*"

- Some states have already developed cultural and linguistic competency continuing education requirements for health professional re-licensure. Maryland should begin to require cultural, linguistic and health literacy competency training for health professional initial licensure and re-licensure.

Recommendations:

- Maryland's health profession boards should require that 5% to 10% of the total continuing education requirement for re-licensure be credits in cultural, linguistic, and health literacy competency.
- Maryland's academic medical centers should identify and/or develop appropriate cultural, linguistic and health literacy competency continuing education materials (both classroom curriculum and individual on-line modules) and make them available to Maryland providers.

- Adopt multicultural health care continuing education (CE) requirements that address the following key components:
    - Amount and frequency of training;
    - Approval process for continuing education credits/units;
    - Curricular structure/Navigation;
    - Compliance monitoring.
- Adopt and promote continuing education curricula that address a standard set of suitable learning objectives adapted from "The Cultural Competency and Health Literacy Primer" (2013). The learning objectives should address health care professionals' knowledge and skills related to cultural diversity, health literacy, cross-cultural communication, proper use of interpreters, bias/stereotyping, social determinants of health, including access to and quality of care, and the impact of these factors on health outcomes and health disparities.
- Adopt and promote continuing education curricula that incorporate a focus on inter-professional education (IPE). An IPE approach enables members of different health profession disciplines to collaborate (and to learn from and with each other) in a teamwork-oriented environment, with the goal of providing the highest quality of care for patients and clients.

The Cultural Competency Workgroup co-chairs, members and staff appreciate the opportunity to investigate this important component of Maryland's initiative to improve health and reduce racial and ethnic disparities among its population. The search was enlightening and elucidating in the discovery of widespread work in cultural, linguistic and health literacy competency at many different levels and sectors of the nation's health and health care delivery system.

I. HEALTH EQUITY AND CULTURAL COMPETENCY IN MARYLAND

A. Challenges and Opportunities for Health Equity in Maryland

The State of Maryland is actively engaged in modernizing its public health and health care delivery systems, linking them both and reforming each to arrive at a new structure with dynamic interaction. The projected results include improved health outcomes and reformed payment and incentive systems that lead to cost- effective operations. Maryland's population of about 6 million residents includes over 2.6 million minorities and almost 800,000 immigrants from many countries. Some of the leading countries of origin for Maryland's minority residents are Nigeria, Ethiopia, Kenya, Jamaica, Haiti, Trinidad & Tobago, El Salvador, Mexico, Dominican Republic, Cuba, India, China and Korea. Among Native Americans in Maryland, prominent tribes in the state include the Cherokee, the Lumbee, and the Piscataway.

This population mix of 45.3% minorities in 2010, and an estimated 51% by 2020, calls for special attention to enable health care, behavioral health and social services to be most cost-effective for a diverse population. In the health care system, citizens are vulnerable due to health illiteracy and the impact of poor health when communicating with health professionals and other staff. Recognizing the importance of communication in health interactions, the Federal government and many states have passed legislation and enacted numerous requirements to ensure that the health care workforce is culturally, linguistically and health literacy competent and prepared to be effective.

While Maryland's diversity (U.S. minorities and immigrants) is increasing, the State's health care delivery and public health workforce is not sufficiently representative of the growing diverse population. For example, African Americans, Hispanics, and Native Americans are underrepresented in the graduates of some of Maryland's health profession schools:

	Black or African American	**Hispanic**	**American Indian or Alaska Native**	**These groups combined**
Maryland Population	**29%**	**8%**	**<1%**	**38%**
Dental School Grads	8%	3%	0%	11%
Medical School Grads	7%	4%	1%	12%
Nursing School (BSN)	29%	3%	<1%	32%
Nursing School (ADN	19%	3%	<1%	22%
Pharmacy School Grads	9%	2%	0%	11%

Source: Office of Minority Health and Health Disparities. Diversity in the Health Professions Fact Sheet. Maryland Department of Health and Mental Hygiene. Baltimore, MD. August 2013.

In addition, there is national-level anecdotal evidence of the under-representation of several Asian/Pacific Islander sub-populations among health profession graduates, although current data collection surveys are not capturing this sub-population data.

B. Current Cultural Competency Initiatives in Maryland

The Department of Health and Mental Hygiene has launched a number of new initiatives over the past two years to implement Maryland's Health Reform program. Among them are the Local State Health Improvement Plans that identify race and ethnic measures for program focus; the Community Integrated Medical Home Project that stimulates innovative service delivery models; the CDC Community Transformation projects that support Statewide and local efforts to reduce chronic disease; the HHS Million Hearts Initiative that strengthens healthy hearts programs; the Maryland Health Enterprise Zones that designated and funded five small geographic areas to saturate resources using diverse community-based partnerships; and the State Health Insurance Marketplace that began enrolling uninsured citizens on October 1, 2013.

Other initiatives underway in the State include the Maryland Health Care Reform Coordinating Council that guides and connects the various ACA efforts; the Maryland Health Quality and Cost Council that promulgates initiatives that focus on increasing quality and safety in health care delivery; the General Assembly's Health and Government Operations subcommittee on Minority Health Disparities that monitors health equity efforts in the State; and health disparities centers at the major health professional institutions.

C. New Strategy for Cultural Competency in Maryland

Looking ahead to 2020 and beyond, Maryland's elected officials, administration, and health system leadership have amplified efforts to accelerate reform of the State's health system.

<u>Health Care Reform Coordinating Council 2011 Initiatives being implemented:</u>

- Diversify Maryland's health care workforce; enhance its cultural and linguistic competence
- Promote and support education and training to expand the State's workforce pipeline
- Explore improvements in policies for licensing health professionals
- Promote cultural, linguistic and health literacy competency assessment and training
- Institute payment reform to incentivize quality improvements and cost savings
- Reduce/eliminate health disparities through financial performance-based incentives.

<u>Maryland pursuit of the Triple Aim in 2014 to address health reform:</u>

- Improve patient satisfaction (cultural, linguistic, health literacy competency is essential)
- Improve health of populations
- Reduce per capita health care costs

<u>Patient Centered Medical Home (PCMH) implementation in 2013:</u>

- Place the patient in the center of the medical intervention and practice
- Empower patients to serve as a team member in their medical management
- Establish organizational and provider cultural and linguistic competency
- Establish health literacy competency
- Use the CAHPS *Cultural Competence Item Set* as part of its program evaluation.

Maryland Health Improvement and Disparities Reduction Act of 2012:

The purpose of the Health Disparities Act of 2012 is to reduce health disparities, improve health outcomes and reduce health costs and hospital admissions and re-admissions. The following provisions are being implemented in the State to achieve these ends:

- Establish Health Enterprise Zones (HEZ)s to target resources to small areas of need
- Require standard measures of race and ethnicity in annual MHCC quality reports
- Require non-profit hospitals to report their efforts to reduce health disparities
- Require health profession educational institutions to report efforts to reduce disparities
- Recommend standards for evaluating the impact of PCMH on health disparities
- Develop standards/criteria for cultural competency in medical and behavioral health.

Maryland Health Care Commission, RELICC Assessment

The Maryland Health Improvement and Disparities Reduction Act of 2012 required the Maryland Health Care Commission (MHCC) to incorporate standard measures regarding race and ethnicity in annual MHCC quality reports. In response to this legislative charge, MHCC began implementing a Maryland specific health benefit plan quality reporting tool in 2013. This tool is the Maryland *Race/Ethnicity, Language, Interpreters, and Cultural Competency (RELICC)* Assessment.

- The tool has been successfully pilot tested.
- Maryland commercial carriers operating inside and outside the Exchange are committed to the use of the RELICC tool for reporting.

Maryland Health Quality and Cost Council (MHQCC), 2012 Cultural Competency Workgroup:

The Maryland Health Improvement and Disparities Reduction Act of 2012 required the MHQCC to establish a Cultural Competency Workgroup that would consider policies and strategies to increase cultural, linguistic and health literacy competency among the state's health care providers and organizations. A report with recommendations was mandated, due December 2013. The charges for the Workgroup were:

- Examine appropriate standards for cultural and linguistic competency for medical and behavioral health treatment and the feasibility and desirability of incorporating these standards into reporting by health care providers and tiering of reimbursement rates;
- Assess the feasibility of and develop recommendations for criteria and standards establishing multicultural health care equity and assessment programs for the Maryland Patient Centered Medical Home program and other health care settings; and
- Recommend criteria for health care providers in Maryland to receive continuing education in multicultural health care, including cultural competency and health literacy training.

II. WORKGROUP METHODOLOGY

There were three in-person meetings of the full Workgroup:

- November 29, 2012: During the inaugural meeting, three separate charges were defined for the workgroup. Workgroup members-at-large were then divided into three Subcommittees established to address one of the three identified charges.
- January 23, 2013: At the second meeting, a presentation on cultural competency was conducted by Ms. Darci Graves (SRA International) to support discussion and a common understanding of cultural competency as an evolving field and to identify strategies for addressing the needed research to be undertaken by each Subcommittee.
- May 14, 2013: During the final in-person meeting, each Subcommittee provided an update on their work progress and a firm timeline was set for completion of deliverables from each Subcommittee.

During this period, the Office of Minority Health and Health Disparities held periodic conference call discussions with the two Workgroup Co-Chairs and with chairs of the subcommittees to assist the process in moving forward on its timeline.

Workgroup Co-Chairs, Dr. Lisa Cooper and Mr. Marcos Pesquera presented updated information on the progress of the Workgroup to the Maryland Health Quality and Cost Council on December 7, 2012, March 18, 2013, and September 13, 2013.

Throughout this process, each Subcommittee coordinated several electronic meetings and teleconferences in order to continue progress with the duties of their charge and work toward a goal of producing a Subcommittee report with their findings. Subcommittee action steps were:

- Conducted literature searches to identify existing local, state and national standards, research, programs and processes relevant to each charge;
- Queried local programs, academic experts and others outside of the Workgroup and subcommittee membership for information on cultural, linguistic and health literacy competency related to each charge;
- Reviewed, examined and considered all materials collected in search of evidence-based or promising practices, and existing opportunities and resources relevant to their respective charges; and
- Conducted careful consideration of materials and the opinion of Subcommittee members to draft reports that described their exploration and presented recommendations to the full Workgroup. The Subcommittees' submission included the individual subcommittee reports with descriptions of their work, lists of members, and numerous appendices.

The staff of the Office of Minority Health and Health Disparities and the Maryland Health Care Commission took all of this material into consideration. Additional input was obtained from the Statewide Health Disparities Collaborative meeting on September 18, 2013, from the Workgroup Co-Chairs, Dr. Lisa Cooper and Mr. Marcos Pesquera, and from additional field work, and drafted into this report for presentation to the Maryland Health Quality and Cost Council. This report is a composite of all work that was completed. It has 14 recommendations.

III. WORKGROUP FINDINGS AND RECOMMENDATIONS

A. Charge 1: Feasibility/Desirability of Reporting & Reimbursement Linkage

1. The Legislative Charge:

"Examine appropriate standards for cultural and linguistic competency for medical and behavioral health treatment and the feasibility and desirability of incorporating these standards into reporting by health care providers and tiering of reimbursement rates by payors;"

This charge contains the following four distinct components to be addressed:

1. Examine **Desirability** of incorporating standards into **Reporting.**
2. Examine **Desirability** of incorporating standards into **Tiered Reimbursement.**
3. Examine **Feasibility** of incorporating standards into **Reporting.**
4. Examine **Feasibility** of incorporating standards into **Tiered Reimbursement.**

2. Findings:

1. Desirability of Incorporating Standards into Reporting - YES

The desirability of incorporating standards into reporting by health care providers derives from evidence that cultural and linguistic competency in clinical care results in benefits to the triple aim of healthcare (1): improved patient experience of care, improved population health, and reduced per-capita cost. The desirability of incorporating standards is also supported by the consensus of expert organizations advocating culturally and linguistically competent care and advocating training of health care professionals in those competencies.

Evidence for Cultural Competency Benefits: Several systematic reviews have documented the benefits of culturally and linguistically competent care (2) (3) (4) (5). The table below provides selected examples of the evidence that culturally linguistically-competent care leads to improved outcomes.

Woerner, L., et al. Project (¡EXITO!): success through diversity and universality for outcomes improvement among Hispanic home care patients. Nurs Outlook. 2009 Sep-Oct; 57(5): 266-73.	
Setting	Hispanic home care patients.
Intervention	A culturally appropriate nursing home care program was developing use of the Leininger Sunrise Enabler approach for Hispanic patients.
Usual Care	Same subjects prior to the implementation of the intervention
Result	Home nursing care utilizing the culturally appropriate program reduced acute hospitalization and emergency care visits. Additionally, patients in the culturally appropriate nursing program had improved medication management, and greater nursing care satisfaction.

Jacobs, E. A., et al. The impact of an enhanced interpreter service intervention on hospital costs and patients satisfaction. J Gen Intern Med. 2007 Nov; 22 Suppl 2:306-11.	
Setting	Public hospital, inpatient Internal Medicine service
Intervention	Enhanced interpreter service using a trained Spanish medical interpreter.
Usual Care	No interpreter services or use of ad hoc interpreters, telephonic interpreters, or the usual hospital interpreter service.
Result	No significant impact of the enhanced interpreter service on measured outcomes (satisfaction with nursing, satisfaction with physicians, satisfaction with hospital stay) for Spanish-speaking patients. Spanish-speaking patients who had a Spanish-speaking physician reported greater satisfaction with physician care and the overall hospital stay than patients with usual care. Spanish –speaking patients who had a Spanish-speaking attending had significantly fewer return ED visits after discharge.

Enriquez, M., et al. Impact of a bilingual/bicultural care team on HIV-related health outcomes. J Assoc Nurses AIDS Care. 2008 Jul-Aug;19(4):295-301.	
Setting	Academic HIV specialty clinic, HIV + Hispanic/Latino adults.
Intervention	A bilingual/bicultural care team was developed and used in the second year of the study.
Usual Care	Usual care (1st year of study) was a non-bilingual/bicultural care team.
Result	In the year after the implementation of the bilingual/bicultural care team, there were more clinic visits per patient than the year prior to the implementation of the care team. Additionally, in the year after implementation of the care team, patients were more likely to have suppressed HIV viral loads <50 copies/ml than the year before the bilingual/bicultural care team was implemented.

Guerrero, E.G. et al. Do cultural and linguistic competence matter in Latinos' completion of mandated substance abuse treatment? Subst Abuse Treat Prev Policy. 2012 Aug 16;7:34.	
Setting	Publically funded treatment programs contracted through the criminal justice system.
Intervention	No intervention arm; observational study.
Usual Care	Existing health care system.
Result	5,150 first-time Latino clients were placed within 48 treatment programs to assess whether culturally and linguistically responsive contexts improve substance abuse treatment adherence. Programs that routinely offered cultural and linguistic services, most importantly Spanish-language translation, were associated with a higher likelihood of patients completing the mandated treatment.

Slean, G.R., et al. Aspects of culturally competent care are associated with less emotional burden among patients with diabetes. Med Care. 2012 Sep; 50(9 Suppl 2):S69-73.	
Setting	Safety-net clinics in two different cities.
Intervention	No intervention arm; observational study
Usual Care	Existing health care system.
Result	502 ethnically diverse patients with diabetes were interviewed to determine if aspects of culturally competent care were associated with the emotional burden of diabetes distress. Patients who reported optimal doctor communication-positive behaviors and optimal trust were associated with lower emotional burden of diabetes distress. Doctor communication- health promotion communication was not associated with emotional burden of diabetes distress.

Fernandez, A., et al. Associations between aspects of culturally competent care and clinical outcomes among patients with diabetes. Med Care. 2012 Sep; 50(9 Suppl 2): S74-9.	
Setting	Urban safety net clinics in two different cities.
Intervention	No intervention arm.
Usual Care	No usual source of care.
Result	Patients were surveyed and chart reviews were conducted on 600 patients with type 2 diabetes and a primary care physician. Patients who reported having high trust in their physician were more likely to have a lower likelihood of poor glycemic control among safety net population patients with diabetes. Doctor communication behavior was not associated with a lower likelihood of poor glycemic control in this safety net population with diabetes.

McEwen, M.M., et al. Type 2 diabetes self-management social support intervention at the U.S.-Mexico border. Public Health Nurs. 2010 Jul-Aug; 27(4):310-9.	
Setting	Community in the Arizona-Sonora, Mexico border region.
Intervention	Culturally-tailored diabetes self-management social support intervention for Mexican American adults with type 2 diabetes living on U.S.- Mexico border. Intervention was developed by a bilingual, bicultural certified diabetes educator and a nurse researcher.
Usual Care	Same subjects prior to the implementation of the intervention.
Result	The culturally tailored intervention was significantly associated with increases in self-care regarding diet, exercise, foot care and increases in overall diabetes self-care. Intervention also decreased diabetes regimen distress and increased diabetes knowledge. The largest effect size observed was the reduction of diabetes regimen distress following the intervention. Physiologic diabetes outcomes did not significantly change following the intervention.

Zeh, P., et al. The impact of culturally competent diabetes care interventions for improving diabetes-related outcomes in ethnic minority groups: a systematic review. Diabet Med. 2012 Oct; 29(10):1237-52.	
Setting	11 studies included- variety of settings with a range of service providers.
Intervention	Varying range of culturally competent interventions- 7 highly culturally competent, 4 moderately culturally competent.
Usual Care	Non-intervention care
Result	Across ten of the studies reviewed, structured interventions that were tailored to ethnic minority groups by means of integrating elements of culture, language, religion, and health literacy skills into practice were found to produce a positive impact on a range of patient-important outcomes.

Michalopoulou, G., et al. Implementing Ask Me 3 to improve African American patient satisfaction and perceptions of physician cultural competency. J Cult Divers. 2010 Summer; 17(2):62-7.	
Setting	Physician offices, African American patients.
Intervention	African American intervention participants received the “Ask Me 3” pamphlet before a visit with a physician. This pamphlet encourages patients to ask their physicians questions during the medical appointment.
Usual Care	African American control patients did not receive the Ask Me 3 pamphlet.
Result	Intervention participants who saw their regular physician during the appointment reported higher satisfaction than controls. All intervention participants reported that they found the questions in the pamphlet helpful, and reported knowing more about their medical condition after their visit.

Flicker, S.M., et al. Ethnic matching and treatment outcome with Hispanic and Anglo substance-abusing adolescents in family therapy. J Fam Psychol. 2008 Jun; 22(3):439-47.	
Setting	Family therapist offices, Hispanic and Anglo substance-abusing adolescents.
Intervention	Adolescents were ethnically matched with family therapists.
Usual Care	Anglo and Hispanic adolescents were seen by Anglo family therapists.
Result	Hispanic adolescents, when ethnically matched with a Hispanic family therapist, had greater decreases in substance use compared to Hispanic adolescents who were matched with an Anglo family therapist. Ethnic matching did not significantly affect substance abuse treatment for Anglo patients.

Sarver, J., et al. Effect of language barriers on follow-up appointments after an emergency department visit. J Gen Intern Med. 2000 Apr; 15(4):256-64.	
Setting	Urban hospital emergency room with English and Spanish-speaking patients.
Intervention	Not an intervention. Possible conditions: 1) language-concordant provider, 2) interpreter used, or 3) interpreter needed but not used.
Usual Care	All three conditions were variants of usual care
Result	Spanish-speaking patients who used an interpreter (could be a family member) or reported that they did not have an interpreter when they thought one was necessary were significantly less likely to be given a referral for a follow-up appointment after the ED visit than Spanish-speaking patients who had a language-concordant physician. Intervention groups were not significantly associated with follow-up appointment compliance.

Basáñez , T., et al. Ethnic group's perception of physicians' attentiveness: implications for health and obesity. Psychol Health Med. 2013; 18(1) 37-46.	
Setting	Variables from the Health Tracking Household Survey 2007 were analyzed to determine if perceived physician attentiveness mediated the relationship between physician health recommendations and patient health status.
Intervention	No intervention arm; observational study
Usual Care	Existing health care system.
Result	Hispanics and African Americans were significantly less likely to perceive their physicians as attentive to their health needs compared to Caucasian patients. Doctors' recommendations for diet and exercise did not significantly affect patients' body mass index for any of the ethnic groups.

Cooper LA, et al. Comparative effectiveness of standard versus patient-centered collaborative care interventions for depression among African Americans in primary care settings: the BRIDGE Study. Health Serv Res. 2013 Feb;48(1):150-74.	
Setting	10 urban community-based primary care practices in Maryland and Delaware
Intervention	patient-centered, culturally tailored collaborative care for African Americans with depression
Comparison Group	State-of-the-art non-tailored collaborative care for depression
Results	Patients in both groups showed statistically significant improvements in depression symptom levels and mental health functioning over 12 months. Traditional mental health treatment rates increased among non-tailored but not culturally-tailored patients. However, culturally-tailored patients had higher adherence to care management visits and rated their care manager as more helpful at identifying their concerns and helping them adhere to treatment.

Endorsements of Cultural Competency: The following table summarizes documents from leading health and healthcare entities supporting cultural competency in clinical care:

Health Entity:	Document:	Statement:
US HHS: Office of Minority Health (OMH)	Website for *National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health and Health Care* (6)	"Health inequities in our nation are well documented, and the provision of culturally and linguistically appropriate services (CLAS) is one strategy to help eliminate health inequities. By tailoring services to an individual's culture and language preference, health professionals can help bring about positive health outcomes for diverse populations. The provision of health care services that are respectful of and responsive to the health beliefs, practices and needs of diverse patients can help close the gap in health care outcomes."
US HHS: Center for Medicare and Medicaid Services (CMS)	Medicare Learning Network (MLN) Matters Number SE0621 *Cultural Competency: A National Health Concern* (7)	"To ensure that providers are prepared for the challenges they face to deliver the right care to every person every time, CMS's Quality Improvement Organizations (QIOs) are working with healthcare providers to become more effective and culturally aware of how they provide care to diverse populations. As part of a national initiative, QIOs are recruiting health providers to participate in a FREE online (web-based) program *A Family Physician's Practical Guide to Culturally Competent Care* to ensure that Medicare providers are prepared to effectively serve the increasingly diverse patient population. QIOs have adopted the Guide as the "Program of Choice" for health care provider cultural competency education."
US HHS: Agency for Healthcare Research and Quality (AHRQ)	*About the CAHPS Cultural Competence Item Set*. Document No. 2312, (2012) (8)	"To be culturally competent, health care providers have to employ various interpersonal and organizational strategies that bridge barriers to communication and understanding that stem from racial, ethnic, cultural, and linguistic differences. In the winter of 2011, the CAHPS Consortium adopted a new set of supplemental items for the CAHPS Clinician & Group Surveys that focus on assessing the cultural competence of health care providers from the patient's perspective."

Health Entity:	Document:	Statement:
US HHS: National Institutes of Health (NIH)	NIH *Clear Communication* webpage (9)	"Cultural competency is critical to reducing health disparities and improving access to high-quality health care, health care that is respectful of and responsive to the needs of diverse patients. When developed and implemented as a framework, cultural competence enables systems, agencies, and groups of professionals to function effectively to understand the needs of groups accessing health information and health care—or participating in research-in an inclusive partnership where the provider and the user of the information meet on common ground."
Institute of Medicine (IOM)	*Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care* (2003) (10)	"Cultural competence may be defined as the ability of individuals to establish effective interpersonal and working relationships that supersede cultural differences…three strategic approaches include direct services, cultural homophilly, and institutional accommodations." (pp.554-555) **Recommendation 5-8:** Enhance patient-provider communication and trust by providing financial incentives for practices that reduce barriers and encourage evidence-based practice. **Recommendation 5-9:** Support the use of interpretation services where community need exists. **Recommendation 6-1:** Integrate cross-cultural education into the training of all current and future health professionals.
Association of American Medical Colleges (AMCC)	*Cultural Competence Education* (2005) (11)	"In 2000, the Liaison Committee on Medical Education (LCME) introduced the following standard for cultural competence: 'The faculty and students must demonstrate an understanding of the manner in which people of diverse cultures and belief systems perceive health and illness and respond to various symptoms, diseases, and treatments. Medical students should learn to recognize and appropriately address gender and cultural biases in health care delivery, while considering first the health of the patient.'"

Health Entity:	**Document:**	**Statement:**
American Medical Association (AMA)	*Cultural Competence Compendium* (1999) (12)	(From the Back Cover) "The Cultural Competence Compendium is a resource for physicians in identifying issues surrounded different populations - and learning to examine their own issues as well - so that the care we as physicians provide is the right care for each and every patient we see and the highest quality of care for every patient."
Heath Research and Educational Trust *(of the American Hospital Association)*	*Becoming a Culturally Competent Health Care Organization* (2013) (13)	"It is imperative that hospitals and health care systems understand not only the diverse patients and communities they serve but also the benefits of becoming a culturally competent organization. Hospitals and care systems must prepare their clinicians and staff to interact with patients of diverse backgrounds to increase patient engagement and education and to help eliminate racial and ethnic disparities in care. To improve understanding of diverse cultures, hospitals and care systems should seek advice from individuals and groups in the communities they serve. These constituencies can help hospitals and care systems develop educational materials, increase patient access to services and improve health care literacy."
The Joint Commission	*Advancing Effective Communication, Cultural Competence, and Patient-and Family Centered Care: A Roadmap for Hospitals* (2010) (14)	"The nation's hospitals traditionally focus on meeting the clinical needs of their patients; they seek to prevent errors and avoid inaccuracies that negatively impact the safety and quality of care. However, patients also have specific characteristics and nonclinical needs that can affect the way they view, receive, and participate in health care. A growing body of research documents that a variety of patient populations experience decreased patient safety, poorer health outcomes, and lower quality care based on race, ethnicity, language, disability, and sexual orientation."

Health Entity:	**Document:**	**Statement:**
National Committee for Quality Assurance (NCQA)	NCQA *Multicultural Health Care Distinction* web page (15)	"Cultural competency is a necessary component of a high quality health care system. NCQA's Multicultural Health Care (MHC) offers distinction to organizations that engage in efforts to improve culturally and linguistically appropriate services and reduce health care disparities. The Multicultural Health Care Distinction evaluates organizations, such as health plans, wellness, disease management and managed behavioral health organizations through use of an evidence-based set of requirements."
National Quality Forum (NQF)	*A Comprehensive Framework and Preferred Practices for Measuring and Reporting Cultural Competency* (2009) (16)	"The National Quality Forum (NQF), an organization dedicated to improving healthcare quality, has endorsed 45 practices to guide healthcare systems in providing care that is culturally appropriate and patient centered. This report presents those practices along with a comprehensive framework for measuring and reporting cultural competency, covering issues such as communication, community engagement and workforce training, and providing healthcare systems with practices they can implement to help reduce persistent disparities in healthcare and create higher-quality, more patient-centered care."
National Association of Social Workers	*Code of Ethics of the National Association of Social Workers* (2008) (17)	1.05 Cultural Competence and Social Diversity. "1. Social workers should understand culture and its function in human behavior and society, recognizing the strengths that exist in all cultures. 2. Social workers should have a knowledge base of their clients' cultures and be able to demonstrate competence in the provision of services that are sensitive to clients' cultures and to differences among people and cultural groups. 3. Social workers should obtain education about and seek to understand the nature of social diversity and oppression with respect to race, ethnicity, national origin, color, sex, sexual orientation, age, marital status, political belief, religion, and mental or physical disability.

Health Entity:	Document:	Statement:
Council on Social Work Education	*Education Policy Accreditation Standard on Cultural Competence* (2012) (18)	Educational Policy 2.1.4 – Engage Diversity and Difference in Practice. "Social workers understand how diversity characterizes and shapes the human experience and is critical to the formation of identity. The dimensions of diversity are understood as the intersectionality of multiple factors including age, class, color, culture, disability, ethnicity, gender, gender identity and expression, immigration status, political ideology, race, religion, sex, and sexual orientation. Social workers appreciate that, as a consequence of difference, a person's life experiences may include oppression, poverty, marginalization, and alienation as well as privilege, power, and acclaim."
Maryland Health Care Commission (MHCC)	Maryland *Race/Ethnicity, Language, Interpreters, and Cultural Competency* Assessment (RELICC) (19)	In 2013, the MHCC collaborated with the private, commercial carriers operating in the State during the development phase for the Maryland RELICC Assessment. RELICC is a quality and performance measurement tool that was customized for the State of Maryland by the National Business Coalition on Health and the Mid-Atlantic Business Group on Health, with input from Maryland's private, commercial carriers. The initial year of RELICC implementation is already underway by Maryland's carriers with health benefit plans that are required to report on a variety of quality and performance metrics on issues surrounding race/ethnicity, language, interpreter need, and cultural competency.

There is evidence that culturally and linguistically competent care improves triple aim outcomes. There is also broad consensus among leading health entities that cultural and linguistic competency is beneficial in health care. The desirability of having a culturally and linguistically competent health care system in Maryland derives from this evidence and these expert opinions, and is amplified by the high racial and ethnic diversity of the State (45.3% minority in the 2010 census and over 50% minority projected before 2020). Assuring that Maryland is moving toward a more culturally and linguistically competent health care system requires measuring that competence. Therefore, incorporating cultural and linguistic competency standards into the quality reporting by providers and health care organizations is desirable, and should be pursued.

2. Desirability of Incorporating Standards into Tiered Reimbursement - YES

Having established the desirability of having a culturally and linguistically competent health care system in Maryland, it is clear that efforts which promote, enable, and incentivize improvements in cultural and linguistic competency are also desirable to reach that goal. Therefore, it is desirable to use incentives based on reimbursement as one means to promote improvements in cultural and linguistic competency. Reimbursement incentives can be based on cultural and linguistic competency training and performance to the extent that training is meaningful and performance can be accurately measured in a manner that is fair to all providers and systems. This is the question of feasibility, which is addressed below.

3. Feasibility of Incorporating Standards into Reporting - YES

The workgroup considered two components to the question of whether incorporating standards for cultural and linguistic competency into reporting by health care providers is feasible:

- Are there currently standards for cultural and linguistic competence that are operationalized for measurement and assessment of:
    - Medical and behavioral health providers in the clinical setting?
    - Health care systems at the organizational level?
- Are there other states, or are there health care related entities, that are currently and successfully utilizing cultural and linguistic competence standards as part of provider, plan and institutional quality reporting?

Clinically Operationalized Standards for Cultural Competency

The Subcommittee working on this charge reviewed several models of cultural competency standards (see appendix 1). Two sets of standards that emerged from that review as the most suitable for measurement and assessment in the clinical setting were:

Maryland *Race/Ethnicity, Language, Interpreters, and Cultural Competency* Assessment (RELICC) (19): This new quality measurement tool was fielded as a pilot program for 2013 quality and performance reporting by commercial health benefit plans in Maryland. Plan performance is evaluated along several criteria including:

- Demographics – Important to understand member, provider, and plan staff demographics.
- Data Use by Plans – Important to understand how the collected data is used by plan staff:
    - Assess adequacy of language assistance to meet members' needs
    - Calculate HEDIS or other clinical quality and performance measures by race, ethnicity, or language
    - Calculate CAHPS or other measures of member experience by race, ethnicity, or language
    - Identify areas for quality improvement

    - Share provider information with enrollees to enable them to select concordant clinicians
    - Share information with provider network to assist them in providing language assistance and culturally competent care
    - Set goals (develop targets for improving minority outcomes and reducing measured disparities in preventive or diagnostic care)
    - Develop disease management or other outreach programs that are culturally sensitive

- Member Language Support – Important to understand type of support provided and its impact.
- Delivery of Culturally Competent Care – Important to understand strategies being employed.
- Other RELICC Information – Important to understand additional organizational innovations.

AHRQ's CAHPS *Survey Cultural Competence Item Set* (8): The Agency for Healthcare Research and Quality's (AHRQ) Consumer Assessment of Health Plans and Systems (CAHPS) *Cultural Competence Item Set* consists of supplemental items designed for use with the CAHPS Clinician and Group Survey. The 34-item supplemental survey is completed by a patient and addresses the cultural competence of a particular provider. The items address the following five topic areas:

- Patient-Provider (or Doctor) Communication
- Complementary and Alternative Medicine
- Experiences of Discrimination Due to Race/Ethnicity, Insurance, or Language
- Experiences Leading to Trust or Distrust (including Level of Trust)
- Linguistic Competency (Access to Language Services)

Other standards operationalized for provider or organizational assessment include:

NCQA Multicultural Health Care Distinction Program (15): The National Committee for Quality Assurance (NCQA) *Multicultural Health Care Distinction Program* awards this distinction to health plans which meet NCQA's *Multicultural Health Care Standards*. These standards organize 15 elements into five domains of Multicultural Health Care. Those five domains are:

- Race/Ethnicity and Language Data
- Access and Availability of Language Services
- Practitioner Network Cultural Responsiveness
- Culturally and Linguistically Appropriate Services Programs
- Reducing Health Care Disparities

Currently, 12 organizations (representing 20 insurance plan products) nationally have achieved this distinction; none of them are organizations operating within Maryland.

The Joint Commission Standards (14): The Joint Commission (formerly Joint Commission on Accreditation of Health Care Organizations or JCAHCO) has incorporated standards regarding cultural and linguistic competency and provider-patient communication in its most recent accreditation standards.

HR.01.04.01 - The hospital provides orientation to staff.

- EP 5: The hospital orients staff on the following: Sensitivity to cultural diversity based on their job duties and responsibilities. Completion of this orientation is documented.

HR.01.05.03 - Staff participate in ongoing education and training.

- EP 1: Staff participate in ongoing education and training to maintain or increase their competency. Staff participation is documented.
- EP 5: Staff participate in education and training that is specific to the needs of the patient population served by the hospital. Staff participation is documented.

PC.02.01.21 - The hospital effectively communicates with patients when providing care, treatment, and services.

- EP 1: The hospital identifies the patient's oral and written communication needs, including the patient's preferred language for discussing health care.
- EP 2: The hospital communicates with the patient during the provision of care, treatment, and services in a manner that meets the patient's oral and written communication needs.

PC.02.02.03 - The hospital makes food and nutrition products available to its patients.

- EP 9: When possible, the hospital accommodates the patient's cultural, religious, or ethnic food and nutrition preferences, unless contraindicated.

PC.02.03.01 - The hospital provides patient education and training based on each patient's needs and abilities.

- EP 1: The hospital performs a learning needs assessment for each patient, which includes the patient's cultural and religious beliefs, emotional barriers, desire and motivation to learn, physical or cognitive limitations, and barriers to communication.

RC.02.01.01 - The medical record contains information that reflects the patient's care, treatment, and services.

- EP 1: The medical record contains the following demographic information:
  - The patient's language and communication needs, including preferred language for discussing health care
- EP 28: The medical record contains the patient's race and ethnicity.

RI.01.01.03 - The hospital respects the patient's right to receive information in a manner he or she understands.

- EP 1: The hospital provides information in a manner tailored to the patient's age, language, and ability to understand.
- EP 2: The hospital provides language interpreting and translation services.
- EP 3: The hospital provides information to the patient who has vision, speech, hearing, or cognitive impairments in a manner that meets the patient's needs.

National Quality Forum (NQF) endorsed practices (16): There are 45 practices overall, 12 of which are captured by the Cultural Competency Implementation Measure (NQF # 1919) (20). These practices include:

- Preferred Practice 3: Ensure that a commitment to culturally competent care is reflected in the vision, goals, and mission of the organization, and couple this with an actionable plan.
- Preferred Practice 4: Implement strategies to recruit, retain, and promote at all levels of the organization a diverse leadership that reflects the demographic characteristics of the service area.
- Preferred practice 8: Integrate into the organizational strategic plan clear goals, policies, operational procedures, and management accountability/oversight mechanisms to provide culturally competent services.
- Preferred practice 10: Implement reward and recognition programs to recognize specific individuals, initiatives, and programs within the organization that promote cultural competency.
- Preferred practice 12: Offer and provide language access resources in the patient's primary written and spoken language at no cost, at all points of contact, and in a timely manner during all hours of operation, and provide both verbal offers and written notices informing patients of their right to receive language assistance services free of charge.
- Preferred Practice 23: Develop and implement a comprehensive care plan that addresses cultural concerns.
- Preferred Practice 30: Implement training that builds a workforce that is able to address the cultural needs of patients and provide appropriate and effective services as required by federal, state, and local laws, regulations, and organizational policies.
- Preferred Practice 32: Collaborate with the community to implement programs with clinical and outreach components to address culturally diverse populations, health disparities, and equity in the community.
- Preferred Practice 37: Ensure that, at a minimum, data on an individual patient's race and ethnicity (using the Office of Management and Budget categories as modified by HRET), and primary written and spoken language are collected in health records and integrated into the organization's management information systems. Periodically update the language information.

- Preferred Practice 40: Apply a quality improvement framework to improve cultural competency and discover and eliminate disparities in care using the race, ethnicity, and primary written and spoken language information collected by the institution.

States Requiring Cultural Competency Assessment and Reporting

The following states require NCQA recognition in their Patient Centered Medical Home (PCMH) Programs, which include items regarding Culturally and Linguistically Appropriate Services (CLAS) (see Charge 2):

- Maryland
- Connecticut
- New York
- Utah
- Vermont

Based on the evidence presented above regarding available assessment instruments and the current use of cultural competency assessment and reporting, its feasibility is confirmed.

4. Feasibility of Incorporating Standards into Tiered Reimbursement – EVOLVING

While assessment and reporting of cultural and linguistic competency is ongoing in several states and health care organizations, direct linkage of reimbursement to such assessment has just begun to evolve. Basing eligibility for PCMH status (and its associated share savings incentive payments) on meeting NCQA PCMH accreditation standards (and its criteria regarding multicultural health care) represents the beginning of such linkages, and is in place in several states (see discussion of Charge 2 and table on page 29).

Linkage of reimbursement to cultural and linguistic competency standards is in theory feasible, but to be implemented fairly requires proficient and accurate assessment of cultural competency, and the exercise of care to be sure that a fiscal incentive system does not unfairly penalize providers who care primarily for minority or other disadvantaged populations. Robust and routine systems for cultural and linguistic competency assessment are just now reaching wider dissemination and use. These are a key pre-requisite to the implementation of reimbursement incentives based on such assessment. This is likely the explanation for the scarcity of reimbursement linkages at this time; as cultural and linguistic competency assessment matures, it is logical that reimbursement linkages will follow.

States Reimbursing for Language Services in Medicaid Programs

A report from the National Health Law Program in 2009 (21) identified 13 states and the District of Columbia as reimbursing for language services on a per-encounter basis in their Medicaid programs. The 13 states were Hawaii, Iowa, Idaho, Kansas, Maine, Minnesota, Montana, New Hampshire, Utah, Vermont, Virginia, Washington and Wyoming. Payments ranged from as low as $0.20 per minute to as much as $3.00 per minute, billed by the minute or by set fractions of hours (per 15 minutes being very common). Some programs had different

rates for different languages (presumably common vs. rare) and for in-person vs. telephonic services. Some programs only reimbursed language services for the fee-for-service enrollees while other programs reimbursed for all enrollees.

In 2012, New York State began reimbursement for language services on a per encounter basis in Medicaid. As one example of a reimbursement model, New York provides no reimbursement for less than 8 minutes of a language service;, pays $11.00 for 8 to 22 minutes of service; and pays $22.00 for more than 22 minutes of services. New York only reimburses for fee-for-service enrollees; and the service is considered a part of the prospective payment for enrollees in managed care (22).

It is clear that per-service reimbursement for language services is in place for many state Medicaid programs. Maryland can use these models to design per-service reimbursement in its Medicaid program and in other health insurance products in Maryland.

Summary of Findings

Cultural and Linguistic Competency assessment and reporting were found to be both feasible and desirable.

Standards for the cultural and linguistic competency performance assessment of medical and behavioral health care providers were found to be currently applied in some settings.

Linking reimbursement to Cultural and Linguistic Competency assessment results was found to be desirable, but its feasibility will require a more broad experience with assessment and reporting.

At least 14 states and the District of Columba reimburse language services on a per service basis in their Medicaid programs, either for their Fee –For-Service enrollees or for all enrollees.

3. Recommendations:

- Integrate the *Maryland RELICC Assessment* quality measurement tool for addressing disparities into the metrics reported in the Maryland *Health Benefit Plan Quality and Performance Report* and in the metrics used to assess the quality of the qualified health plans participating in the State's Health Benefit Exchange, the *Maryland Health Connection.*
- Adapt the concepts in AHRQ's CAHPS *Cultural Competence Item Set* (CCIS) for use in plan assessment for the Maryland *Health Benefit Plan Quality and Performance Report*. This item set broadly covers cultural, linguistic and health literacy competency of providers as reported by their patients.
- Adapt the concepts in AHRQ's CAHPS *Cultural Competence Item Set* (CCIS) for use in assessment of the quality of the State Medicaid MCOs.

- Adapt the concepts in AHRQ's CAHPS *Cultural Competence Item Set* (CCIS) for use in the State's program for assessing hospital quality.
- Ensure that third party payors reimburse healthcare organizations and private physician practices for provision of appropriate language services, including qualified bilingual staff and contractual foreign language and sign language interpreters per encounter, rather than as a bundled payment.
- Assess annually whether the maturity of cultural, linguistic and health literacy competency assessment and reporting in the State is sufficient to begin to link some portion of reimbursement to performance in those competencies.

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B. Charge 2: Feasibility of Incorporating Standards into PCMH Assessment

1. The Charge:

"Assess the feasibility of and develop recommendations for criteria and standards establishing multicultural health care equity and assessment programs for the Maryland Patient Centered Medical Home (PCMH) program and other health care settings."

This charge contains the following three distinct components to be addressed:

1. Examine **Appropriate Standards** for cultural and linguistic competency assessment
2. Examine **Feasibility** of incorporating standards into **PCMH Assessment Programs**
3. **Recommend Criteria and Standards** for PCMH

Standards for other health care settings in general were covered under Charge 1 (page 11)

2. Findings:

1. Examination of Appropriate Standards

This charge substantially overlaps with one component of charge 1 (discussed previously). Several existing national assessment standards and tools that are in current use were discussed under Charge 1. These included the AHRQ CAHPS *Cultural Competence Item Set* (1), the NCQA's *Multicultural Health Care Standards* used to award the NCQA *Multicultural Health Care Distinction* (2), the *National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health and Health Care* (3), the cultural and linguistic competency standards currently incorporated in The Joint Commission's accreditation guidelines (4), and the National Quality Forum's *Comprehensive Framework and Preferred Practices for Measuring and Reporting Cultural Competency* (5). The existence of vetted national standards with tools developed for clinical care assessment makes it unnecessary for Maryland to develop its own unique set of standards. Adoption (with modification as needed) of these existing standards is preferred.

Particular themes that can be highlighted from the existing standards include a focus on training, language access, and data collection. The following enhancements to current standards are recommended:

Staff Training

- Staff training should include annual cultural, linguistic and health literacy competency training for all staff (both clinical and support staff).
- Staff training should include how to properly collect data to accurately capture race, ethnicity, language, social determinants, sexual orientation, and gender identity, and why the quality of such data is important.

Language Access

- Increase language access, including translation of documents (such as consent forms and patient education materials) into the languages of the population, as well as the provision of services from qualified bilingual staff or trained medical interpreters.
- Assess the competency of multilingual staff and medical interpreters in a standardized manner.
- Address health literacy and plain language communication needs related to medical encounters, patient education materials, etc.
- Measure patient satisfaction/experience in a manner that is inclusive of diverse populations and allows for patient surveys to be administered in languages other than English.
- Stratify patient satisfaction/experience data by race, ethnicity, and language (as well as other demographic data, such as gender identity, sexual orientation, social determinants, etc.).

Data Collection

- Improve the accuracy of race, ethnicity, language, sexual orientation, gender identity, and social determinants data collected by hospitals, clinics and other health organizations and insurers.
- Stratify clinical process measures and outcome measures by race, ethnicity, and language (with future consideration of the inclusion of sexual orientation, gender identity, and social determinants).
- Use continuous quality improvement to reduce disparities in vulnerable populations.

NCQA Patient Centered Medical Home Accreditation: The National Committee for Quality Assurance has an accreditation program for Patient Centered Medical Homes (6). Overall, NCQA assesses 21 elements across six domains in its PCMH certification program:

- Enhance Access/Continuity
- Identify/Manage Patient Populations
- Plan/Manage Care
- Provide Self-Care Support/Community Resources
- Track/Coordinate Care
- Measure/Improve Performance

Performance on this assessment is tiered, with Level 1 recognition being the lowest scoring recognition, and Level 3 being the highest scoring recognition.

Within the domain "Enhance Access/Continuity" there are seven elements; and the sixth element is "Element F: Culturally and Linguistically Appropriate Services". The four factors contained within that element assess whether a practice is:

- Assessing the racial and ethnic diversity of its population
- Assessing the language needs of its population

- Providing interpretation or bilingual services to meet the language needs of its population
- Providing printed materials in the languages of its population

States Indirectly Linking PCMH Incentive Payments to Cultural Competency: Several states have tied achievement of specific levels of NCQA PCMH recognition to receipt of the various incentive payments associated with PCMH status. Some examples are presented in the table below:

State	Linkage of NCQA Recognition to Payments
Maryland (Statewide Multi-Payer PCMH Program)	A practice that is selected to participate in the program will be required to obtain NCQA PPC-PCMH Level 1+ or better recognition by December 31, 2011 and NCQA PPC-PCMH Level 2+ within 18 months of program commencement (7).
Maryland (Care First PCMH Program)	"Care First provides additional quality points in the incentive calculation for practices achieving various levels of NCQA accreditation (8)."
Connecticut (Medicaid)	In order to qualify as a PCMH, a practice must attain NCQA Level 2 or Level 3 PCMH recognition (9).
New York	Two PCMH pilot programs in New York require NCQA PCMH Level 2 or Level 3 recognition (10).
Utah (Children's Health Insurance Program Reauthorization)	"Implementation Measures (factor in determining proportion of at-risk incentive to be paid) – NCQA Patient Centered Medical Home scoring system or modification thereof (11)."
Vermont (Blueprint for Health)	Practices receive enhanced per-member per-month payment that varies by NCQA PCMH recognition score (12).

As can be seen in the table above, in Maryland the statewide multi-payer PCMH program (coordinated by the Maryland Health Care Commission) requires Level 2 or higher NQCA recognition for continued participation in the PCMH program. Care First's PCMH program gives additional quality points in its incentive calculation for higher levels of NCQA recognition.

2. Feasibility of Incorporating Standards into PCMH Assessment Programs

The feasibility and desirability of incorporating cultural and linguistic competency assessment and reporting into healthcare quality assessment was discussed and confirmed in the previous section (Charge 1). This feasibility of provider and practice-level assessment can be extended to Patient Centered Medical Homes. NCQA incorporates cultural and linguistic competency related elements and factors in its PCMH recognition program. Therefore incorporation of cultural and linguistic competency standards into PCMH assessment programs is feasible.

3. Recommendations:

- Maryland's PCMH programs should require or incentivize participating practices to meet the cultural competency standards contained in national PCMH recognition products.
- Maryland's PCMH programs should examine the feasibility of using the AHRQ's CAHPS *Cultural Competence Item Set* for provider-level and practice-level assessment of cultural and linguistic competency. This item set broadly covers cultural, linguistic and health literacy competency of providers as reported by their patients.
- Maryland's PCMH programs should require or incentivize participating practices to meet the NCQA *Multicultural Health Care Standards* or a similar standard.
- Maryland's PCMH programs should assess annually whether the maturity of cultural, linguistic and health literacy competency assessment and reporting in the programs is sufficient to begin to link some portion of reimbursement to performance in those competencies.

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C. Charge 3: Criteria for Continuing Education in Multicultural Health Care

1. The Charge:

"Recommend criteria for health care providers in the State to receive continuing education in multicultural health care, including cultural competency and health literacy training."

2. Findings:

The desirability of a culturally and linguistically competent health care system in Maryland was confirmed and discussed in reference to Charge 1 of the Workgroup *(see page 11*)

Cultural Competency Training Mandates in other States

Targeting a specific portion of health professional continuing education (CE) credits required for re-licensure toward a particular subject matter is not unusual. For example, Massachusetts requires for physician re-licensure that 2 CE hours be spent studying the Board's recommendations, 2 hours be spent studying end of life care, and 10 hours be spend studying risk management. Physicians prescribing controlled substances must also complete 3 hours of study in effective pain management (1). Therefore targeting some portion of CE requirements to specific types of training is not without precedent.

States with Cultural Competency Licensure Requirements: Some states have already developed cultural and linguistic competency continuing education requirements for health professional re-licensure. Those states and their continuing education requirements for cultural and linguistic competency are summarized in the table below:

State	Cultural Competency Related Continuing Education Requirement
New Jersey	Physicians are required to have 6 hours of cultural competency education as a one-time (i.e. not repeated with each renewal) requirement for licensure. This can be as CME, or if documented, can be fulfilled in medical school or residency. New Jersey mandates this cultural competency training in the medical school curricula of medical schools in New Jersey (2).
Connecticut	Physicians are required to have one contact hour of education or training in cultural competency every two years (3).
Oregon	Health boards are authorized to adopt rules that require licensees to receive cultural competency continuing education. The Oregon Health Authority must develop a list of approved continuing education opportunities. Public universities and colleges may require providers of health services to students to participate in cultural competency CME at least once every two years (4).

State	Cultural Competency Related Continuing Education Requirement
California	All CME courses that have a patient care component and are offered by CME providers in California are required to contain curriculum that includes cultural and linguistic competency (5).
Washington	Health profession boards are authorized to offer continuing education in cultural competency. Health boards are also authorized to require instructors of continuing education programs to integrate cultural competency into their curricula. Each health profession training program in in the state must incorporate cultural competency training into the curriculum (6).

Based on the evidence of and national consensus for culturally and linguistically competent health care, and on the examples of the states listed above in adding cultural competency training requirements for health professional re-licensure, Maryland should begin to require cultural, linguistic, and health literacy competency training for health professional initial licensure and re-licensure. Currently only two health occupation boards in Maryland require such training for re-licensure (the Maryland Board of Examiners of Psychologists and the Maryland Board of Chiropractic and Massage Therapy Examiners).

3. Recommendations:

- Maryland's health profession boards should require that 5% to 10% of the total continuing education requirement for re-licensure be credits in cultural, linguistic, and health literacy competency.
- Maryland's academic medical centers should identify and/or develop appropriate cultural, linguistic and health literacy competency continuing education materials (both classroom curriculum and individual on-line modules) and make them available to Maryland providers.
- Adopt multicultural health care continuing education (CE) requirements that address the following key components:
    - Amount and frequency of training;
    - Approval process for continuing education credits/units;
    - Curricular structure/Navigation;
    - Compliance monitoring.
- Adopt and promote continuing education curricula that address a standard set of suitable learning objectives adapted from "The Cultural Competency and Health Literacy Primer" (2013). The learning objectives should address health care professionals' knowledge and skills related to cultural diversity, health literacy, cross-cultural communication, proper use of interpreters, bias/stereotyping, social determinants of health, and the impact of these factors on health outcomes and health disparities.

- Adopt and promote continuing education curricula that incorporate a focus on inter-professional education (IPE). An IPE approach enables members of different health profession disciplines to collaborate (and to learn from and with each other) in a teamwork-oriented environment, with the goal of providing the highest quality of care for patients and clients.

4. References:

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IV. ACKNOWLEDGEMENTS

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V. GLOSSARY

Terms

Cultural Competency - A set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among professionals that enables effective work in cross -cultural situations.

Health Disparities - Differences between two or more population groups in health outcomes and in the prevalence, incidence, or burden of disease, disability, injury or death.

Health Equity - The attainment of the highest level of health for all people. Achieving health equity requires valuing everyone equally with focused and ongoing societal efforts to address avoidable inequalities, historical and contemporary injustices, and the elimination of health and health care disparities.

Health Literacy - The degree to which individuals have the capacity to obtain, process, and understand basic health information and services needed to make appropriate health decisions.

Healthcare Disparities - Difference between two or more population groups in health care access, coverage, and quality of care, including differences in preventive, diagnostic, and treatment services.

Linguistic Competency - The capacity to communicate effectively, and convey information in a manner that is easily understood by diverse audiences including persons of limited English proficiency, those who have low literacy skills or are not literate, individuals with disabilities, and those who are deaf or hard of hearing.

Acronyms

AAMC – Association of American Medical Colleges

ACA - Affordable Care Act

AHA – American Hospital Association

AHRQ - Agency for Healthcare Research and Quality

CAHPS - Consumer Assessment of Health Plans and Systems

CDC - Centers for Disease Control and Prevention

CE - Continuing Education

CLAS – National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care

CMS – Center for Medicare and Medicaid Services

CSWE – Council on Social Work Education

IPE - Interprofessional Education

HEZ – Health Enterprise Zone

HEDIS – Healthcare Effectiveness Data and Information Set

HRET – Health Research and Educational Trust

MHCC – Maryland Health Care Commission

MHHD - Maryland Office of Minority Health and Health Disparities

MHQCC - Maryland Health Quality and Cost Council

NASW – National Association of Social Workers

NCQA - National Committee for Quality Assurance

NQF – National Quality Forum

PCMH - Patient Centered Medical Home

RELICC – Race/Ethnicity Language Interpreters, and Cultural Competency assessment

VI. APPENDICES

A. Charge 1: Feasibility/Desirability of Reporting & Reimbursement Linkage

B. Charge 2: Feasibility of Incorporating Standards into PCMH Assessment

C. Charge 3: Criteria for Continuing Education in Multicultural Health Care

Appendix A

Charge 1 Report

Feasibility / Desirability of Reporting and Reimbursement Linkage

July 2013

Charge 1 Subcommittee

Activities Report

for the

MHQCC Cultural and Linguistic Competency Workgroup

July 2013

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of the Cultural and Linguistic Competency Workgroup

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Charge to the Subcommittee

The inaugural meeting of the Maryland Health Quality and Cost Council's Cultural and Linguistic Competency Workgroup was held on November 29, 2012. During the meeting, three separate charges were defined for the Workgroup. Workgroup members-at-large were later divided into three Subcommittees established to tackle one of the three charges identified. Our Subcommittee was responsible for activities associated with Charge 1, which is described as follows:

> *"To examine appropriate standards for cultural and linguistic competency for medical and behavioral health treatment and the feasibility and desirability of incorporating these standards into reporting by health care providers and tiering of reimbursement rate by payors.*
>
> *Report on Charge 1 Subcommittee Activities to the Cultural and Linguistic Competency Workgroup by September 30, 2013 on the following action steps:*
>
> - ***Identify existing** individual and organization-level **standards** for cultural, linguistic and health literacy competency*
> - ***Identify** who or **what entities will be the focus** of reporting and performance evaluation, tiered reimbursement, and the expected results*
> - *Identify and **examine** formal **models** of how existing cultural, linguistic and health literacy standards and guidelines are being applied in health care settings*
> - ***Identify** existing evidence-based or **promising examples** of provider (individual-level and organizational-level) **reporting** and performance evaluation that formally incorporates cultural, linguistic and health literacy competencies*
> - *Identify and **examine** evidence-based or **promising practices in tiered reimbursement mechanisms***
> - ***Examine the feasibility of** provider compliance with identified promising practices in reporting and **performance evaluation and tiered reimbursement** mechanisms. Include particular consideration of solo practitioners and practices that specialize in complementary/alternative medicine*
> - *Based on knowledge obtained in prior action steps, **develop recommendations for** incorporating cultural, linguistic and health literacy competencies into provider **reporting requirements and reimbursement mechanisms**"*

Over the following seven month period, the Co-Leaders and Subcommittee staff members met to examine whether culturally and linguistically appropriate services and health literacy standards could be linked to a tiered reimbursement system. The group initially examined the existing standards, determined the necessary antecedents to the development of a tiered reimbursement system, and identified which standards should be the primary focus of the Charge 1 Subcommittee as it moved forward.

Models of Competency Standards

Through a collaborative approach, Charge 1 Subcommittee members have identified several Models of standards for racial, ethnic, cultural, linguistic, and health literacy competency. One Focus Model, four Public Models-In-Practice, six Private Models-In-Practice, and two Non-Focus Models have been identified. It should be noted that some of these Models employ more than one set of competency standards. The Model descriptions provided in the pages that follow shall describe each Model, and include information of those Models that employ more than one set of competency standards when applicable. Following are the definitions for each of the four categories of Models of Competency Standards:

Focus Model

A single Focus Model is a Model of competency standards for cultural, linguistic and health literacy that the Charge 1 Subcommittee has determined to contain significant elements of promising practices related to reporting, performance evaluation and tiered reimbursement. This Focus Model has been explored at a high level of detail and has been deemed the sole Focus Model for the Subcommittee to support. Charge 1 Subcommittee's detailed findings on the Focus Model are included below.

Model-In-Practice

Public Models include Models of competency standards for cultural, linguistic and health literacy that the Subcommittee has determined to be in various stages of implementation and practice by State of Maryland Agencies and thus would be duplicative for the Subcommittee to explore beyond a moderate level of detail. Gross findings of these Public Models-In-Practice are included below for high-level informational purposes only.

Private Models include Models of competency standards for cultural, linguistic and health literacy that the Subcommittee has determined to be in various stages of implementation and practice by commercial carriers operating within the State of Maryland and are proprietary to the commercial carrier thus the Subcommittee has conducted explorations of each carrier-specific program at a rudimentary level of detail. Crude findings of these Private Models-In-Practice are included below for high-level informational purposes only.

Non-Focus Model

Additional Non-Focus Models include Models of competency standards for cultural, linguistic and health literacy that the Subcommittee has determined to contain promising practices that lay just outside the scope of practices related to reporting, performance evaluation and tiered reimbursement. These Non-Focus Models contain a limited scope that is site-of-care-specific to Managed Behavioral Healthcare Organizations (MBHOs) or to hospitals. A brief narrative describing these Non-Focus Models are also included below for cursory-level informational purposes.

Focus Model: Consumer Assessment of Healthcare Providers and Systems - Supplemental Cultural Competency Item Set from the Agency for Healthcare Research and Quality

The factors deemed necessary for the development of a tiered reimbursement system included routine and consistent data collection by race and ethnicity for Maryland health and healthcare organizations (HCOs); evidence of a baseline assessment of Culturally and Linguistically Appropriate Standards (CLAS) for HCOs in Maryland, and an examination of the readiness factors for the provision of CLAS. Given that measurement of cultural competency in HCOs is possible due to the development of recent cultural competency measurement tools, the other discussion that emerged was examining whether cultural competency measures could be linked to the Agency for Healthcare Research and Quality's (AHRQ) Consumer Assessment of Health Provider and Systems (CAHPS) due to its preexisting linkages to Medicare reimbursement. To examine the feasibility of the proposed linkage to Medicare reimbursement, the Subcommittee decided that discussions be linked to the Health Services Cost Review Commission (HSCRC) due to current proposed revisions to Maryland's Medicare Waiver System.

Antecedents to the Development of a Tiered Reimbursement System

The antecedents for the development of a tiered reimbursement system for the provision of culturally and linguistically appropriate care are measurable and could inform the development of a tiered reimbursement system for cultural competency in Maryland, yet there is limited evidence that the antecedents are routinely available. First, there is limited evidence that "routine" data collection by race and ethnicity for HCOs in Maryland is consistently being performed. Second, evidence of baseline assessments of organizational cultural competency in Maryland hospitals could not be detected. Additionally, an assessment of readiness for implementation of standards and guidelines related to the provision of culturally and linguistically appropriate services were not available.

Collection of Data by Race and Ethnicity

Collection of data by race and ethnicity and demographic assessments of the community are core components that relate directly to the provision of CLAS. This requirement has been reinforced by The Joint Commission and the Affordable Care Act, yet many HCOs and health maintenance organizations in Maryland report inconsistent recording of race and ethnicity data. Strengthening this data collection is a key strategic goal for the state as demonstrated by the development of several key initiatives and measures including the Maryland Race/Ethnicity, Language, Interpreters, and Cultural Competency (RELICC) Assessment. The Joint Commission (2010) recommendations for improved race and ethnicity data collection may assist in closing these gaps (The Joint Commission, 2010, p. 36). The recommendations include the option of using population-level demographic data on race, ethnicity, language, and disability which may be obtained from U.S. Census Bureau figures; local school enrollment profiles; voter registration records, and public health department databases. It is also recommended that national and state literacy and health literacy levels, available from the 2003 National Assessment of Adult Literacy Survey, be considered when developing HCO related forms, patient education materials, or discharge instructions. National and state level data on sexual orientation from Web sites such as www.census.org and www.gaydata.org could also be used to develop initiatives that address the health concerns of lesbian, gay, bisexual, or transgender

patients. Indirect data analysis methods such as geocoding (that is, matching addresses to community needs) and surname analysis to plan services and target community-based interventions have also been recommended, but should be used with caution. Focus groups or interviews with the community leaders may also help to identify changes in the demographics and needs of the surrounding community.

Measurement of Readiness to the Provision of CLAS

Readiness is the organization's receptiveness to change, including support and advocacy for the change and dedicated time and resources. Studies done in other states have identified strong leadership commitment and motivation; the need for a systematic approach to implementation of the National Standards for CLAS; and integration of cultural competency into management systems such as human resources (including supporting a diverse workforce), information systems and QI as organizational readiness factors necessary for successful implementation and adoption. Several research recommendations were presented in the studies and included the need to develop benchmark data on hospital level cultural competency, examine CEO motivation and support, and quantify the impact of organizational implementation of the National Standards for CLAS on patient satisfaction, revenues, and financial performance. An assessment of readiness factors in Maryland could assist in a better understanding of the delivery of culturally and linguistically appropriate services in Maryland.

Baseline Assessment of Maryland HCOs for Cultural and Linguistic Competence

There is a growing but limited body of research examining organizational adoption of the National Standards for CLAS. Most of the studies, whether national or state focused, examining organizational adoption of the standards on CLAS have been cross-sectional or qualitative in nature (3, 6-8, 10-12). These studies were successful in identifying key readiness factors that may drive organizational implementation and adoption of the CLAS standards. These antecedents include strong leadership commitment and motivation; the need for a systematic approach to implementation of the National Standards on CLAS; and integration of cultural competency into management systems such as human resources, information systems and performance improvement management systems. Yet, the current studies have limited generalizability. Most participating hospitals were geographically located in the southwest region of the country, predominantly in California (47%) (Diamond, Wilson-Stronks, & Jacobs, 2010; Weech-Maldonado, Dreachslin, et al., 2012; Weech-Maldonado, Elliott, et al., 2012; Wilson-Stronks, 2007). Additionally, judgment sampling was utilized; it was grounded in a demographic-driven sampling criterion, which focused primarily on race and ethnicity criteria from the U.S. Census Bureau and did not account for other indicators including socioeconomic status and geographical differences in groups. Individual states including California (Weech-Maldonado, Elliott, et al., 2012), Pennsylvania (Weech-Maldonado, Dreachslin, et al., 2012), New Jersey(Betancourt, 2005), New York (Carrillo, 2007) and Alabama (Davis & Whitman, 2008) have examined adoption of the National Standards for CLAS in their hospitals. However, evidence of an assessment in Maryland could not be identified. A baseline assessment of cultural competency in Maryland HCOs may help to assess adoption of CLAS within hospitals in Maryland. A better understanding of whether Maryland HCOs have implemented cultural and linguistic standards could inform the development of a tiered reimbursement system.

Measurement Tools for Cultural Competency in HCOs

Tools are available to comprehensively measure the provision of cultural and linguistic services in Maryland HCOs. The Cultural Competency Assessment Tool for Hospitals (CCATH) was designed to assess organizational adherence to the National Standards for CLAS. The CCATH offers opportunities for benchmarking and the development of performance management plans for Maryland HCOs. The development and testing of the CCATH was funded by the Department of Health and Human Services, in conjunction with the National Office of Minority Health and the Commonwealth (Weech-Maldanado, et al., 2012). The tool uses a systems approach and has two subsystems: management and clinical. The management subsystem focuses on leadership; management systems and operations; workforce diversity and training, and community engagement. The clinical subsystem focuses on patient-provider communication; care delivery and supporting mechanisms. The tool allows for the examination of the structures (policies and programs) and processes (practice and culture) related to the National Standards for CLAS in hospitals.

Linking Reimbursement to Cultural Competency by Using Patient Experience Data

If an assessment of HCOs could be done, earlier studies indicate that benchmarking data on organizational cultural competency could be linked to patient reported experiences with care. The CAHPS program measures patient experiences with care and is a multi-year initiative of the AHRQ. The CAHPS data is publically available and currently linked to Medicare reimbursement. Multiple CAHPS survey types are available including specifically for clinic and health groups (CG-CAHPS) and healthcare organizations (H-CAHPS). The CAHPS survey has been known to serve as a "barometer" for culturally competent care. Recently AHRQ added two supplemental surveys that specifically address health literacy and cultural competency. While the basic CAHPS surveys when aggregated by race and ethnicity have served as a measure of cultural competency in multiple studies, the cultural competency and health literacy item sets are more specific. Recent studies using CAHPS data indicate that 15% of African Americans, 13% of Hispanics, and 11% of Asians, compared to 1% of Whites, indicated that they would have received better care if they were of a different race or ethnicity. The Cultural Competence Item Set is a supplemental option to the CAHPS survey and incorporates the concepts of trust, discrimination, linguistic and complementary medical services, and equitable treatment into the survey. The Health Literacy Item Set measures how well health information is communicated from the patients' perspective and incorporated concepts of communication with providers, disease self-management, and communication about medicines, tests, and forms. The CAHPS surveys and the two item sets are available in English and Spanish.

Model-In-Practice 1 (Public): Workforce Diversity Initiative from the Maryland Office of Minority Health and Health Disparities Collaborative

In 2005, The Maryland Office of Minority Health and Health Disparities (MHHD) received a five-year grant from the federal Office of Minority Health as part of the State Partnership Grant Program. This Program seeks to facilitate the improvement of minority health and elimination of health disparities. Broadly, the Workforce Diversity Initiative activities focus on four areas:

- *Developing partnerships with health professions schools*
- *Collaborating on issues of recruitment; data collection and monitoring and cultural competency training*
- *Developing and conducting on-going awareness campaign*
- *Serving as a clearinghouse for national and state-based resources*

The grant initiative targets two areas: (1) increase workforce diversity and cultural competency, including matriculation from health professional schools; and (2) promote greater focus on eliminating minority health disparities within the State and local health department programs through implementing a comprehensive evaluation program aiming to achieve system change in the Department of Health and Mental Hygiene (DHMH).

1. The Office of Minority Health and Health Disparities participated in numerous programs related to increasing workforce diversity and cultural competency. These included:
    - Outreach to over 450 individual stakeholders in the state through technical assistance and local presentations on workforce diversity and cultural competency
    - Participation in a Statewide Commission on the Shortage in the Healthcare Workforce
    - Establishment of baseline data and continued monitoring of annual enrollment and graduation rates of minority students in health professions schools in Maryland
    - Facilitating two nursing roundtable forums, with 32 attendees representing 9 baccalaureate nursing programs to discuss curriculum enhancement, faculty sharing, pipeline outreach and the pressing need for faculty and clinical placements
    - Facilitated discussions between the Historically Black Colleges and Universities schools of nursing and the Maryland Higher Education Commission (MHEC) regarding improving access to state funds to support students, faculty and infrastructure
    - Met with the Maryland Association of Community Colleges and discussed potential opportunities for collaboration with the state's community colleges on health workforce diversity issues
    - Held meetings with MHEC and the Maryland Independent College and University Association (MICUA) to share strategies for monitoring and promoting the inclusion of cultural competency training in professional education programs

- Provided technical assistance to MHEC in developing a standardized survey of college and university-based cultural diversity activities in the state
- Submitted a report to the State Legislature on cultural competency training in Maryland's health professions schools. The report (developed in response to House Bill 942 (2008)) is a compilation and analysis of data reported on cultural competency courses and clinical experiences offered to health professions students at nine Maryland universities. The report was shared with MHEC, MICUA, and the participating health professions schools
- Collaborated with Sinai, Maryland General and St. Agnes hospitals to develop a cultural competency training module for physicians-in-training
- Provided technical assistance to Sinai Hospital leadership in conducting an Administrative Grand Rounds discussion on health disparities, using excerpts from the documentary "Unnatural Causes" to illustrate the role of cultural competency in providing safe and effective health care. Served on the Sinai Hospital Health Disparities Community Advisory Panel
- Worked with the DHMH Health Occupations Boards to promote cultural competency awareness among the state's health professional licensees. Presented cultural competency concepts to new board members at the DHMH Council of Boards and the Commission new board member trainings; wrote five articles on cultural competency for Board newsletters and websites; and provided information about more than 60 opportunities related to cultural competency training, conferences and technical assistance resources
- Provided technical assistance to the Maryland Board of Psychologists to develop Board guidelines for continuing education credits in cultural competency
- Provided health career information to diverse students at four urban middle schools and held a "health careers day" at DHMH for employees' children on "Bring Your Child to Work Day"
- Continuously scanned, monitored and disseminated developments in national guidelines and promising practices. Disseminated over 100 publications on the latest research and over 90 funding opportunities related to diversity recruitment and retention practices and culturally and linguistically-responsive care

2. The Office of Minority Health and Health Disparities participated in numerous programs related to Health Department Assessment & Systems Change. The purpose of the Systems Change initiative is to encourage and assist DHMH programs that address the major health disparities in Maryland to conduct a self-assessment and produce actions plans. The action plans are to identify specific changes in the programs that would measure, report and increase the rate of reductions in health disparities. Five DHMH programs completed action plans. These programs were implemented within the HIV/AIDS Administration; Family Health Administration's Center for Maternal and Child Health and Diabetes Prevention and Control Program; the Community Health Administration's Epidemiology and Disease Control Programs; the Mental Hygiene Administration; and the Assistant Attorney General's Office in the State Health Department. It should be noted that The Family Health

Administration and Mental Hygiene Administration have begun to implement the recommendations in their respective action plans.

HIV/AIDS Administration

- Provided Cultural Competency Training Workshop for the HIV/AIDS Administration leadership staff

- MHHD provided technical assistance to the Health Communications Division of the HIV/AIDS Administration in its development of an Action Plan for serving minority communities

Family Health Administration

- Office of Chronic Disease Prevention - MHHD membership on Executive Committee of the Maryland Asthma Control Program and the Statewide Asthma Training Committee. MOTA grantees serve as a resource in Maryland Asthma Control Program community outreach activities

- Center for Maternal and Child Health – MHHD membership on the Babies Born Healthy Summit planning committee and collaboration with the Maternal and Child Health program on reducing Infant Mortality (MHHD-FHA)

- Office for Genetics and Children with Special Health Care Needs - Joint staffing for the Statewide Steering Committee on Developing Services for Adults with Sickle Cell Disease

Community Health Administration

- MHHD served on the planning team for the new online network of environmental health data called the Environmental Public Health Tracking Network

- MHHD participated in the proceedings of the Statewide Taskforce on Minority Participation in the Environmental Community and the Commission on Environmental Justice and Sustainable Communities

- MHHD provided technical assistance to the Office of Epidemiology & Disease Control Programs in the development of an Action Plan to increase awareness of and treatment for Hepatitis C in minority communities

Behavioral Health and Disabilities

- MHHD staff members served on the Maryland delegation to the National Policy Summit on the Elimination of Disparities in Mental Health Care, sponsored by the U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration

- Jointly with the Mental Hygiene Administration, staffed the Maryland Workgroup on Cultural Competency and Workforce Development for Mental Health Professionals (House Bill 524 (2007)) and contributed to the final report to the State Legislature

Assistant Attorney General's Office in State Health Department

- Provided Cultural Competency Training Workshop to the leadership staff in the DHMH Office of the Attorney General

Model-In-Practice 2 (Public): Maryland Multi-payer Patient Centered Medical Home Program from the Maryland Health Care Commission

The Maryland Multi-payer Patient Centered Medical Home Program (MMPP), established unanimously by the 2010 General Assembly, is designed to improve patients' health status and elevate the role of the primary care provider in our health system. Maryland's MMPP medical homes provide primary care clinicians – both physicians and nurse practitioners – with financial incentives and technical assistance to expand access to high-quality primary care, promote wellness and prevention, advance care by using multi-disciplinary teams, and coordinate care to improve disease management and the overall health of their patients. Primary care clinicians and health insurance carriers share incentives to reduce patient costs and increase quality through this pilot program.

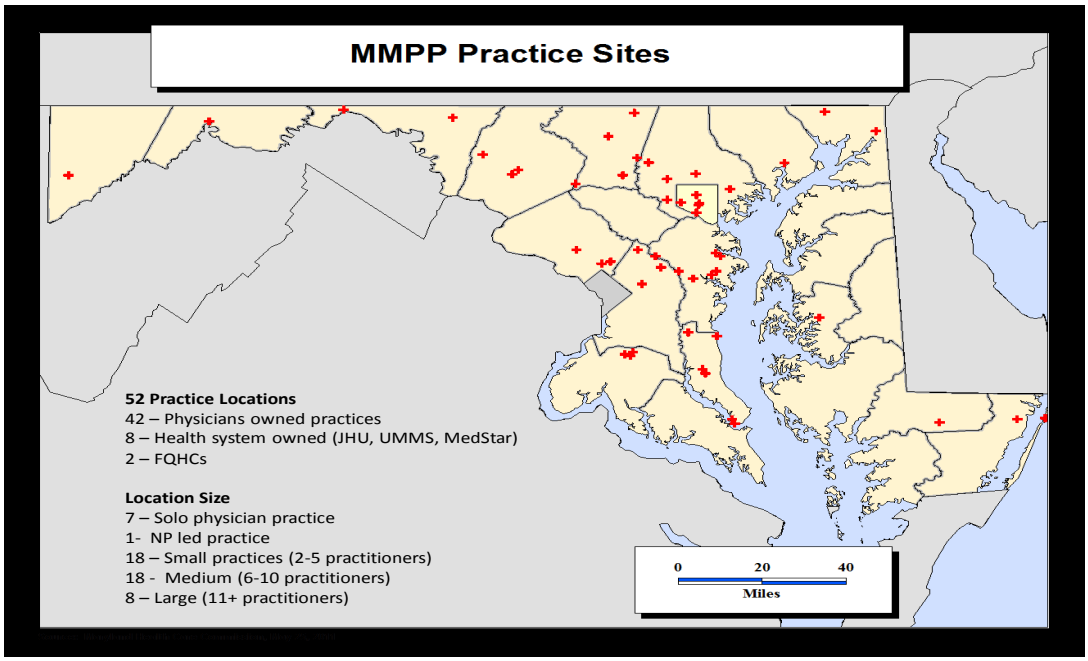
The Maryland Health Care Commission (MHCC) selected a diverse set of practices to participate in the MMPP, which launched in May 2011 with 53 pilot practices. One practice voluntarily left the program in December 2011. The remaining practices, reflecting a broad range of practice sizes, structures, including academic medicine-affiliated, health system-owned, and clinician-owned practices, and geographic locations across the State, were selected in order to test what it takes to transform a traditional practice into a Patient Centered Medical Home (PCMH) Program practice. It should be noted that the MHCC did not initially consider the racial/ethnic mix of clinicians in making the pilot practice selections. Despite this, when compared to the overall race and ethnicity mix of Maryland's primary care physicians, the MMPP has proven itself to be remarkably diverse in its composition. There are somewhat more African American physicians and fewer Asian American physicians. Also, Non-Hispanic white physicians are represented in the MMPP in almost the same proportion as the overall primary care physician population. Table 1 sets forth the race and ethnicity breakdown of MMPP physicians and primary care physicians statewide; while Exhibit 1 displays the MMPP practices' locations. The five largest commercial health insurers in the State are required to participate. Six of the seven Medicaid managed care organizations (MCOs) also agreed to participate after the Medicaid Administration solicited their participation. Medicare is not participating in the MMPP program.

Table 1 – Race/Ethnicity Distribution of Primary Care Physicians in the MMPP and Statewide

Race/Ethnicity	**MMPP**	**Statewide**
Caucasian (Non-Hispanic)	49%	48%
Black/African American	27%	17%
Hispanic/Latin American	2%	4%
Asian	18%	26%
Other	5%	9%

Source: 2011-2012 Maryland Board of Physician Licensure Survey

Exhibit 1 – Maryland's Multi-payer Patient Centered Medical Home Participating Practices' Locations



Source: Maryland Health Care Commission

Chapter 3 of 2012 Health Enterprise Zone Legislation establishes Health Enterprise Zones (HEZ). Chosen zones will form action plans (similar to plans in economic development zones) aimed at increasing the health outcomes for citizens of those zones. Specifically, the legislation requires that any practice in a HEZ that wishes to become an MMPP practice be given priority for entry into the program. In January of 2013, five HEZs were selected. Three of the HEZ's selected proposed to create new patient centered medical homes. These include the West Baltimore Primary Care Access Collaboration, Anne Arundel Health Systems, and the Prince George's Health Department.

In addition to establishing HEZs, Chapter 3 of 2012 Health Enterprise Zone Legislation required the MHCC to look at the role of the MMPP in reducing health disparities. The MHCC convened a task force consisting of providers and payers participating in the State multi-payer program. The conclusions of this task force included recognition that the current shared savings payment methodology in the MMPP program makes an implicit assumption that practices will identify reducing disparities as one strategy for reducing total patient spending. Practices receive up to 50 percent of any savings in the total cost of care for patients in that medical home. There are significantly more financial incentives to reduce disparities by providing better access to primary care to all patients and more effective care management of patients with chronic conditions. Implicit in this model is a greater emphasis on patient engagement in care.

However, there was recognition that physician-based shared savings initiatives can widen resource gaps among physicians' organizations. Those physicians located in areas with

recognized greater health disparities might be less able to obtain bonuses due to their difficult-to-treat patient mix. Several pay-for-performance programs established in the last decade have published findings, one of which was that practices with a higher percentage of minority patients were less likely to generate total savings in the cost of care. These results suggest that reward programs may need to be designed to provide additional incentives to practices that serve more vulnerable populations. [1, 2, 3]

There are three key financial incentives that are aligned with the goal of reducing disparities. First, participating carriers and MCOs pay prospective, semi-annual payments to participating practices. The fixed transformation payment (FTP) is paid prospectively on a per member per month rate depending on the size of the practice and its level of NCQA PCMH recognition. These payments are, in effect, economic development funds. Practices are required to expend 35 percent of their FTP payments on the care management function. Approximately $9.4 million has been invested in the program since its inception by commercial payers and Medicaid MCOs.

A second financial incentive for practices to participate in the program is the shared savings component. A practice must achieve a savings against its expected total costs of care (minus FTP payments received) and report on up to 21 process and outcome measures that gauge the quality of care provided to its patients for the practice to earn shared savings. The expected total cost of care is calculated from the 2010 total costs of care for patients attributed to the participating practice site, adjusted for overall growth in health care spending. The 21 quality measures are all National Quality Forum recognized. Five of the measures are specific to pediatric patients.

A third financial incentive involves the implementation of a scoring methodology which allows practices to earn credit through both achievement (doing well relative to a defined performance threshold) and improvement (doing well relative to the practice's own previous performance). Practice sites receive two scores for each quality measure reported: an achievement score and an improvement score. A practice site's performance score for each measure is the higher of the achievement or improvement score. This allows for all practice sites to have an opportunity to earn credit regardless of their initial performance level. High performing practice sites with little room for improvement are rewarded with a high (or passing) achievement score, while lower performing practice sites have the opportunity to earn credit through improvement relative to their baseline performance.

The selection of performance measures required for reporting which highlight existing disparities in care can be used to spark action, especially if reductions in the disparity as well as meeting a

[1] Joel S. Weissman. and Romana Hasnain-Wynia. and Robin M. Weinick. and Raymond Kang. and Christine Vogeli. and Lisa Iezzoni. and Mary Beth Landrum. "Pay-For-Performance Programs to Reduce Racial/Ethnic Disparities: What Might Different Designs Achieve?" *Journal of Health Care for the Poor and Underserved.* 2012; 23.1, 144-160.

[2] Friedberg, Mark W. Safran, Dana Gelb, Coltin, Kathryn,Dresser, Marguerite,Schneider, Eric C. "Paying For Performance In Primary Care: Potential Impact On Practices And Disparities," *Health Affairs.* 2010; 29,5, 926-932.

[3] Casalino, Lawrence P, Arthur Elster, Andy Eisenberg, Evelyn Lewis, John Montgomery, and Diana Ramos. "Will Pay-for-Performance and Quality Reporting Affect Health Care Disparities?" *Health Affairs*. 2007; 26(3):w405-w414.

quality level are part of the financial incentive. When shared savings programs include performance measures that exhibit disparities, developers must design the methodology to reward practices for both the absolute performance and for relative performance improvement gained through narrowing the gaps in care.

The MMPP program is currently in year two of the three-year pilot program. Participating practices and carriers signed an agreement specifying participants' responsibilities for participation, including data reporting and payment requirements prior to the program's launch. The terms of that Participation Agreement may be altered only by agreement of all signatories. Thus, incorporating racial and ethnic performance data requirements into the practices' data reporting and in the shared savings payment methodology is only feasible in the next generation of the program. At its discretion, the General Assembly will decide whether the Maryland PCMH program will continue past 2014.

If the General Assembly extends the Maryland PCMH Program beyond calendar year 2014, program components should include explicit requirements for reductions in health disparities only if the carriers' data collection efforts increase. Medicaid and Medicare both collect racial and ethnic data on enrollees; however, only Medicaid participates in the MMPP. At the carrier level, demographic information such as racial and ethnic information is just beginning to be gathered. Currently, there are no carriers in Maryland that have been successful at collecting data on race and ethnicity, through a direct means, for their entire population of enrolled members. In order for incentives for reductions in disparities to be included in this program, data collection must be accurate and robust at the carrier level. In addition, an estimation methodology for collecting and reporting race and ethnicity data according to indirect means must be agreed upon by both participating practices and carriers. Although the MHCC could establish a process to impute the patients' racial and ethnic characteristics for participating practices using census data and participant zip code information in Maryland's Medical Care Data Base (MCDB), due to the inexact nature of imputation, such estimation should not be used in the methodology for incentive payment requirements. As an alternative, data collected by the practices through their electronic health record (EHR) systems could be used as part of a multichannel data collection effort. In this scenario, data reported by the practices could be audited by the carriers and verified through analysis of claims submissions to the MCDB. This alternative would mitigate issues surrounding demographic data collection at the time of enrollment in a carrier's health benefits plan. Important components of the MMPP include:

Increase Engagement in Improving Minorities' Health Status within the Current Program

There is opportunity to increase engagement by the program participants in improving minority patients' health status and outcomes within the existing program. All current practices operate EHR systems. As mentioned above, scoring standards and factors associated with achieving NCQA recognition require practices to identify and manage patient populations through collection of demographic data, including race. Practices' EHR systems must include report-generation functionality and the data must be searchable.

The MHCC should engage with MMPP practices in using their EHR systems to generate reports on key process measures, such as diabetic screening, by race and ethnicity characteristics. Through the Maryland Learning Collaborative, the MHCC could provide training on the use of

practices' EHR systems for collecting and reporting data by race and ethnicity characteristics through the Commission's established, secure data portal. The initial set of data measures should focus on patient care processes, such as medication adherence, rather than patient treatment outcomes.

Increase Pressure on Carriers to Collect Data

Carriers in Maryland are in the early stages of collecting enrollee data by race and ethnicity. In order to implement a PCMH program encompassing the measurement of patients' health outcomes by these characteristics, data must be collected at the carrier level. Carriers should collect these data through a variety of channels, including their health benefit plan enrollment process and through patients' self-reporting as they use carriers' electronic portals.

Require Minority Improvement Plans and Bonus Incentives in Future Programs

Assuming that the Maryland General Assembly extends the Maryland PCMH Program beyond calendar year 2014, future PCMH programs should include a requirement for the inclusion of practice-specific performance improvement plans. These plans should be data driven from the practices' EHR systems and address the needs of the unique patient population enrolled in each practice. These performance improvement plans should include a component to address disparities in care and must be included in the practices' quality measure reporting to the MHCC.

Further, all new Maryland PCMH programs, whether launched as a multi-payer or single payer initiative, should be required to include a methodology for setting baseline patient health status data and making additional bonus payments to practices for improvements in their minority patients' health status outcomes.

Model-In-Practice 3 (Public): Disparities Program from the Maryland Health Services Cost Review Commission

The HSCRC staff has prepared a Disparities Report that was respectfully submitted to the Governor and Maryland General Assembly on January 1, 2013. The report includes recommendations on improving the collection of hospital patient race and ethnicity data and use of these data in hospital quality incentive programs.

Please refer to Appendix 1 at the end of this report for a copy of the cover letter and Disparities Report.

Model-In-Practice 4 (Public): The Maryland Race/Ethnicity, Language, Interpreters, and Cultural Competency Assessment (RELICC) from the Maryland Health Care Commission
and
Model-In-Practice 5 (Private): Six Participating Private Commercial Carriers In Maryland That Are Required Use RELICC

Reducing and ultimately eliminating healthcare disparities in Maryland is a State priority that has been identified by the Lieutenant Governor, Anthony Brown. In response to this State priority, and to address requirements in the Maryland Health Improvement and Disparities Reduction Act of 2012 regarding quality reporting for health benefit plans, the MHCC has begun implementing a Maryland-specific health benefit plan quality reporting tool in 2013 that will begin to measure how many state regulated plans are collecting race, ethnicity, and related data through either direct or indirect methods.

In 2013, the MHCC was pleased to have had the opportunity to collaborate with the private, commercial carriers operating in the State during the development phase for the Maryland RELICC Assessment. RELICC is a quality and performance measurement tool that was customized for the State of Maryland by the National Business Coalition on Health and the Mid-Atlantic Business Group on Health, with input from Maryland's private, commercial carriers. The initial year of RELICC implementation is already underway by Maryland's carriers with health benefit plans that are required to report on a variety of quality and performance metrics.

Maryland's private, commercial carriers that participate in quality and performance reporting to the State are now in the implementation phase for RELICC. Through the use of RELICC, carriers are now able to begin preparations for an updated reporting process that incorporates performance measures related to race/ethnicity, language, interpreter need, and cultural competency issues. Also through RELICC, carriers are preparing to begin reporting on many of the initiatives their health benefit plans are implementing, which target disparities elimination. With successful use of the RELICC tool, carriers will be able to identify organizational strengths and opportunities for improvement as they relate to the elimination of healthcare disparities. The six participating private, commercial carriers that each have unique programs, policies and procedures to address cultural and linguistic competency, and who are required to begin using RELICC include Aetna, CareFirst, Cigna, Coventry, Kaiser Permanente, and United Healthcare. In addition, it should be noted that two of the private, commercial carriers, CareFirst and Cigna, also have carrier-specific PCMH programs that are in various stages of implementation.

It should be noted that requirements for all private, commercial health benefit plan quality and performance reporting, and reporting to the Maryland MCDB, do not apply to self-insured plans, as they must comply with the statutory and regulatory requirements of the federal Employee Retirement Income Security Act (ERISA), and are specifically exempt from meeting Maryland's statutory and regulatory requirements for health benefit plans. The ERISA statute applies to all self insured plans, the Maryland State Employees health benefits plans, the federal employee health benefits plans, and TRICARE military benefit plans which (combined) encompasses more than 50% of the total insured Maryland population.

Non-Focus Model 1: SAMHSA Cultural Competence Standards for Managed Behavioral Health Care Organizations from the Center for Mental Health Services at the Substance Abuse and Mental Health Services Administration

The Substance Abuse and Mental Health Services Administration (SAMHSA) and its Center for Mental Health Services (CMHS) developed the SAMHSA Cultural Competence Standards for Managed Behavioral Health Care Organizations to improve the availability of high-quality services for "four underserved/underrepresented racial/ethnic groups" – notable, African Americans, Hispanics, Native Americans/Alaska Natives, and Asian/Pacific Islander Americans. To that end, it convened four national panels representing each of the four core racial/ethnic groups, and each was comprised of mental health professionals, families and consumers.

These standards present demographic and health profiles for each of the four major racial/ethnic groups. They also identify 16 "Guiding Principles" including those of cultural competence, consumer-driven system of care, community-based system of care, managed care, and natural support, etc. Specific standards of systems functioning and quality care are identified along with associated implementation guidelines. Appropriate performance indicators also are identified along with recommended outcomes.

Non-Focus Model 2: Joint Commission's Patient-Centered Communication Standards

In August 2008, the Joint Commission, with funding from The Commonwealth Fund, began an initiative to advance the issues of effective communication, cultural competence, and patient- and family-centered care in hospitals. The project focused on developing accreditation standards for the hospital program and developing a monograph to help hospitals better meet patient needs. The Patient-Centered Communication standards were approved in December 2009 and released to the field in January 2010.

The standards are published in the annual Comprehensive Accreditation Manual for Hospitals (CAMH): The Official Handbook. Joint Commission surveyors began evaluating compliance with the patient-centered communication standards on January 1, 2011; there was a one-year grace period and findings did not affect accreditation decisions until January 1, 2012 at the earliest.

RECOMMENDATIONS

Support the efforts of the initiatives being implemented across Maryland:

- *HSCRC Medicare Waiver Agreement Modification - The Program is Already Underway*
- *MHQCC Workforce Diversity Initiative - The Program is Already Underway*
- *MMPP PCMH - The Pilot Program Is Already Underway*
- *RELICC - The Initial Year of Health Benefit Plan Reporting is Already Underway*

At the conclusion of all meetings and discussions, the Charge 1 Subcommittee of the Cultural and Linguistic Competency Workgroup proposed that future discussions of linking cultural and linguistic competency to a tiered reimbursement system be done in conjunction with the HSCRC. While we believe that meeting with the HSCRC is an important next step, our committee was unable to formally meet with the HSCRC due to time constraints and current activities related to modifying the Medicare Waiver agreement. Maryland is the only state in the nation to have a Medicare Waiver agreement. It allows Medicare reimbursement to providers to be controlled by the State's HSCRC.

In closing, the subcommittee noted that while there is potential for the future, there is currently limited evidence to support linking cultural and linguistic standards to reimbursement. Maryland could be well positioned in the future by strengthening the collection of health data by race and ethnicity, performing an assessment of cultural competency in hospitals, clinics and other health organizations and insurers, examining patient reported experiences with care by race and ethnicity and other culturally related factors, and discussing the proposed development of a tiered reimbursement system with the HSCRC. Until such time as cultural and linguistic competency can be successfully tied to reimbursement, it is further recommended that every effort be given to related initiatives and programs being implemented across the State of Maryland, including the Workforce Diversity Initiative, the MMPP PCMH Program and the Maryland RELICC Assessment.

Appendix 1

HEALTH SERVICES COST REVIEW COMMISSION
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Toll Free: 1-888-287-3229
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January 1, 2013

The Honorable Martin O'Malley
Governor of Maryland
100 State Circle
Annapolis, Maryland 21401-1925

The Honorable Anthony G. Brown
Lt. Governor of Maryland
State House
Annapolis, Maryland 21401-1925

The Honorable Thomas V. Mike Miller, Jr.
President of the Senate
H-107 State House
Annapolis, MD 21401-1991

The Honorable Michael E. Busch
Speaker of the House
H-101 State House
Annapolis, MD 21401-1991

RE: Health Services Cost Review Commission Disparities Report

The Health Services Cost Review Commission (HSCRC) staff respectfully submits to the Governor and Maryland General Assembly our report and recommendations on improving the collection of hospital patient race and ethnicity data and use of these data in hospital quality incentive programs. This submission is required by the Maryland Health Improvement and Disparities Reduction Act of 2012.

Sincerely,

Patrick Redmon, Ph.D.
Executive Director

cc: Ben Stutz, Policy Director, Lt. Governor's Office
Vicki Gruber, Chief of Staff, Senate President's Office
Kristin Jones, Chief of Staff, House Speaker's Office
Patrick Dooley, DHMH
Marie Grant, DHMH

I. Executive Summary

The Maryland Health Improvement and Disparities Reduction Act of 2012 ("the 2012 Act") created by Senate Bill 234 and House Bill 439 requires the HSCRC to:

- Study the feasibility of including racial and ethnic performance data tracking in quality incentive programs;
- Report to the General Assembly on or before January 1, 2013, data by race and ethnicity in quality incentive programs where feasible; and,
- Submit a report on or before January 1, 2013, to the Governor and in accordance with §2-1246 of the State Government Article, the General Assembly that explains when data cannot be reported by race and ethnicity and describes necessary changes to overcome those limitations.

In addition, the 2012 Act requires hospitals to include in their community benefit report submissions to the HSCRC a description of the hospital's efforts to track and reduce disparities in the community services by the hospital.

To meet its charge, beginning in June of 2012, HSCRC staff convened the *Hospital Race and Ethnicity Disparities Work Group ("Work Group"),* a multi-stakeholder group of individuals working to improve on disparities in Maryland healthcare; to guide HSCRC staff efforts and work in analyzing the status of hospital patient race and ethnicity data collection; and consider how these data may be used in payment incentive programs for hospitals.

In collaboration with the Work Group, the hospital industry including the Maryland Hospital Association, along with HSCRC staff, developed the key findings and recommendations listed below.

- The HSCRC is able to track racial and ethnic performance data in its quality programs; however, based on analysis of hospital administrative discharge data, quality data, and on information collected through surveying Maryland hospitals, there is wide variation in the race and ethnicity data categories and data collection methods used across hospitals.

- The race data currently collected by hospitals do reveal some statewide differences in hospital quality data for white versus black populations; however, the need for tighter standardization in the data collected and the collection methods used by hospitals is a barrier to making hospital-to-hospital comparisons using the data at the current time.

- HSCRC has developed and recommends targeted activities to improve and standardize hospital race ethnicity data collection, including:

    - Requiring all US Office of Management and Budget (Statistical Policy Directive 15, 1997 revision) race categories be collected (as of July 1, 2012)

    - Convening a statewide meeting of hospital staff on December 12, 2012 to heighten hospitals' awareness of the importance of accurate and consistent race and ethnicity data collection

    - Convening several training sessions for hospitals throughout the State in the first quarter of calendar year 2013 to improve race and ethnicity data collection

    - Requiring hospitals to collect all discrete racial categories a patient self-identifies as well as the patient's preferred language when receiving health care and country of origin/ancestry/granular ethnicity

- HSCRC will continue to analyze race and ethnicity data and monitor data quality using hospital discharge and quality data sets, while simultaneously considering methodology options for use of the data in incentive programs

The Commission's Community Benefit Work Group also met to discuss disparities issues pursuant to the 2012 Act. As a result, the Hospital Community Benefit Reports that will be submitted for FY 13 (due in December 2013) will include additional information on hospitals' community services population by race and ethnicity; identify who was consulted from the respective racial and ethnic groups in the community regarding community health needs; and identify measurable disparities and poor health status of racial and ethnic minority groups relating to hospitals' community health initiatives.

II. Background

Maryland Health Improvement and Disparities Reduction Act of 2012

The 2012 Act, signed April 10, 2012, establishes a four year, $4 million per year pilot project to reduce health disparities in the State; to improve health care access and outcomes such as infant mortality, obesity and cancer; and to lower health costs and hospital readmissions. The law also contains a number of permanent provisions aimed at reducing health disparities.

Core aspects of the law include:

- Creating Health Enterprise Zones (HEZs) where health outreach will be targeted, with grants for community nonprofits and government agencies along with tax breaks for health care providers who come to practice in HEZs;
- Establishing a standardized way to collect data on race and ethnicity in health care (both public and private providers), and ensure carriers are working to track and reduce disparities;
- Requiring hospitals to describe their efforts to track and reduce health care disparities; and
- Establishing a process to set criteria for health care providers on cultural competency and health literacy training and continuing education.

As stated in the Executive Summary, the HSCRC was also charged specifically with studying the feasibility of including racial and ethnic performance data tracking for use in its incentive programs, reporting to the General Assembly and the Governor on these data trends, and explaining the necessary changes to overcome limitations on use of these data in incentive programs.

HSCRC Activities to Meet the Requirements of the Disparities Reduction Act of 2012

Following the passage of the 2012 Act, HSCRC staff formed the *Hospital Race and Ethnicity Disparities Work Group ("Work Group")* to consider the overlapping recommendations from the *Maryland Health Disparities Collaborative Workgroups* (established by the Department of Health and Mental Hygiene), to review and deliberate on HSCRC staff's data analyses and findings, and to advise staff based on their expertise. The Hospital Race and Ethnicity Disparities Work Group comprises a broad array of member stakeholders including individuals serving in hospital clinical quality, case mix/coding and access/admission roles; the Maryland Hospital Association; staff from several state health agencies working to improve disparities in Maryland healthcare; and healthcare disparity experts from academic, research, payer and improvement organizations. Appendix A contains a roster of the Work Group members.

HSCRC staff also undertook several months of best practices review and data analyses of:

- Hospital race and ethnicity data collected and submitted in the HSCRC administrative discharge and Quality Based Reimbursement (QBR) data sets;
- Hospital survey data on race and ethnicity data collected and collection practices; and
- External review of best practices and tools that support improved hospital race and ethnicity data collection and reporting.

The results of the data and hospital survey analyses and the external best practices review are detailed in Sections that follow.

Current HSCRC Incentive Programs Linked with Hospital Performance

In 2008, HSCRC began implementing two quality initiatives very similar to the federal Medicare Value Based Purchasing (VBP) program in the planning stages. These programs include the Quality-Based

Reimbursement (QBR) and Maryland Hospital Acquired Conditions (MHAC) programs.
In the QBR initiative, hospital reimbursement rates vary depending on each hospital's achievement on specified process of care (e.g., patients having a heart attack receiving aspirin upon arrival to the hospital) and patient experience (e.g., how well patients rated their communication with nurses during their hospitalization) measures. The QBR program utilizes core measures data that hospitals are already reporting to CMS and the state. All measures improved from 2007 to 2010, and variation between hospitals has also decreased substantially in almost all measures.

The MHAC program assesses measures of medical complications and readjusts payment hospital rates accordingly, using administrative data hospitals report to the HSCRC that parallel the claims data submission. Since the program began, there has been a 27.5 percent decrease in the complication rate in Maryland hospitals.

The results of HSCRC staff's initial analyses of race and ethnicity data in the QBR and MHAC programs are provided in Section III below.

Racial Disparity in Hospital Admission Rates and Severity Produce Excess Costs

The rationale for examining hospital quality measures and performance-based reimbursement data is found in the known Black vs. White disparities in Maryland in Hospital admission rates and admission severity. These disparities generate significant excess health care costs in the State.

- Agency for Healthcare Research and Quality's (AHRQ) State Snapshots documents higher Black admission rates for many Ambulatory Care Sensitive Conditions. http://statesnapshots.ahrq.gov/snaps11/SnapsController?menuId=61&state=MD&action=disparities&level=80&caretype=3
- Age-adjusted Analysis of all-cause admission rates by the Office of Minority Health and Health Disparities has found that the Black admission rate in 2011 was 1.35 times higher than the White rate. This means that 26% of Black admissions were excess (compared to the expected Black admissions if the Black admission rate was the same as the White rate). These excess admissions cost $ 767 million (the frequency disparity cost)
- For most age groups, the average cost per Black admission exceeded the White average cost, reflecting higher severity among Black admissions. Applying the average cost difference to the expected Black admissions shows an additional $ 47 million of excess cost (the severity disparity cost).

III. Review of Maryland Hospital Data/Trends on Race and Ethnicity

HSCRC staff conducted a series of analyses of statewide aggregate and individual hospital data and trends in the following areas:

- Patient race and ethnicity composition statewide trends (Figure 1);
- Patient race and ethnicity composition by hospital for FY 2012 (Figures 2 and 3)
- Comparison of race and ethnicity in the QBR and HSCRC discharge data sets for CY 2011 (Figure 4);
- QBR race and ethnicity data statewide trends CY2011 (Figure 5); and,
- MHAC race and ethnicity data statewide trends CY 2011 (Figure 6).

In general, based on review of the data analysis, the HSCRC staff and the Work Group agreed that the degree of variation in the use of "other" and "unknown" categories for race and ethnicity, and inconsistencies in the race categories collected across hospitals, limited our ability to identify true disparities in care within and among hospitals at the present. Data at the Statewide level for Black vs.

White comparisons were felt to be sufficient at the present time to examine whether disparities in hospital quality metrics between those two groups exist in the State overall.
The Figures referenced above are provided below along with a brief discussion of each of the analysis findings and its implications.

Hospital Race and Ethnicity Composition Statewide and by Hospital

Figure 1 below illustrates the statewide changes in patient race and ethnicity as submitted in the HSCRC hospital discharge data set from 2007 to 2012. Of particular note are the substantial increases in the "unknown" (59%) and "biracial" (775%) categories for race as well as the "unknown" category for "ethnicity" (292%), which is a result of dramatic change in FY2012 data.

Figure 1. Trends in Hospital Discharges by Race and Ethnicity Statewide, FY 07-12

	FY07	FY08	FY09	FY10	FY11	FY12	FY07-FY12 Change
RACE							
WHITE	454,334	458,373	458,241	445,806	427,708	411,925	**-9.33%**
AFRICAN AMERICAN	242,924	246,275	249,965	252,358	242,876	235,747	**-2.95%**
ASIAN/PACIFIC ISLANDER	13,911	14,458	14,881	15,746	15,495	16,024	**15.19%**
NATIVE AMERICAN	1,745	1,777	1,801	1,629	2,075	2,997	**71.75%**
OTHER	40,475	42,603	44,835	43,622	39,827	33,855	**-16.36%**
BIRACIAL	523	802	1,038	1,295	2,441	4,575	**774.76%**
UNKNOWN	1,371	1,519	1,761	2,084	2,326	2,176	**58.72%**
ETHNICITY							
NOT SPANISH HISPANIC ORIGIN	706,896	716,874	724,669	709,346	674,282	599,179	**-15.24%**
SPANISH HISPANIC ORIGIN	28,535	29,592	28,736	29,225	29,894	30,388	**6.49%**
UNKNOWN	19,852	19,341	19,117	23,969	28,572	77,845	**292.13%**
TOTAL	**755,283**	**765,807**	**772,522**	**762,540**	**732,748**	**707,299**	**-6.35%**

As illustrated in Figure 2 below, the analysis of hospital-specific coding of race for FY2012 discharges revealed wide variation in hospital coding of "other"—with the lowest hospital at 0% and the highest hospital at 25%—, "two or more"—with the lowest hospital at 0% and the highest hospital at 8%—, and "unknown"—with the lowest at 0% and the highest at 4%.

More strikingly, as shown in Figure 3, the hospital-specific coding of ethnicity of "unknown" (i.e., Hispanic or non-Hispanic as a separate variable) for FY 2012 discharges revealed a range of 0.1% for the lowest hospital and 100% for the highest hospital, with a statewide average of 16%.

Figure 2. Race Coding by Hospital in the HSCRC Discharge Data Set, FY 2012

HOSPITAL NAME	WHITE	AFRICAN AMERICAN	ASIAN/ PACIFIC ISLANDER	NATIVE AMERICAN	OTHER	BIRACIAL	UNKNOWN
GARRETT COUNTY	99.4%	0.3%	0.1%		0.0%	0.1%	
WESTERN MARYLAND HEALTH SYSTEM	96.8%	2.6%	0.1%	0.0%	0.3%	0.1%	0.1%
CARROLL COUNTY	93.1%	3.9%	0.4%	0.2%	2.0%	0.3%	0.2%
ATLANTIC GENERAL	89.5%	9.1%	0.2%		1.0%	0.1%	0.2%
MERITUS	89.4%	7.2%	0.5%	0.1%	2.2%	0.6%	
UNION HOSPITAL OF CECIL COUNTY	88.9%	7.9%	0.4%	0.1%	2.5%	0.2%	
UPPER CHESAPEAKE HEALTH	85.8%	10.8%	0.6%	1.0%	1.6%	0.3%	0.0%
CALVERT	82.0%	16.7%	0.6%	0.1%		0.4%	0.2%
FREDERICK MEMORIAL	81.4%	10.1%	1.8%	0.1%	6.2%	0.4%	
HARFORD	80.6%	17.0%	0.8%	0.4%	1.1%	0.1%	0.0%
ST. JOSEPH	78.5%	16.1%	1.9%	0.1%	3.0%	0.3%	0.1%
CHESTER RIVER HOSP. CENTER	78.5%	17.5%	0.0%	0.0%	3.6%	0.3%	0.0%
ANNE ARUNDEL	78.0%	19.0%	1.5%	0.1%	0.9%	0.2%	0.5%
B.W.M.C	77.8%	16.1%	1.5%	0.4%	3.4%	0.2%	0.6%
FRANKLIN SQUARE	77.5%	17.8%	0.3%	0.1%	3.1%	0.3%	0.9%
MCCREADY	77.5%	22.0%			0.3%	0.3%	
ST. MARY	75.0%	19.9%	0.4%	0.1%	3.6%	1.0%	0.1%
MEMORIAL AT EASTON	74.9%	19.6%	0.3%	0.1%	5.0%	0.1%	0.0%
G.B.M.C.	70.6%	23.6%	2.6%	0.2%	2.6%	0.3%	
MONTGOMERY GENERAL	70.3%	19.1%	4.8%	0.3%	3.5%	1.2%	0.4%
SUBURBAN	70.1%	13.5%	4.7%	0.2%	10.8%		0.6%
PENINSULA GENERAL	69.7%	24.8%		0.3%	5.2%		0.0%
DORCHESTER GENERAL	68.6%	29.5%	0.3%		1.7%		
HARBOR	63.7%	30.6%	0.3%	0.1%	3.3%	0.4%	1.5%
HOPKINS BAYVIEW MED CTR	62.9%	26.0%	1.0%	0.3%	9.6%	0.2%	
CIVISTA	59.5%	34.2%	0.8%	0.1%	5.1%	0.3%	
HOWARD COUNTY	59.4%	22.5%	10.0%	0.1%	7.4%	0.5%	0.0%
KERNAN	57.3%	33.6%	0.7%	0.5%	7.9%		
JOHNS HOPKINS	52.2%	39.1%	2.0%	0.2%	6.2%	0.2%	0.2%
ST. AGNES	52.0%	40.5%	2.8%	0.5%	3.9%	0.1%	0.1%
SHADY GROVE	51.0%	17.9%	12.6%	1.0%	15.3%	1.6%	0.6%
UNIVERSITY OF MARYLAND	48.3%	45.5%	0.8%	0.6%	4.8%		0.0%
UNION MEMORIAL	44.7%	51.7%	0.3%	0.1%	1.9%	0.0%	1.2%
HOLY CROSS	40.7%	39.6%	7.0%	3.6%	0.8%	7.9%	0.4%
GOOD SAMARITAN	40.7%	57.5%	0.2%	0.0%	1.4%	0.1%	0.2%
SINAI	38.4%	56.2%	1.8%	0.3%	3.2%	0.1%	
MERCY	37.8%	58.0%	1.0%	0.1%	2.9%	0.2%	
NORTHWEST	36.7%	60.6%	0.6%	0.3%	1.8%	0.1%	
LAUREL REGIONAL	32.3%	50.8%	1.9%	0.3%	14.7%		
SOUTHERN MARYLAND	25.2%	72.8%	1.7%	0.2%	0.0%		0.0%
WASHINGTON ADVENTIST	21.0%	45.2%	4.3%	0.5%	25.0%		3.9%
BON SECOURS	20.5%	76.1%	0.2%		3.1%	0.0%	0.1%
DOCTORS COMMUNITY	19.2%	73.2%	1.1%	0.0%	6.4%	0.1%	0.0%
MARYLAND GENERAL	17.4%	80.1%	0.5%	0.1%	1.6%		0.2%
FT. WASHINGTON	15.5%	79.5%	3.2%	0.1%	1.7%		
PRINCE GEORGE	11.9%	75.2%	0.8%	0.3%	11.9%		
State Average	**60.0%**	**32.8%**	**1.8%**	**0.3%**	**4.5%**	**0.5%**	**0.4%**
Highest %	**99.4%**	**80.1%**	**12.6%**	**3.6%**	**25.0%**	**7.9%**	**3.9%**
Lowest %	**11.9%**	**0.3%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**

Figure 3. Ethnicity Coding by Hospital in the HSCRC Discharge Data Set, FY 2012

HOSPITAL NAME	Yes	No	Unknown
CALVERT			100.0%
MCCREADY			100.0%
UPPER CHESAPEAKE HEALTH	0.2%	16.5%	83.3%
HARFORD	0.2%	16.6%	83.2%
HOLY CROSS	19.7%		80.3%
SUBURBAN	2.8%	73.2%	24.0%
KERNAN	0.6%	82.9%	16.5%
FRANKLIN SQUARE	0.7%	87.7%	11.6%
UNIVERSITY OF MARYLAND	1.7%	87.4%	11.0%
LAUREL REGIONAL	9.1%	81.5%	9.4%
ST. JOSEPH	1.9%	89.8%	8.3%
JOHNS HOPKINS	1.6%	90.6%	7.8%
UNION HOSPITAL OF CECIL COUNT	1.3%	91.4%	7.4%
MONTGOMERY GENERAL		94.6%	5.4%
MERITUS	1.2%	93.9%	4.9%
HARBOR	7.5%	88.1%	4.5%
SHADY GROVE	9.0%	87.1%	3.9%
ANNE ARUNDEL	3.2%	93.3%	3.5%
BON SECOURS	0.3%	96.9%	2.7%
PRINCE GEORGE	11.5%	85.9%	2.5%
CHESTER RIVER HOSPITAL CENTER	19.9%	78.3%	1.9%
CIVISTA	2.7%	95.6%	1.7%
MEMORIAL AT EASTON	22.1%	76.1%	1.7%
BALTIMORE WASHINGTON MEDICAL CENTER	3.2%	95.4%	1.5%
DORCHESTER GENERAL	16.8%	82.4%	0.9%
UNION MEMORIAL	1.5%	97.7%	0.9%
DOCTORS COMMUNITY	3.4%	95.9%	0.8%
MERCY	0.9%	98.5%	0.7%
ST. AGNES	3.5%	96.0%	0.6%
MARYLAND GENERAL	1.1%	98.4%	0.5%
CARROLL COUNTY	0.6%	99.0%	0.3%
WESTERN MARYLAND HEALTH SYSTEM	0.2%	99.6%	0.2%
ATLANTIC GENERAL	0.4%	99.4%	0.2%
GOOD SAMARITAN	1.0%	98.8%	0.2%
ST. MARY	2.2%	97.7%	0.1%
GARRETT COUNTY	0.1%	99.8%	0.1%
FREDERICK MEMORIAL	4.5%	95.5%	
SINAI	1.1%	98.9%	
WASHINGTON ADVENTIST	26.4%	73.6%	
PENINSULA GENERAL	2.3%	97.8%	
HOPKINS BAYVIEW MED CTR	2.7%	97.3%	
NORTHWEST	0.9%	99.2%	
G.B.M.C.	1.1%	99.0%	
HOWARD COUNTY	4.6%	95.4%	
SOUTHERN MARYLAND	2.1%	97.9%	
FT. WASHINGTON	1.4%	98.6%	
State Average	**4.6%**	**88.8%**	**16.2%**
Highest %	**26.4%**	**99.8%**	**100.0%**
Lowest %	**0.1%**	**16.5%**	**0.1%**

QBR and MHAC by Race and Ethnicity

As an initial step to attempt to validate race and ethnicity coding, HSCRC staff examined the correlation of these variables between the QBR process of care clinical measures and the HSCRC discharge data sets. QBR data record the race and ethnicity variables from the medical charts, while HSCRC discharge data sets may have different sources of this information. However, one would expect 100% compatibility between these two data sets as race and ethnicity information should be uniform in all hospital records. Nonetheless, there is still the possibility that the race and ethnicity information is incorrect on both data sets. As Figure 4 illustrates, using CY 2011 data, there was an overall high matching rate of 96% for race and 95% for ethnicity, but there is quite a wide variation between hospitals and between race and ethnicity categories, with an overall lowest hospital match rate of 81% for race and 22% for ethnicity.

Figure 4. Comparison of Race Coding from Clinical Process of Care (QBR) Measures and HSCRC Inpatient Data Set-CY2011

Race/Ethnicity Category in Clinical Process of Care Measures	Total Number of Patients	Percent of Patients with Matching Race/ Ethnicity	Lowest Hospital Match Rate
Race			
WHITE	36,714	98.74%	71.14%
AFRICAN AMERICAN	16,882	99.19%	93.68%
ASIAN/PACIFIC ISLANDER	736	75.27%	19.05%
NATIVE AMERICAN	193	50.26%	8.33%
UNKNOWN	1,371	7.80%	1.61%
OVERALL	55,899	96.16%	81.59%
Ethnicity			
SPANISH HISPANIC ORIGIN	879	80.09%	20.00%
NOT SPANISH HISPANIC ORIGIN	55,019	95.73%	17.77%
OVERALL	55,899	95.48%	22.36%

Note: Records are linked using Hospital ID, Date of Birth, Sex, Zip code of Residence, Admission Date and Discharge Date.

Analysis of Race and Ethnic Differences in QBR and MHAC Data

HSCRC staff analyzed current hospital quality information used in the performance based incentive programs by race and ethnicity. Given the concern about data reliability (see matching results above), the HSCRC conducted this analysis for illustrative purposes. While the data quality is good (not great) for the white and black categories on an overall statewide basis, the HSCRC would expect this to improve over time as best practices become more prevalent. Further, due to the variation among hospitals, hospital-by-hospital analyses would not be appropriate at this time. As data quality improves and collection practices are standardized across the State; however, HSCRC would expect to conduct similar analyses on a hospital-by-hospital basis.

An analysis of CY 2011 racial and ethnic differences in the clinical process of care measure scores used in the QBR program produced mixed results. As Figure 5 illustrates below, there is variation in

black/white differences when reviewed measure by measure with, for example, blacks scoring 5% lower in the AMI 8A measure (Heart Attack Patients Receiving Primary Percutaneous Coronary Intervention within 90 minutes), and scoring 8% higher on the CAC 3 measure (Home management plan given for child with asthma). Although the information on race categories other than white/black and ethnic groups is provided in the analysis, the rates for these racial and ethnic groups are not reliable due to a small number of patients in each clinical measure, and due to inconsistencies in data collection for these particular minorities.

HSCRC staff analyzed trends in the MHAC complication rates statewide for the black and white populations from FY 2010 to FY 2012. As Figure 6 shows, based on data currently available, blacks had lower raw and risk adjusted rates of complications than whites , although the raw rate difference of -15% was much higher than the risk adjusted rate of -5% in FY2012. Since the program started in FY2010, complication rates declined much faster for blacks than whites resulting in increased black and white differences over time. However, HSCRC's current risk adjustment method may be limited to measure racial and ethnic differences in complication rates as it is based on the severity of illness of the patient by the diagnosis related group (using APR-DRGs). As further analysis is done in the future, the Commission will consider adding other risk adjustment factors such as age, and source of admission. Further work to determine which approaches to risk adjustment are best suited to disparity analysis needs to be done.

In both quality programs, statewide racial and ethnic differences in quality of hospital care reflect two dimensions of disparity: within hospital variation (different racial and ethnic groups receiving different quality of care in the same hospital), and across hospital variation (minority groups receiving their care in lower performing hospitals). HSCRC will continue to analyze race and ethnicity data using hospital discharge and quality data sets, while simultaneously considering methodologies for incentive programs differentiating these two dimensions of disparity in hospital quality.

Figure 5. QBR Process of Care Measures by Race and Ethnicity, CY 2011

Measure	White	Black/African American	American_Indian	Asian	Hawaiian	UTD	Black-White Difference	Hispanic_Yes	Hispanic_No	Hispanic Difference
AMI-8a - Primary PCI Received Within 90 Minutes of Hospital Arrival	91.5	86.5	100	97.1	100	100	-5.0	91.3	91.3	0.0
PN-7 Influenza vaccination	95.1	92.3	100	92.8	100	95.2	-2.8	95.1	94.3	0.8
PN-2 Pneumococcal vaccination	96.5	94.1	91.7	91.6	100	95.2	-2.4	95.7	95.9	-0.2
PN-3b Blood culture before first antibiotic – Pneumonia	95.4	93.4	96.8	98	100	95.3	-2.0	96.6	94.8	1.8
SCIP INF 4- Cardiac Surgery Patients with Controlled 6 A.M. Postoperative Serum Glucose	93.9	91.9	94.4	96.8	100	93.1	-2.0	97.6	93.5	4.1
AMI-1 Aspirin at Arrival	99.1	97.5	100	100	100	100	-1.6	100	98.8	1.2
AMI-2 Aspirin prescribed at discharge	99.3	98	93.9	99.3	100	99.6	-1.3	100	99	1.0
SCIP CARD 2 Surgery Patients on Beta-Blocker Therapy Prior to Admission Who Received a Beta-Blocker During the Perioperative Period	95.3	94.5	78.8	92.4	100	96.7	-0.8	92.8	95.1	-2.3
SCIP INF 2- Antibiotic selection	98.1	97.3	97.3	96.4	96.3	98.2	-0.8	97.7	97.9	-0.2
AMI-5 Beta blocker prescribed at discharge	98.9	98.2	97.1	100	100	98.6	-0.7	98.9	98.7	0.2
SCIP INF 3- Antibiotic discontinuance within appropriate time period postoperatively	96.7	96	95.5	96.6	96.3	97.5	-0.7	96.3	96.6	-0.3
PN-6 Initial Antibiotic Selection for CAP in Immunocompetent Patient	95.8	95.3	91.3	96.3	100	95.2	-0.5	97.2	95.6	1.6
AMI-4 Adult smoking cessation advice/counseling	99.2	98.9	88.9	100	100	100	-0.3	100	99.1	0.9
HF-1 Discharge instructions	90.8	90.5	94.6	93.2	92.3	92.8	-0.3	93.8	90.7	3.1
SCIP VTE 1- Surgery Patients with Recommended Venous Thromboembolism Prophylaxis Ordered	97.2	96.9	94.7	95.3	95.5	98.3	-0.3	97	97.1	-0.1
HF-2 Left ventricular systolic function (LVSF) assessment	99	98.8	100	100	100	99.6	-0.2	99.5	98.9	0.6
AMI-3 ACEI or ARB for LVSD	97.4	97.3	100	100	100	96.8	-0.1	100	97.4	2.6
CAC-1a - Relievers for Inpatient Asthma (age 2 through 17 years) – Overall Rate	100	100	100	100	100	100	0.0	100	100	0.0
SCIP INF 6- Surgery Patients with Appropriate Hair Removal	99.8	99.8	100	100	100	99.8	0.0	99.8	99.8	0.0
PN-4 Adult smoking cessation advice/counseling	98.5	98.6	100	100	100	97.5	0.1	97	98.6	-1.6
SCIP INF 1- Antibiotic given within 1 hour prior to surgical incision	97.2	97.3	90	97.1	92.6	98.5	0.1	98	97.3	0.7
SCIP VTE 2 - Surgery Patients with Recommended Venous Thromboembolism Prophylaxis Given 24 hours prior and after surgery	96.3	96.4	94.7	95.3	95.5	97.9	0.1	96.7	96.4	0.3
HF-3 ACEI or ARB for LVSD	96.3	96.5	100	97.8	100	96.1	0.2	97.5	96.4	1.1
CAC-2a - Systemic Corticosteroids for Inpatient Asthma (age 2 through 17 years) – Overall Rate	99.4	99.9	100	100	100	99.3	0.5	100	99.7	0.3
HF-4 Adult smoking cessation advice/counseling	98.6	99.1	100	100	100	100	0.5	100	98.9	1.1
CAC-3-Home Management Plan of Care (HMPC) Document Given to Patient/Caregiver	76.4	84.5	94.7	88.2	57.1	83.7	8.1	83.1	82.1	1.0

Figure 6. Trends in Hospital Complication Rates, Black Vs. White, FY 2010-12

Rates	Race Group	FY2010	FY2011	FY2012	% Change
Observed State PPC Rates	White	2.14	2.05	1.90	-11.19%
	Black	1.81	1.74	1.59	-12.33%
	% Difference in Rate for Blacks	-15.40%	-15.43%	-16.50%	
Risk Adjusted State PPC Rates	White	2.11	1.97	1.81	-14.15%
	Black	2.05	1.91	1.71	-16.61%
	% Difference in Rate for Blacks	-2.60%	-3.13%	-5.38%	

PPC Rate: Potentially Preventable Complication Rate per 1,000 at risk. Patients can be at risk of multiple complications.

Risk Adjusted for the severity of the patients using APR-DRG Severity of Illness categories.

Hospital Survey Results on Race and Ethnicity Data, Collection Practices, and Training

At the recommendation of the Work Group, in July of 2012, HSCRC staff surveyed hospital access staff on race and ethnicity data elements collected, data collection practices, and training of staff on data collection. The survey yielded the results below.

- 37 of Maryland's 46 hospitals responded.
- All respondents indicated they collect Black and White categories, and nearly all collect Asian and American Indian/Native Alaskan.
- There is wide variation in data collection when a patient identifies as being more than one race, with some hospitals collecting each race, some collecting "biracial," some collecting "multiracial", etc.
- 30 hospitals reported they collect race and ethnicity data elements separately, and 7 reported they collect them combined.
- Most hospital respondents collect preferred language and most do not collect country of origin.
- All but one hospital indicated they use patient self-reported data for race/ethnicity, and 15 of 37 hospitals also indicated they use staff observation.
- Content and timing of staff training on race and ethnicity data collection varied greatly.
- Tools and resources are not widely used by hospitals to support accurate and complete race and ethnicity data collection.
- Half of hospital respondents identified areas of training or support from which the hospital would benefit.

As a result of the survey findings, the Work Group recommended changes in data collection requirements as well as training sessions for frontline hospital staff across the State on best practices in collecting race and ethnicity data.

IV. Changes in HSCRC Hospital Patient Race and Ethnicity Data Requirements

In their discussions, the Work Group supported HSCRC staff's recommendation to require hospitals to collect race categories consistent with the US Office of Management and Budget categories. Table 5 below indicates the HSCRC-imposed changes that were effective for discharges beginning July 1, 2012.

Figure 7. Updated Race Categories Beginning with Discharges FY 2013 (July 1, 2012)

Old Race Categories			Revised Race Categories		
	Category	Code		Category	Code
(a)	White	1	(a)	White	1
(b)	African American	2	(b)	**Black or** African American	2
(c)	Asian or Pacific Islander	3	(c)	Asian	3
(d)	American Indian/Eskimo/Aleut	4	(d)	American Indian **or Alaska Native**	4
(e)	Other	5	(e)	Other	5
(f)	Biracial	6	(f)	**Two or more races**	6
(g)	Unknown	9	(g)	**Native Hawaiian or Other Pacific Islander**	7
			(h)	Unknown	9

In addition to the changes above, the Work Group recommended that hospitals begin to collect all discrete race categories that apply to a patient as well as country of origin and preferred language beginning with July 1, 2013 discharges. HSCRC will require this as of the recommended date.

V. Best practices training on collecting race and ethnicity data from patients

The Work Group discussed the available tools to support better data collection, including the training developed by the Center for Health Disparities and the Guide entitled, *Improving Health Equity Through Data Collection AND Use: A Guide for Hospital Leaders* developed by the Health Research and Educational Trust in partnership with the American Hospital Association. All agreed such tools were a valuable resource that could be more aggressively and uniformly used by hospitals to more accurately collect race and ethnicity data.

HSCRC is collaborating with the Maryland Hospital Association (MHA) and Maryland Healthcare Education Institute (MHEI) to support improvement in patient race and ethnicity data collection, and ultimately improvement in disparities in health and hospital care. A statewide meeting was convened on December 12, 2012 to heighten hospitals' awareness of the current status of disparities data collection and to inform hospitals of the three regional training sessions that will be convened during the first quarter of CY 2013 on data collection best practices. The target audiences of these training sessions are hospital staff with responsibility for ensuring that frontline access, including quality and other staff that collect patient race and ethnicity data, do so accurately and appropriately.

VI. Conclusion

As the Maryland Health Improvement and Disparities Reduction Act of 2012 requires that HSCRC consider use of race and ethnicity data in hospital payment incentive programs, HSCRC recognizes, through its data analyses and Work Group deliberations, that it is not currently feasible to use the race and ethnicity data collected by hospitals for performance comparisons linked with incentives. Further, it is crucial that all hospitals participate in the statewide training sessions planned by HSCRC in conjunction with MHA and MHEI. The sessions will be convened through the first quarter of calendar year 2013. Hospitals are invited to send individuals who will train frontline staff in the following areas:

- The importance of accurate race and ethnicity data collection:
    - Compliance with the US OMB race categories (required by HSCRC as of July 2012).
    - Collection and storage of all discrete racial categories that the patient indicates applies to them (will be added July 2013).
    - Collection of ethnicity data separate from race (currently required by HSCRC).
    - Collection of new data elements including language preference and country of origin/ancestry/granular ethnicity (HSCRC will begin adding these elements July 2013).

- How hospitals can inform/educate the public as to why this information is collected, including assurances of individual data confidentiality.

- Best practices of having patients self-identify their race and ethnicity, e.g., a standardized written document for patients to self-identify, available in multiple languages.

- Conflict management at collection for frontline staff.

- Guidelines/best practices for patients who are not capable of answering, for example, unconscious or disoriented patients.

HSCRC staff will continue to analyze race and ethnicity data submitted in the administrative discharge data as well as the array of quality of measures collected, analyzed, and used for its performance initiatives linked with payment. As race and ethnicity reporting and data quality improve, the Commission will consider adding race and ethnicity elements into its quality programs as feasible and appropriate. HSCRC staff will continue working with the Department of Health and Mental Hygiene on the most efficacious method to accomplish this goal.

Appendix A
Hospital Race and Ethnicity Disparities Work Group
(Updated June 6, 2012)

ROSTER

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Appendix B

Charge 2 Report

Feasibility of Incorporating Standards into PCMH Assessment

July 2013

Maryland Health Quality and Cost Council
Cultural and Linguistic Competency Workgroup
Subcommittee 2

Charge 2. Assess the feasibility of and develop recommendations for criteria and standards establishing multicultural health care equity and assessment programs for the Maryland Patient-Centered Medical Home (PCMH) program and other health care settings.

I. Background and Summary of Workgroup Response

a. Subcommittee 2 (see Appendix A for a list of participants) was charged with completing the following action steps:

i. Examine current assessment programs and certifications (i.e., Georgetown University National Center for Cultural Competence (NCCC), National Quality Forum, HRSA, NCQA Distinction in Multicultural Health Care, Joint Commission, URAC, Hopkins Center for Health Disparities Solutions).

ii. Examine existing evidence-based or promising assessment or evaluation practices being applied in other health care settings in Maryland and nationally.

iii. Examine existing evidence-based or promising assessment or evaluation practices being applied in patient-centered medical homes in Maryland and nationally.

iv. Discuss and determine whether the final recommended assessment tool should be a standalone assessment or one component of a more general assessment tool that already exists.

v. Based on knowledge obtained in prior action steps, develop recommendations for criteria and standards for a multicultural health care equity and assessment program that is applicable to Maryland's patient-centered medical home program and other health care settings.

II. Methods of Review

a. Subcommittee 2 conducted an exhaustive literature review of the patient-centered medical home and other healthcare settings as they related to health equity, health disparities, and cultural competency (see Appendix B).

b. Subcommittee 2 conducted a review of various cultural and linguistic competency standards (see Appendix C):
    - Department of Health and Human Services, Office of Minority Health, National Enhanced Culturally and Linguistically Appropriate Services (CLAS) Standards,
    - The Joint Commission, Advancing Effective Communication, Cultural Competence, and Patient- and Family-Centered Care Standards,
    - National Quality Forum (NQF), A Comprehensive Framework and Preferred Practices for Measuring and Reporting Cultural Competency,
    - NCQA Multicultural Health Care Distinction Program, and
    - Substance Abuse and Mental Health Services Administration (SAMHSA) Cultural Competency Standards in Managed Care Mental Health Services.

c. Subcommittee 2 then conducted a review of the cultural and linguistic competency standards present in the various PCMH recognition program standards (see Appendix D):

    - NCQA Patient-Centered Medical Home,
    - URAC Patient Centered Health Care Home,
    - The Joint Commission Primary Care Medical Home, and
    - Accreditation Association for Ambulatory Health Care (AAAHC) Medical Home.

Since the majority of the 52 physician practices participating in the Maryland Multi-Payer PCMH Demonstration project and Maryland Learning Collaborative have achieved NCQA PCMH recognition, the Subcommittee especially focused upon the NCQA PCMH standards.

d. Based upon the reviews conducted in b. and c. above, Subcommittee 2 developed a list of proposed multicultural health care equity standards and cross-walked those standards to the patient-centered medical home recognition program standards (see Appendix E).

e. Next, Subcommittee 2 used a document compiled by Dr. Josepha Campinha-Bacote entitled, “Cultural Assessment Tools” (http://www.transculturalcare.net/assessment-tools.htm) and reviewed all of the organizational cultural competency assessment tools and/or

bibliographies of such tools that were listed. Of the 28 assessment tools and/or bibliographies of such tools, 19 were reviewed due to the others being unavailable due to dead webpage links (see Appendix F). A scoring tool was then developed whereby each tool was scored based upon 5 domains that were weighted according to importance and then multiplied by a score of how well the tool met the criteria for that domain (see Appendix G). Of the 19 tools and/or bibliographies of such tools, 14 were scored since bibliographies did not constitute tools (see Appendix H). The organizational cultural competency assessment tools were then ranked from highest to lowest total weighted score (see Appendix I).

III. Recommendations

IMPAQ International, LLC will be conducting an evaluation of the Maryland Multi-Payer PCMH program, which will include such questions as—1) can the model achieve savings?; 2) does the model increase satisfaction; and 3) can PCMH reduce disparities? Subcommittee 2 contacted IMPAQ for specific information on how cultural competency and health disparities reduction will be evaluated in the assessment (see Appendix J).

Based upon the reviews conducted above, Subcommittee 2 recommends the following multicultural health equity standards:

- The National Culturally and Linguistically Appropriate Services (CLAS) Standards, the latest version of which was released on April 24, 2013, should be used, see: https://www.thinkculturalhealth.hhs.gov/Content/clas.asp.
- Staff training should include annual cultural competency training for all staff (both clinical and support staff).
- Staff training includes how to properly collect data to accurately capture race, ethnicity, language, social determinants, sexual orientation, and gender identity and includes why the quality of such data is important.
- Accurate collection of race, ethnicity, and language data.
    - Although the existing PCMH standards follow the meaningful use of electronic health records standards, the meaningful use standards do not include a quality of data component. For example, a patient's race, ethnicity, or language could be recorded incorrectly, but the practice still would receive credit because data was present in the field.
        - For additional information on how to collect race, ethnicity, and language data, see:

- American Medical Association (AMA), Commission to End Health Care Disparities (CEHCD), Collecting and Using Race, Ethnicity, and Language Data in the Ambulatory Settings: A White Paper with Recommendations, 2011.
- Health Research & Educational Trust (HRET) (in partnership with the American Medical Association) Disparities Toolkit
- Hospitals in Pursuit of Excellence (HPOE): Improving Health Equity through Data Collection AND Use: A Guide for Hospital Leaders
- Institute of Medicine. Race, Ethnicity, and Language Data: Standardization for Health Care Quality Improvement. Washington, DC: The National Academies Press, 2009

- Data collection includes sexual orientation, gender identity, and other social determinants of health, such as income, educational level, insurance status, etc.
    - For additional information, see:
        - Institute of Medicine. Collecting Sexual Orientation and Gender Identity Data in Electronic Health Records, http://www.nap.edu/catalog.php?record_id=18260
        - U.S. Department of Health and Human Services, Office of Minority Health, Plan for Health Data Collection on Lesbian, Gay, Bisexual and Transgender (LGBT) Populations, http://minorityhealth.hhs.gov/templates/browse.aspx?lvl=2&lvlID=209
        - Centers for Disease Control and Prevention (CDC), Social Determinants of Health, http://www.cdc.gov/socialdeterminants/
        - World Health Organization Commission on Social Determinants Final Report, http://www.who.int/social_determinants/thecommission/finalreport/en/index.html
- Stratification of process measures (by race, ethnicity, and language with future consideration of inclusion of social determinants of health).
    - Use a multi-pronged approach—training for private practices (webinars, conference calls, etc.) vs. those with quality improvement support from health plans, broader organization (such as if part of a health system), etc.
- Stratification of clinical measures (by race, ethnicity, and language with future consideration of inclusion of social determinants of health).
    - Use a multi-pronged approach—training for private practices (webinars, conference calls, etc.) vs. those with quality improvement support from health plans, broader organization (such as if part of a health system), etc.

- Use of continuous quality improvement to reduce disparities in vulnerable populations
    - This must go beyond identifying disparities and implementing continuous quality improvement for vulnerable populations and should include a demonstration of disparities reduction for a vulnerable population.
- Language access includes the provision of bilingual staff or qualified medical interpreters.
    - Interpretation services can be provided via in-person, telephonic, or video remote interpreting.
- Language access includes translation of documents, such as consent forms and patient education materials, into the languages of the population.
- The competency of bilingual staff and interpreters is assessed.
- Health literacy and plain language is addressed as it relates to medical encounters, patient education materials, etc.
- Patient satisfaction/experience includes diverse populations.
    - Consider requiring use of the CAHPS Cultural Competence and Health Literacy item sets, which are currently optional components of the CAHPS surveys, see:
        - http://www.cahps.ahrq.gov/clinician_group/cgsurvey/aboutculturalcompetenceitemset.pdf and http://www.cahps.ahrq.gov/clinician_group/cgsurvey/aboutitemsetaddressinghealthliteracy.pdf.
- Patient satisfaction/experience surveys are offered in languages other than English.
- Patient satisfaction/experience data is stratified by race, ethnicity, and language (as well as other demographic data, such as gender identity, sexual orientation, social determinants of health, etc.)

All of the above-mentioned recommendations support the “Maryland Health Equity Guidelines and Principles” published by the Maryland Office of Minority Health and Health Disparities in November 2012, see: http://dhmh.maryland.gov/mhhd/SiteCollectionDocuments/Health%20Equity%20Guidelines%20and%20Principles%20Brief%2011.8%20%281%29.pdf.

In addition, the Health Services Cost Review Commission (HSCRC) Health Disparities Workgroup recommended three changes to the data submission requirements hospitals for the collection and reporting of race, ethnicity, and preferred spoken language for a health-related encounter, which also should be considered.

- Revisions to the Inpatient and Outpatient Casemix Data Submission Requirements, http://www.hscrc.state.md.us/documents/HSCRC_PolicyDocumentsRepor

ts/PolicyClarification/2013-01-24-fy14-data-submission-requirements-revisions.pdf

- Maryland Hospital Inpatient Data Submission Elements and Format FY 2014, http://www.hscrc.state.md.us/documents/Hospitals/DataReporting/ReportRequirementsDueDates/2014/hscrc-InpDataSubReqFY2014v10-2013-07-19.pdf
- Maryland Hospital Outpatient Data Submission Elements and Format FY2014,
- http://www.hscrc.state.md.us/documents/Hospitals/DataReporting/ReportRequirementsDueDates/2014/hscrc-OutpDataSubReqFY2014v5-2013-07-18.pdf

Subcommittee 2 acknowledges the burden on physician practices of conducting multiple assessments. However, none of the existing PCMH assessment tools adequately incorporates or addresses cultural and linguistic competency. Therefore, Subcommittee 2 recommends the following standalone organizational cultural competency assessment tools:

- CAHPS Cultural Competence and Health Literacy item sets (to be used in conjunction with one of the following standalone assessment tools)
  - http://www.cahps.ahrq.gov/clinician_group/cgsurvey/aboutculturalcompetenceitemset.pdf and
  - http://www.cahps.ahrq.gov/clinician_group/cgsurvey/aboutitemsetaddressinghealthliteracy.pdf.
- Clearview Organizational Assessments-360 suite of tools (http://www.clearview360.org/), which provides organizational cultural competency assessment tools for a variety of healthcare settings:
  - PCMH360 for physician practices
  - COA360 for hospitals and healthcare organizations
  - BHSS360 for behavioral health and social services.

Lastly, the NCQA Draft PCMH Standards for 2014 were open for public comment from June 17-July 22, 2013. Since Subcommittee 2 is not an independent entity, it was not possible to submit public comments independently. However, Dr. Thomas LaVeist and Audrey Whetsell (Medical Home Development Group) are currently Cabinet members of the Patient-Centered Primary Care Collaborative (PCC) Patients, Families, and Consumer Center. The Center submitted public comments on the NCQA Draft PCMH Standards, which provided a means for the Subcommittee to submit its current recommendations on multicultural health care equity standards for consideration in national standards (see Appendix K).

Cheri Wilson 7/27/13 9:23 PM
Comment [1]: Appendix K will be forthcoming as soon as I receive the final document from Audrey Whetsell.

Appendices (based upon order of appearance in the report):

A. Committee Participants
B. Literature Review
C. Cultural and Linguistic Competency Standards
D. Cultural and Linguistic Competency Standards in the Patient-Centered Medical Home (PCMH) Standards
E. Crosswalk of Proposed Multicultural Healthcare Equity Standards vs. PCMH Standards
F. Review of Organizational Assessment Tools and/or Bibliographies of Tools
G. Weighted Scoring Tool
H. Scoring of Organizational Assessment Tools
I. Final Weighted Score Ranking
J. Cultural Competency Provisions of the IMPAQ International, LLC Evaluation of the Maryland Multi-Payer PCMH Program
K. Patient-Centered Primary Care Collaborative (PCPCC) Public Comments on Cultural and Linguistic Competency in the Draft 2014 NCQA PCMH Standards

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Appendix B: Cultural and Linguistic Competency Standards

CLAS (Dianne Houston-Crockett)	The Joint Commission (Cheri Wilson)	National Quality Forum (Cheri Wilson)	NCQA Multicultural Health Care Distinction (Dianne Houston-Crockett)	SAMHSA CC Standards in Managed Care Mental Health Services (Cheri Wilson)
The CLAS standards do not have an assessment tool	Addressing qualifications for language interpreters and translators (revised)	Published in February 2009	MHC uses evidence-based standards to evaluate how health care plans and other health and wellness organizations measure, analyze and adjust their services to meet the health care needs of diverse populations. Health care organizations can earn MHC Distinction by meeting standards in these areas: ■Race/Ethnicity and Language Data Collection ■Access and Availability of Language Services ■Practitioner Network Cultural Responsiveness ■Culturally and Linguistically Appropriate Services Programs ■Reducing Health Care Disparities MHC distinction standards are modeled after Federal Office of Minority Health (OMH) Standards.	Principle of Cultural Competence: Cultural competence includes attaining the knowledge, skills, and attitudes to enable administrators and practitioners within systems of care to provide effective care for diverse populations, i.e., to work within the person's values and reality conditions. Recovery and rehabilitation are more likely to occur where managed care systems, services, and providers have and utilize knowledge and skills that are culturally competent and compatible with the backgrounds of consumers from the four underserved/underrepresented racial/ethnic groups, their families, and communities. Cultural competence acknowledges and incorporates variance in normative acceptable behaviors, beliefs, and values in: o determining an individual's mental wellness/illness, and o incorporating those variables into assessment and treatment.
15 standards, including a principle standard with the remaining standards divided into 3 domains--1) governance, leadership, and workforce, 2) communication and language assistance, 3) engagement, continuous improvement, and accountability	Identifying patient communication needs (new)	45 best practices organized into 7 domains (number of practices in each domain represented in parentheses following the domain name)	Based on CLAS standards. Requires HEDIS benchmarks for outcomes measures by race and gender. Also relies on CAHPS survey to measure patient experience with providers.	Principle of Consumer-Driven System of Care: A consumer-driven system of care promotes consumer and family as the most important participants in the service-providing process. Whenever possible and appropriate, the services adapt self-help concepts from the racial/ethnic culture, taking into account the significant role that mothers and fathers play in the life of consumers from the four groups.
The language and communication standards mirror Title VI of the Civil Rights Act of 1964	Addressing patient communication needs (new)	1 .Leadership (7)	Does not factor in accommodation for disability or sexual orientation.	Principle of Community-Based System of Care: A community based system of care includes a full continuum of care. The focus is on: including familiar and valued community resources from the minority culture; investing in early intervention and preventive efforts; and treating the consumer in the least restrictive environment possible.
Take a broad view of diversity--race, ethnicity, language, gender identity, sexual orientation, religion, health literacy, and disability	Collecting race and ethnicity data (revised)	2. Integration into Management Systems and Operations (4)		Principle of Managed Care: The costs of a public managed health care delivery system are best contained through the delivery of effective, quality services, not by cutting or limiting services. Effective systems provide individualized and tailor-made services that emphasize outcome-driven systems and positive results. Such systems acknowledge the importance of added-value inclusion of ethnic/cultural groups as treatment partners. The system includes an emphasis on managing care, not dollars. It recognizes that dollars will manage themselves if overall care is well managed. It recognizes racial/ethnic group-specific variables which have significant implications for individualized assessment and treatment.

Appendix B: Cultural and Linguistic Competency Standards

CLAS (Dianne Houston-Crockett)	The Joint Commission (Cheri Wilson)	National Quality Forum (Cheri Wilson)	NCQA Multicultural Health Care Distinction (Dianne Houston-Crockett)	SAMHSA CC Standards in Managed Care Mental Health Services (Cheri Wilson)
	Collecting language data (revised)	3. Patient-Provider Communication (10)		Principle of Natural Support: Natural community support and culturally competent practices are viewed as an integral part of a system of care which contributes to desired outcomes in a managed care environment. Traditional healing practices are used when relevant or possible, and family is defined by function rather than bloodlines, as individuals from the four groups generally conceive of family much more broadly than nuclear family.
	Patient access to chosen support individual (new)	4. Care Delivery and Supporting Mechanisms (6)		Principle of Sovereign Nation Status: Systems of health care for Native Americans who are members of sovereign nations shall acknowledge the right of those sovereign nations to participate in the process of defining cultural competent managed care.
	Non-discrimination in patient care (new)	5. Workforce Diversity and Training (3)		Principle of Collaboration and Empowerment: Consumers from the four groups and their families have the capacity to collaborate with managed care systems and providers in determining the course of treatment. The greater the extent of this collaboration, the better the chances are that recovery and long-term functioning will occur and be sustained. The risk of psychological dependency and lower functioning increases with a decrease in collaboration with consumers and families. Empowering consumers and families enhances their self esteem and ability to manage their own health.
	Providing language services (revised)	6. Community Engagement (5)		Principle of Holism: Consumers from the four groups are more likely to respond to managed care systems, organizations, and providers who recognize the value of holistic approaches to health care and implement these in their clinical work, policies, and standards. Where holistic approaches are absent, there is greater risk that consumers from the four groups will over-utilize mental health services, resulting in increased costs.
		7. Data Collection, Public Accountability, and Quality Improvement (10)		Principle of Feedback: Managed care systems, organizations, and providers shall improve the quality of their services and enhance desired outcomes of their service delivery to consumers from the four groups through legitimate opportunities for feedback and exchange. Where such opportunities for feedback are absent, there is a greater likelihood that the system of managed care services and policies will not be congruent with the needs of consumers from the four groups and will not result in high levels of consumer satisfaction. Managed care systems that lack opportunities for this feedback limit their chances of making culturally specific corrections in their approaches to services while simultaneously increasing their risks.

CLAS (Dianne Houston-Crockett)	The Joint Commission (Cheri Wilson)	National Quality Forum (Cheri Wilson)	NCQA Multicultural Health Care Distinction (Dianne Houston-Crockett)	SAMHSA CC Standards in Managed Care Mental Health Services (Cheri Wilson)
				Principle of Access: For consumers from the four groups to seek, utilize, and gain from mental health care in a Managed Health Plan, services, facilities, and providers shall be accessible. Where services and facilities are geographically, psychologically, and culturally accessible, the chances are increased that consumers from the four populations will respond positively to treatment for mental illness. Inadequate access to services will result in increased costs, limited benefit to the consumer, and a greater probability that services will not result in the outcomes desired.
				Principle of Universal Coverage: Populations of the four groups have higher than average frequencies of unemployment and receipt of transfer payments, along with lower disposable income. Where health care coverage, benefits, and access are based on employment or ability to pay, consumers from the four groups are more likely to be medically underserved. The greater the extent to which health care is universally available without regard to income, the greater the likelihood that the health status of consumers from the four groups will be enhanced.
				Principle of Integration: Consumers from the four groups have higher than expected frequencies of physical health problems. Integrating primary care medicine, mental health, and substance abuse services in a Managed Care Plan increases the potential that consumers from the four groups will receive comprehensive treatment services and recover more rapidly, with fewer disruptions due to a fragmented system of care.
				Principle of Quality: The more emphasis that managed care systems place on ensuring continuous quality culturally competent service to consumers from the four groups, the greater the likelihood that relapse will be prevented; with sickness treated appropriately and costs lowered. The less emphasis placed on providing quality services to consumers from the four groups, the greater the chances that costs will increase.
				Principle of Data Driven Systems: The quality of decision making, service design, and clinical intervention for consumers from the four groups in managed health care is increased where data on prevalence, incidence, service utilization, and treatment outcomes are used to inform and guide decisions.

CLAS (Dianne Houston-Crockett)	The Joint Commission (Cheri Wilson)	National Quality Forum (Cheri Wilson)	NCQA Multicultural Health Care Distinction (Dianne Houston-Crockett)	SAMHSA CC Standards in Managed Care Mental Health Services (Cheri Wilson)
				Principle of Outcomes: Consumers from the four groups and their families evaluate services on the basis of actual outcomes relative to the problems that stimulated help seeking in a managed care environment. The greater the extent to which managed care plans, organizations, and providers emphasize and measure these outcomes in comparison to the expectations of consumers from the four groups, the higher the degree of consumer satisfaction.
				Principle of Prevention: States, managed care organizations, and provider organizations should provide community education programs about mental illness and the risk factors associated with specific disorders. The goal should be to increase the capacity of families to provide a healthy environment and to identify the early warning signs of mental health problems. Early problem identification and intervention can prevent the exacerbation and reduce the disabling effect of mental illness.
				Standard
				A Cultural Competence Plan for both public and private sectors shall be developed and integrated within the overall organization and/or provider network plan, using an incremental strategic approach for its achievement, to assure attainment of cultural competence within manageable but concrete timelines.
				Implementation Guidelines
				The Cultural Competence Plan shall include:
				Development and integration with the participation and representation of top and middle management administrators, front-line staff, consumers and/or their families, sovereign tribal nations, and community stakeholders;
				An individual at the executive level with responsibility for and authority to monitor implementation of the Cultural Competence Plan;

Appendix C: Cultural and Linguistic Competency Standards in the PCMH Standards

NCQA (Salliann Alborn, Cyntrice Bellamy, Dianne Houston-Crockett, Sandy Kick, Steven Ragsdale, Cheri Wilson)	URAC (Steven Ragsdale)	The Joint Commission (Cheri Wilson)	AAAHC (Sandy Kick)
page 11/53	Page 6/33	D. FOCUS AREA: PATIENT LANGUAGE & COMMUNICATION NEEDS	conducted onsite; compliance assessed in 3 categories: Substantially compliant; partially compliant; non-compliant
PCMH1 -		1. The primary care clinician and the interdisciplinary team identify the patient's oral and written communication needs, including the patient's preferred language for discussing health care. [PC.02.01.21/E1]	Awards: 3 year term of distinction: substantial compliance with standards; 2-year term of certification: a portion of org's operations are acceptable, others need to be addressed in time, Plan for Improvement necessary; or 1-year term of recognition: Not in compliance with standards and orgs demonstration of continued compliance not sufficiently well established to grant a longer term. Must correct deficiencies within six months.
Element F - CLAS	Presents and delivers information in a way that is appropriate to the diversity of the patient population, including: (i) Literacy levels; (ii) Language d differences; (iii) Cultural differences; and (iv) disabilities	2. The primary care clinician and the interdisciplinary team communicate with the patient in a manner that meets the patient's oral and written communication needs. [PC.02.01.21/EP2]	Standards include:
process oriented	Provides a meaningful use data crosswalk with URAC Standards; includes	3. The clinical record contains the patient's communication needs, including preferred language for discussing health care. [RC.02.01.01/EP1]	1.Patient Rights and Responsibilities and Relationship
no tool to evaluate impact of measures	enhancing access	4. The organization provides language interpreting and translation services.	2. Governance and Administration
no CC training (annual for all staff)	patient reminders	5. The clinical record contains the patient's race and ethnicity. [RC.02.01.01/EP 28]	3. Clinical Records and Health Information
number of points assigned is low	ongoing care management protocols	E. FOCUS AREA: PATIENT EDUCATION, HEALTH LITERACY, & SELF-MANAGEMENT	4. Continuity of Care

Appendix C: Cultural and Linguistic Competency Standards in the PCMH Standards

NCQA (Salliann Alborn, Cyntrice Bellamy, Dianne Houston-Crockett, Sandy Kick, Steven Ragsdale, Cheri Wilson)	URAC (Steven Ragsdale)	The Joint Commission (Cheri Wilson)	AAAHC (Sandy Kick)
how dealing with low literacy levels	medication review and reconciliation	1. The interdisciplinary team identifies the patient's health literacy needs. [PC.02.02.01/EP 24]	5. Comprehensiveness
not dealing with culture	care coordination	2. The primary care clinician and the interdisciplinary team incorporate the patient's health literacy into the patient's education. [PC.02.02.01/EP 25]	6. Accessibility
no health literacy standards	appropriate use of clinical guidelines	Note: The Primary Care Medical Home Recognition is not a standalone recognition. A PCMH must also achieve ambulatory care recognition. At the time of the review, the Subcommittee did not have access to the Ambulatory Care Standards.	7. Quality
no requirement to collect REAL data from patients	EMR		with details around conducting meaningful QI studies
PCMH2 - Identify and Manage Patient Populations	Electronic Communication Portal		Cultural Competence related standards:
race	performance reporting		Subchapter 1: Rights/Responsibilities: 1.A: Patients are treated with respect, consideration and dignity.
ethnicity	Core 21 Communication Practices; provide but no impact study		1c: patient disclosures and records are treated confidentially, and patients are given the opportunity to approve or refuse their release, except when release is required by law
preferred language (not required to ask patients)	Core 26 Access to and Monitoring of Services The organization: (a) Establishes standards to assure that consumers have access (b) Defines and monitors its performance with respect to the access standards.		1E. Patients are given the opportunity to participate in decisions involving their health care, except when such participation is contraindicated for medical reasons
no sexual orientation or gender identity (transgender)	Descriptions of the processes used to provide information and support to consumers: (i) For whom English is not their primary language; (ii) From different cultural backgrounds; and (iii) With special needs, such as cognitive or physical impairments		1 - Subchapter II - Relationship
no disability status	Health Literacy Communication Requirement		1-II-A. Patient can identify his/her physician and patient care team members
do these demographic variables to clinical outcome or process measures	Information is presented and delivered in ways that are sensitive to the diversity of the organization's enrollment		1-II-B. Phys explains info in a manner that is easy to understand
EHRs need to collect social determinant information (such as housing, access barriers, disability, etc.)	Core 7 Staff Training Program		1-II-C. Physician listens carefully to patient and, when appropriate, the patient's personal caregiver. Caregivers may include a parent, legal guardian, or person with the patient's power of attorney.

Appendix C: Cultural and Linguistic Competency Standards in the PCMH Standards

NCQA (Salliann Alborn, Cyntrice Bellamy, Dianne Houston-Crockett, Sandy Kick, Steven Ragsdale, Cheri Wilson)	URAC (Steven Ragsdale)	The Joint Commission (Cheri Wilson)	AAAHC (Sandy Kick)
no requirement for training on how to properly collect REAL data	CM 8 Case Manager Professional Development		1-II-D. Phys speaks to the patient about his/her health problems and concerns
Element C - Comprehensive Health Assessment	Core Diversity Requirements		1-II-E. Phys provides east-to-understand instructions about taking care of health concerns
Family/social/cultural characteristics	Staff at all levels and across all disciplines receive ongoing education and training in culturally and linguistically appropriate service delivery.		1-II-F. Phys knows important facts about the patient's health history
Communication needs	preferred language both verbal offers and written notices informing them of their right to receive language assistance services is part of a collection of standards		1-II-G. Phys spends sufficient time with the patient.
Behaviors affecting health	LEP patients/consumers offered interpreter services and bilingual staff is offered as a collective of standards		1-II-H. Phys is as thorough as the patient feels is needed
no questions about culture	Cultural Sensitivity Requirements		1-II-I.Staff keeps the patient informed with regard to his/her appointment when delayed.
no questions about health beliefs	Core 9 (Self) Staff Assessment Program		1-II-J. Phys addresses specific principles to prevent illness
no questions about health literacy	Quality Mgmt: administers program that promotes objective and systematic measurement, monitoring, and evaluation of services and implements quality improvement activities based upon the finding.		1-II-K. Phys speaks with the patient about making lifestyle changes to help prevent illness.
no questions about language needs	Quality Management Documentation Requirements		1-II-L. Phys inquires as to the patient's concerns/worries/stressors.
need to be MUST PASS items	Feedback loops to consumers		1-II-M. Phys inquires as to the patient's mental health statues (i.e. sad/empty or depressed).
Element A: Measure Performance	Noteworthy that URAC views its standards for whole populations and not focused on disparate groups.		1-II-N. Medical home provides svcs within a team framework and that "team" provider concept has been conveyed to the patient.
Performance data stratified for vulnerable populations (to assess disparities in case)			1-II-O. Family is included as appropriate in patient care decisions, treatment and educ
process measure - no requirement to do something to reduce disparities			1-II-P. Medical Home treats its patients with cultural sensitivity
Element B: Measure Patient/Family Experience			1-II-Q. When the need arises, reasonable attempts are made for health care professionals and other staff to communicate in the language or manner primarily used by patients.
The practice obtains feedback on the experiences of vulnerable patient groups			2. Governance and Administration: No specific requirements to collect data on race/ethnicity
definition of vulnerable populations is narrow does not include items such as immigration status, pregnancy status, race, ethnicity, language, prison re-entry population, etc.)			3. Clinical Records and Health Information: No specific CC standards appear to be included

NCQA (Salliann Alborn, Cyntrice Bellamy, Dianne Houston-Crockett, Sandy Kick, Steven Ragsdale, Cheri Wilson)	URAC (Steven Ragsdale)	The Joint Commission (Cheri Wilson)	AAAHC (Sandy Kick)
Element C: Continuous Quality Improvement			4. Continuity of Care: No specific CC standards appear to be included
Set goals and address at least one identified disparity in care or service for vulnerable populations			5. E. Comprehensiveness: Org facilitates the provision of high-quality health care as demonstrated by education of, and effective communication with, those served concerning the diagnosis and treatment of their conditions, appropriate preventive measures, and use of the health care system
Training for clinicians on appropriately entering data into EHRs			5. I. Knowledge of community resources that support the patient's (and family's, as appropriate) needs are known by the Medical Home.
What are the EHR vendors used in Maryland? Does it include modifications based upon state regulations			5J. The community's service limitations are know and alternate sources are coordinated by the Medical Home.
GE Centricity, EPIC, eClinicalWorks, NexGen, ATHENA, Greenway			5. M-1 Health Education and Health Promotion: Services provided or made avail by the org are appropriate to the needs of the patients served
David Sharp - MHCC			5.M.2: Health education and health promotion services are provided by personnel that: have necessary and appropriate training, educ, credentials and skills to carry out their responsibilities…and more that don't mention CC specifically
review possibility of state requesting EHR changes			5.M.9: Health education and disease prevention programs should be comprehensive and consider the medical, psychological, social, and cultural needs of the population. Topics that should be considered include: (7 bullets, none mentioning CC)
How is this measured? Are these aligned with HEDIS or SHIP measures?			6. B. Accessibility: Patients are routinely and continuously assessed for their perceptions about access to the Medical Home (provider availability, information, clinical record contents, advice, routine care, and urgent care).
Lack of on-site survey (only submit online documentation)			7. E. Quality: The org facilitates the provision of high-quality health care as demonstrated by the following: …1, 2, 3, 4, Patient Satisfaction)
			7.G. Medical Home assesses and continuously improves the services it provides: measurements, quality studies, data trending, and benchmarking are key tools in a QI/mgmt program [BUT does not mention collecting/tracking by race/ethnicity or other specific categories]

NCQA (Salliann Alborn, Cyntrice Bellamy, Dianne Houston-Crockett, Sandy Kick, Steven Ragsdale, Cheri Wilson)	URAC (Steven Ragsdale)	The Joint Commission (Cheri Wilson)	AAAHC (Sandy Kick)
			7H. Org develops and implements a QI program…[no specific requirement for CC assessment]
			7.J. In addition to standards presented in QI section, QI program should include at least 1 study every three years on each of following topics: Patient/physician relationship; continuity of care; comprehensiveness of care; accessibility to care; clinical study.

Appendix D: Crosswalk of Proposed Multicultural Healthcare Equity Standards vs. PCMH Standards

Proposed Standards	NCQA Patient-Centered Medical Home	URAC Patient Centered Health Care Home	The Joint Commission Primary Care Medical Home	AAAHC Medical Home
Requires CLAS standards or other specified equivalent standards	PCMH 1, Element F is entitled "Culturally and Linguistically Appropriate Services (CLAS)," but does not specifically reference the CLAS or other specified equivalent standards	Does not specifically reference the CLAS or other specified equivalent standards	Does not specifically reference the CLAS or other specified equivalent standards	Does not specifically reference the CLAS or other specified equivalent standards
Staff training includes cultural competency	PCMH 1, Element G, The Practice Team: Training and designating care team members in communication skills Factor 7: Care team members are trained on effective patient communication for all segments of the practice's patient population but particularly the vulnerable populations. Vulnerable populations are "those who are made vulnerable by their financial circumstances or place of residence, health, age, personal characteristics, functional or developmental status, ability to communicate effectively, and presence of chronic illness or disability," (AHRQ) and include people with multiple comorbid conditions or who are at high risk for frequent hospitalizations or ER visits. Training may include information on health literacy, or other approaches to addressing communication needs. **[Although includes health literacy, does not include cultural and linguistic competency training]**	PCH-PA 1: (COR) Staff Training Requirements The Practice establishes ongoing training programs and initial orientation, which are documented and include the following, if applicable: (c) PCHCH culture and provision of courteous customer service in a culturally-appropriate manner;	None	None
Staff training includes how to properly collect data to accurately capture race, ethnicity, language, social determinants, sexual orientation and gender identity	None	None	None	None
Data collection includes race, ethnicity, and language	Follows meaningful use of EHRs stage 1 standards for collection of data for more than 50% of its patients--race, ethnicity, and preferred language. Patients not required to discuss communication needs.	Data collection not specifically mentioned, but refers to Appendix F, which outlines meaningful use of EHR standards	Clinical record contains patient's race and ethnicity as well as patient's communication needs, including preferred language	None
Data collection includes sexual orientation and gender identity	None	None	None	None
Data collection includes other social determinants of health	Family/social/cultural characteristics, but doesn't provide any specific examples of social determinants	None	None	None
Stratification of process measures (by race, ethnicity, language, etc.)	None	None	None	None

Appendix D: Crosswalk of Proposed Multicultural Healthcare Equity Standards vs. PCMH Standards

Proposed Standards	NCQA Patient-Centered Medical Home	URAC Patient Centered Health Care Home	The Joint Commission Primary Care Medical Home	AAAHC Medical Home
Stratification of clinical outcomes measures (by race, ethnicity, language, etc.)	PCMH 6: Measure and Improve Performance Element A Measure Performance: Performance data stratified for vulnerable populations (to assess disparities in care). Factor 4: The data collected by the practice for one or more measures from factors 1–3 is stratified by race and ethnicity or by other indicators of vulnerable groups that reflect the practice's population demographics, such as age, gender, language needs, education, income, type of insurance (i.e., Medicare, Medicaid, commercial), disability or health status. Vulnerable populations are "those who are made vulnerable by their financial circumstances or place of residence, health, age, personal characteristics, functional or developmental status, ability to communicate effectively, and presence of chronic illness or disability," (AHRQ) and include people with multiple co-morbid conditions or who are at high risk for frequent hospitalization or ER visits.	None	None	None
Use of continuous quality improvement to reduce disparities in vulnerable populations	PCMH 6: Measure and Improve Performance Element C Implement Continuous Quality Improvement: Set goals and address at least one identified disparity in care or service for vulnerable populations. The practice identifies areas of disparity among vulnerable populations, sets goals and acts to improve performance in these areas. Vulnerable groups should reflect the practice's population demographics, such as age, gender, race, ethnicity, language needs, education, income, type of insurance (i.e., Medicare, Medicaid, commercial), disability or health status. Vulnerable populations are "those who are made vulnerable by their financial circumstances or place of residence, health, age, personal characteristics, functional or developmental status, ability to communicate effectively, and presence of chronic illness or disability," (AHRQ) and include people with multiple comorbid conditions or who are at high risk for frequent hospitalization or ER visits.	Views its standards for whole populations and not focused on vulnerable populations.	None	None

Appendix D: Crosswalk of Proposed Multicultural Healthcare Equity Standards vs. PCMH Standards

Proposed Standards	NCQA Patient-Centered Medical Home	URAC Patient Centered Health Care Home	The Joint Commission Primary Care Medical Home	AAAHC Medical Home
Patient satisfaction/experience includes diverse populations	Uses CAHPS PCMH tool. The practice uses survey data or other means to assess quality of care for its vulnerable subgroups. Patient self-identification in the survey may provide the basis for the sub-groups. Vulnerable populations are "those who are made vulnerable by their financial circumstances or place of residence, health, age, personal characteristics, functional or developmental status, ability to communicate effectively, and presence of chronic illness or disability," (AHRQ) and include people with multiple co-morbid conditions or who are at high risk for frequent hospitalization or ER visits.	Recommends use of CAHPS PCMH tool. No mention of diverse populations	None	None
Patient satisfaction/experience surveys offered in languages other than English	None	None	None	None
Patient satisfaction/experience data stratified by race, ethnicity, language	Possibly by race, ethnicity, although methodology not specified in standards.	None	None	None
Language access includes provision of bilingual staff or interpreters	Providing interpretation or bilingual services to meet the language. Language services may include third-party interpretation services or multilingual staff. Under Title VI of the Civil Rights Act, clinicians who receive federal funds are responsible for providing language and communication services to their patients as required to meet clinical needs. Requiring a friend or family member to interpret for the patient does not meet the intent of this standard. Studies demonstrate that patients are less likely to be forthcoming with a family member present, and the family member may not be familiar with medical terminology. A third party tends to be more objective. needs of its population	No mention of language access, bilingual staff, or interpreters	Interpreters and bilingual staff	None

Appendix D: Crosswalk of Proposed Multicultural Healthcare Equity Standards vs. PCMH Standards

Proposed Standards	NCQA Patient-Centered Medical Home	URAC Patient Centered Health Care Home	The Joint Commission Primary Care Medical Home	AAAHC Medical Home
Language access includes translation of documents	Providing printed materials in the languages of its population. The practice identifies individual languages spoken by at least 5 percent of its patient population and makes materials available in those languages. The practice provides the forms that patients are expected to sign, complete or read for administrative or clinical needs to patients with limited English proficiency in the native language of the patient. Factor 4 is NA if the practice provides documentation that no single language (other than English) is spoken by 5 percent or more of its patient population. The practice must provide a written explanation for an NA response.	Doesn't mention specifically. Need to go beyond offering language translation services to include having clinical, educational and consent documents in major languages served by provider/center.	Translation of documents. Need to go beyond offering language translation services to include having clinical, educational and consent documents in major languages served by provider/center.	None
Competency of bilingual staff and interpreters is assessed	None	None	None	None
Health literacy is included, plain language requirements	Included only in context of communication training for staff. No mention to health literacy as it relates to medical encounters, patient education materials, etc.	PCH-PA 3: (COR) Health Literacy The PCHCH implements written policies and/or documented procedures to provide information that: [--] (a) Conforms to the literacy levels of the patients, as practice; [3] (b) Helps patients be aware of what effect a health care decision may have for their daily lives; and [3] (c) Presents and delivers information in a way that is appropriate to the diversity of the patient population, including: [--] (i) Literacy levels; [3] (ii) Language differences; [3] (iii) Cultural differences; and [3] (iv) Cognitive and/or physical impairments. [3]	Section on health literacy. Requirements need to specify that oral and written information be developed in a manner that supports the patients decision making about health care options and the outcome of those decisions on overall health status.	None
Recognition based on single set of standards or multiple standards.	Single set of standards	Single set of standards	PCMH standards plus Ambulatory Care Standards to which the subgroup did not have access.	Single set of standards

	Clearview Organizational Assessments-360 (COA360) (Cheri Wilson)	Patient Centered Medical Home-36-(PCMH360) (Roger Clark)	Behavioral Health and Social Services-360 (BHSS360) (Cheri Wilson)	Communication Climate Assessment Toolkit (C-CAT) (Cheri Wilson)
Website	http://clearview360.org/how-we-can-help-you/coa360	http://clearview360.org/how-we-can-help-you/pcmh360	http://clearview360.org/how-we-can-help-you/bhss360	http://www.ama-assn.org/ama/pub/physician-resources/medical-ethics/the-ethical-force-program/patient-centered-communication.page?
Tool Developer/Sponsor	Hopkins Center for Health Disparities Solutions, Johns Hopkins Bloomberg School of Public Health	Hopkins Center for Health Disparities Solutions, Johns Hopkins Bloomberg School of Public Health	Hopkins Center for Health Disparities Solutions, Johns Hopkins Bloomberg School of Public Health in conjunction with the Substance Abuse and Mental Health Services Administration (SAMHSA), Office of Behavioral Health Equity (OBHE), Cultural Competence and Elimination of Disparities (CCED) Workgroup	The Ethical Force Program® American Medical Association

	Clearview Organizational Assessments-360 (COA360) (Cheri Wilson)	**Patient Centered Medical Home-36-(PCMH360) (Roger Clark)**	**Behavioral Health and Social Services-360 (BHSS360) (Cheri Wilson)**	**Communication Climate Assessment Toolkit (C-CAT) (Cheri Wilson)**
How is the tool administered?	• Through the Department of Health Policy of Management, Johns Hopkins Bloomberg School of Public Health, Center for Health Disparities Solutions or through a COA360 Certified Consultant. • All surveys administered online. (Paper questionnaires available upon request for patients.) • Available Languages: English, Arabic, Portuguese, Russian, Spanish, Vietnamese and other languages upon request	There is a unique number that you provide your patients during the checkout period. The patient will enter this unique number on the PCMH 360 Website, and all of their results will be uploaded into your web based improvement portal.	• Through the Department of Health Policy of Management, Johns Hopkins Bloomberg School of Public Health, Center for Health Disparities Solutions	• Free version administered through the American Medical Association Ethical Force Program®. (Free version entails paper surveys with data entry and analysis to be completed by the surveying institution). Paid version administered through a C-CAT consultant. • Available Languages: English, Chinese , Polish, Spanish, and Vietnamese
Who participates?	• Separate questionnaires given to: • Administrators • Clinical staff • Non-clinical staff • Patients	This is a patient survey.	• Separate questionnaires given to: • Administrators • Clinical/service providers • Clerical/administrative staff • Patients	• Separate questionnaires given to: • Executives • Staff • Adult patients • Pediatric patients

Appendix E: Review of Organizational Assessment Tools and/or Bibliographies of Tools

	Clearview Organizational Assessments-360 (COA360) (Cheri Wilson)	Patient Centered Medical Home-36-(PCMH360) (Roger Clark)	Behavioral Health and Social Services-360 (BHSS360) (Cheri Wilson)	Communication Climate Assessment Toolkit (C-CAT) (Cheri Wilson)
On what standards is the tool based?	• Based upon the: • U.S. Department of Health and Human Services, Office of Minority Health. CLAS Standards • The Joint Commission Standards on Effective Communication, Cultural Competence, and Patient-Centered Care • Human Rights Campaign (HRC), Healthcare Equality Index (HEI) Core Four • The Agency for Healthcare Research and Quality HCAHPS patient experience survey	PCMH 360 is built on the foundation of the PCMH-CAHPS tool. On top of the CAHPS questions PCMH 360 adds: Cultural Competency; Health Literacy; Employee Engagement; Health Equity Index	• Based upon the: • U.S. Department of Health and Human Services, Office of Minority Health. CLAS Standards • The Joint Commission Standards on Effective Communication, Cultural Competence, and Patient-Centered Care • Human Rights Campaign (HRC), Healthcare Equality Index (HEI) Core Four • The Agency for Healthcare Research and Quality HCAHPS patient experience survey	• Based upon the: • Ethical Force Program™ Consensus Report, Improving Communication—Improving Care: How Health Care Organizations can Ensure Effective, Patient-Centered Communication with People from Diverse Populations
Evidence-based/validated	• Scientifically validated by Johns Hopkins researchers (TA LaVeist, R Relosa, and N Sawaya. "The COA360: A Tool for Assessing the Cultural Competency of Healthcare Organizations." Journal of Healthcare Management 53:4 (July/August 2008): 257-267).	Validated by Johns Hopkins Researchers School of Public Health (Thom LaVeist)		• Scientifically validated by AMA (M Wynia, M Johnson, T McCoy, LP Griffin, and CY Osborn. "Validation of an Organizational Communication Climate Assessment Toolkit." American Journal of Medical Quality 25:6 (November/December 2010): 436-443).

Appendix E: Review of Organizational Assessment Tools and/or Bibliographies of Tools

	Clearview Organizational Assessments-360 (COA360) (Cheri Wilson)	Patient Centered Medical Home-36-(PCMH360) (Roger Clark)	Behavioral Health and Social Services-360 (BHSS360) (Cheri Wilson)	Communication Climate Assessment Toolkit (C-CAT) (Cheri Wilson)
What are the domains?	25 Domains • Promote Equity and Quality • Governance and Leadership • Promote Workforce Diversity • Cultural Competency Training • Provide Language Services • Notice of Availability of Language Services • Ensuring Language Proficiency • Signage and Translated Materials • Goals, Policies, and Accountability • Organizational Assessments & Quality Improvement • Collecting Patient Background Data • Community Assessment • Community and Consumer Involvement • Cross-cultural Conflicts Resolution • Annual CLAS Reporting • Human Rights Campaign Healthcare Equality Index Core Four • Patient/Client Satisfaction • Discrimination/Bias • Patient/Client Trust • Organizational Values • Organizational Processes • Cultural Inclusion Vision • Modified HCAHPS (patient survey)	4 Domains: 1) Patient/Family Experience; 2) Patient Satisfaction; 3) Health Literacy; 4) Cultural Competency of medical practice	25 Domains • Promote Equity and Quality • Governance and Leadership • Promote Workforce Diversity • Cultural Competency Training • Provide Language Services • Notice of Availability of Language Services • Ensuring Language Proficiency • Signage and Translated Materials • Goals, Policies, and Accountability • Organizational Assessments & Quality Improvement • Collecting Patient Background Data • Community Assessment • Community and Consumer Involvement • Cross-cultural Conflicts Resolution • Annual CLAS Reporting • Human Rights Campaign Healthcare Equality Index Core Four • Patient/Client Satisfaction • Discrimination/Bias • Patient/Client Trust • Organizational Values • Organizational Processes • Cultural Inclusion Vision • Modified HCAHPS (patient survey)	9 Domains • Leadership Commitment • Information Collection • Community Engagement • Workforce Development • Individual Engagement • Cross-Cultural Communication • Language Services • Health Literacy • Performance Evaluation
Length of questionnaires	• Administrator – 117 questions • Clinical Staff – 117 questions • Non-clinical Staff – 117 questions • Patients/Clients – 61 questions • Note: The online questionnaire can be completed in increments and submitted anytime before the end of the assessment period.	Comprised of 2 questionnaires; 47 total questions	Similar number of questions to the COA360	• Executives – 70 questions • Staff - 74 questions • Adult patients – 45 questions (English), 56 (non-English) • Pediatric patients – 46 (English), 57 (non-English)

	Clearview Organizational Assessments-360 (COA360) (Cheri Wilson)	Patient Centered Medical Home-36-(PCMH360) (Roger Clark)	Behavioral Health and Social Services-360 (BHSS360) (Cheri Wilson)	Communication Climate Assessment Toolkit (C-CAT) (Cheri Wilson)
Diversity and disparities groups included	• Race • Ethnicity • Nationality • Language • Religion • Sexual identity		• Race • Ethnicity • Nationality • Language • Religion • Sexual identity	• Race • Ethnicity • Language
Benchmarking	• Benchmarking against like units/departments and hospitals		• Benchmarking against like behavioral health or social services organizations	• Benchmarking against C-CAT consensus report
Reporting	• Assessment results available online as a .pdf document immediately after assessment completed. • Certain domains stratified by diversity and disparities groups.	Assessment results are access through the web-based improvement portal that provides access to all of your data and allows you to run real-time reports. Reports were specifically designed to meet the requirements of the NCQA-recognition programs.	• Assessment results available online as a .pdf document immediately after assessment completed. • Certain domains stratified by diversity and disparities groups.	Unknown

	Clearview Organizational Assessments-360 (COA360) (Cheri Wilson)	**Patient Centered Medical Home-36-(PCMH360) (Roger Clark)**	**Behavioral Health and Social Services-360 (BHSS360) (Cheri Wilson)**	**Communication Climate Assessment Toolkit (C-CAT) (Cheri Wilson)**
Additional information	• Brand recognition of Johns Hopkins • Available for any size or type of healthcare organization—valuable for ACO accreditation: o Hospitals o Medical practices (PCMH) o Health plans o Behavioral health and social service organizations • Opportunity to join and benefit from the learning of the Culture-Quality-Collaborative (CQC)	Brand recognition of Hopkins. Conforms and supports meeting NCQA-PCMH Standards (assist practice in getting up to 22 points, 10 of which are auto-credit points)		• Brand recognition of American Medical Association • Available for any size or type of hospital

	CAHPS® Clinical and Group Survey, Cultural Competence Item Set (Sandy)	Cultural Competence Assessment Tool for Hospitals (CCATH) (Roger Clark)	Culture Care Connection CLAS Assessment Survey (Cheri Wilson)	Tailoring Initiatives to Meet the Needs of Diverse Populations: A Self-Assessment Tool (Cheri Wilson)
Website	https://www.cahps.ahrq.gov/clinician_group/cgsurvey/aboutculturalcompetenceitemset.pdf	http://www.diversityconnection.org/diversityconnection/membership/Resource%20Center%20Docs/CCATHOverview.pdf	http://culturecareconnection.org/navigating/assessment.html	http://www.jointcommission.org/assets/1/6/HLCOneSizeFinal.pdf (see pp. 47-53)
Tool Developer/Sponsor	Agency for Healthcare Research and Quality (AHRQ)	Department of Health and Human Services (DHHS) Office of Minority Health (OMH)	Stratis Health	Joint Commission

	CAHPS® Clinical and Group Survey, Cultural Competence Item Set (Sandy)	Cultural Competence Assessment Tool for Hospitals (CCATH) (Roger Clark)	Culture Care Connection CLAS Assessment Survey (Cheri Wilson)	Tailoring Initiatives to Meet the Needs of Diverse Populations: A Self-Assessment Tool (Cheri Wilson)
How is the tool administered?		Mail Survey of all general and children hospitals listed in the California Hospital Association Directory in 2006 (344 Hospitals)	Can take either take full survey or only those sections that interest you--culturally competent care, language access services, organizational supports. Administered online via the Cvent event management survey administration tool. This is an assessment for individuals to complete. In order to do a must contact Stratis Health. Facility-wide CLAS Assessment Individual assessments may not be enough to help you fully understand how well your facility is performing in relation to the CLAS Standards. Stratis Health can facilitate a facility or organization-wide survey to help you focus energy and resources. We can also provide a summary report, including a gap analysis with customized action steps and ideas to further your cultural efforts.	These are the interview questions from the Hospitals, Language, and Culture report in which 60 different hospitals were interviewed. This is not an organizational assessment tool.
Who participates?	Patients	344 Hospitals in the 2006 California Hospital Association Directory	Managerial and administrative staff with policy-making responsibilities Clinical staff members who regularly serve patients (e.g., providers, nurses, medical assistants, lab technicians) Front line staff (e.g., front desk, security, telephone triage)	Diverse staff groups participate in focus groups/interview sessions

	CAHPS® Clinical and Group Survey, Cultural Competence Item Set (Sandy)	Cultural Competence Assessment Tool for Hospitals (CCATH) (Roger Clark)	Culture Care Connection CLAS Assessment Survey (Cheri Wilson)	Tailoring Initiatives to Meet the Needs of Diverse Populations: A Self-Assessment Tool (Cheri Wilson)
On what standards is the tool based?	The Cultural Competence Item Set was developed through funding from the Agency for Healthcare Research and Quality (AHRQ) to the CAHPS Consortium. Additional support for this item set was provided through a grant from the Commonwealth Fund. In the winter of 2011 CAHPS Consortium adopted a new set of supplemental items for the CAHPS Clinician & Group Surveys that focus on assessing the cultural competency of health care providers from the patient's perspective. In May 2012 these supplemental items were revised slightly to align with the questions and placement instructions with the 2.0 version of the Clinician & Group Surveys.	Based on CLAS Standards. Designed to assess hospitals adherence to the CLAS Standards	2000 CLAS Standards	Not mentioned
Evidence-based/validated	The development process included the following steps: 1) Development of a conceptual model; 2) Literature review and environmental scan; 3) Development of domains and an initial set of items; 4) translation of item set into Spanish 5) Cognitive testing of items in English and Spanish 6) Field testing 7) Construction of composite measures.	The CCATH was subject to extensive qualitative testing, including pilot testing, focus groups and cognitive interviews (Hays et al. 2006)	not mentioned	Based on Chapters 4-7 of the Hospitals, Language, and Culture report

	CAHPS® Clinical and Group Survey, Cultural Competence Item Set (Sandy)	Cultural Competence Assessment Tool for Hospitals (CCATH) (Roger Clark)	Culture Care Connection CLAS Assessment Survey (Cheri Wilson)	Tailoring Initiatives to Meet the Needs of Diverse Populations: A Self-Assessment Tool (Cheri Wilson)
What are the domains?	5 Domains: - 1) Patient-provider (or doctor) communication; 2) Complementary and alternative medicine; 3) Experiences of discrimination due to race/ethnicity, insurance, or language; 4) Experiences leading to trust or distrust, including level of trust, caring and truth-telling; 5) Linguistic competency (Access to language services)	12 Domains - 1) Clinical Cultural Competency Practices; 2) Human Resources Practices; 3) Diversity Training; 4) Availability of Interpreter Services; 5) Interpreter Services Policies; 6) Quality of Interpreter Services; 7) Translation of /Written Materials; 8) Leadership and Strategic Planning; 9) Performance Management Systems and Q1; 10) Data Collection on Inpatient Population; 11) Data Collection on Service Area; 12) Community Representation	culturally competent care, language access services, organizational supports	Building a Foundation, Collecting and Using Data to Improve Services, Accommodating the Needs of Specific Populations, Establishing Internal and External Collaborations
Length of questionnaires	Patient-Provider Communication (8 questions); Complementary and alternative medicine (5 questions); Experiences of discrimination due to race/ethnicity, insurance or language (2 questions); Experiences leading to trust or distrust, including level of trust, caring, and truth-telling (6 questions); Interpreter services (13 questions)		culturally competent care--19 questions; language access services--18 questions; organizational supports--20 questions	There is a single questionnaire

	CAHPS® Clinical and Group Survey, Cultural Competence Item Set (Sandy)	Cultural Competence Assessment Tool for Hospitals (CCATH) (Roger Clark)	Culture Care Connection CLAS Assessment Survey (Cheri Wilson)	Tailoring Initiatives to Meet the Needs of Diverse Populations: A Self-Assessment Tool (Cheri Wilson)
Diversity and disparities groups included	Providers can assess the extent to which survey responses differ by the race, ethnicity, or language of respondents		not mentioned	Not mentioned
Benchmarking	Health care organizations using this item set can use the composite measures for benchmarking and reporting at the group level. Composite measures include: 1: Providers [Doctors] are polite and considerate (3 items not listed here); 2: Providers [Doctors] are caring and inspire trust (5 items not listed here). At level of individual providers, health care organizations can share item-level scores in order to help providers better understand the behaviors that promote effective communication with a diverse patient pop.		not mentioned	Not mentioned
Reporting	Exact mechanism unknown. This item set is intended to generate data that health care providers can use to improve their cultural competency by: 1) identifying specific topic areas for quality improvement; 2) recognizing particular behaviors that inhibit effective communication; 3) measuring the effect of behaviors that promote effective communication...Having identified opportunities for improvement and embarked on QI activities, the providers can then field the items again to evaluate the success of improvement activities.		when an individual completes a survey, doesn't receive any results, just some suggestions on how to improve in that domain; would have to work specifically with stratis health to get a report, gap analysis, etc. as well as to administer throughout the entire organization	Not mentioned

	CAHPS® Clinical and Group Survey, Cultural Competence Item Set (Sandy)	Cultural Competence Assessment Tool for Hospitals (CCATH) (Roger Clark)	Culture Care Connection CLAS Assessment Survey (Cheri Wilson)	Tailoring Initiatives to Meet the Needs of Diverse Populations: A Self-Assessment Tool (Cheri Wilson)
Additional information	Eight of the items in the Cultural Competence Item Set are also part of the Item Set for Addressing Health Literacy.		The purpose of this assessment is to: · Evaluate how well your facility meets national cultural and linguistic standards · Gain a broad understanding of systems, policies, and practices that may impact an facility's ability to meet the CLAS Standards · Assess needs and identify future strategies related to cultural challenges · Serve as a baseline to measure future improvement	

	Cultural Competence Self Assessment Protocol for Health Care Organizations and Systems (Sandy Kick)	Culturally and Linguistically Appropriate Health Care Services for Virginians	Tools for Assessing Cultural Competence (need to go directly to the website for the individual tools)	Summary Report Cultural Competence in Primary Health Care: Perspectives, Tools and Resources
Website	http://erc.msh.org/provider/andrulis.pdf	Dead link	Dead link	Dead link
Tool Developer/Sponsor	Dennis Andrulis, Thomas Delbanco, Laura Avakian and Yoku Shaw-Taylor			

	Cultural Competence Self Assessment Protocol for Health Care Organizations and Systems (Sandy Kick)	Culturally and Linguistically Appropriate Health Care Services for Virginians	Tools for Assessing Cultural Competence (need to go directly to the website for the individual tools)	Summary Report Cultural Competence in Primary Health Care: Perspectives, Tools and Resources
How is the tool administered?	The self-assessment "audit" is conducted within the healthcare organization			
Who participates?	A task force of stakeholders within the organization is chosen. This small committee must represent certain key functions of departments. A typical self-assessment team consists of 8 to 12 people. It is suggested that interviews be conducted with individuals from twenty different areas be included, including Board of Trustees, union leadership, community leaders, among other more direct roles in a healthcare organization.			

	Cultural Competence Self Assessment Protocol for Health Care Organizations and Systems (Sandy Kick)	Culturally and Linguistically Appropriate Health Care Services for Virginians	Tools for Assessing Cultural Competence (need to go directly to the website for the individual tools)	Summary Report Cultural Competence in Primary Health Care: Perspectives, Tools and Resources
On what standards is the tool based?	not mentioned			
Evidence-based/validated	not mentioned			

	Cultural Competence Self Assessment Protocol for Health Care Organizations and Systems (Sandy Kick)	Culturally and Linguistically Appropriate Health Care Services for Virginians	Tools for Assessing Cultural Competence (need to go directly to the website for the individual tools)	Summary Report Cultural Competence in Primary Health Care: Perspectives, Tools and Resources
What are the domains?	1) Ethnic/cultural characteristics (Board, Staff and Patient/Community Profiles; Healthcare Organizational Recognition of Diversity Needs); 2) Healthcare Organizational Approaches to Accommodating Diversity Needs and Attributes (Diversity training; Human Resource Programs; Union Presence); 3) Healthcare Organizational Links to Patients and the Communities you Serve (Healthcare Organizational Links to Community; Organizational Adaptation to Diversity; Database Systems and Data Development; Staff Issues; Patient Issues; Business Strategies Attracting Patients from Diverse Cultures)			
Length of questionnaires	17 Suggested In-person Interview Questions; Questionnaire by Part: Part 1: Ethnic/Cultural Characteristics: 14 questions. Part 2: Healthcare Organizational Approaches to Accommodating Diversity Needs and Attributes: 25 questions; Part 3: Healthcare Organizational Links to Patients and the Communities you Serve: 77 questions			

	Cultural Competence Self Assessment Protocol for Health Care Organizations and Systems (Sandy Kick)	Culturally and Linguistically Appropriate Health Care Services for Virginians	Tools for Assessing Cultural Competence (need to go directly to the website for the individual tools)	Summary Report Cultural Competence in Primary Health Care: Perspectives, Tools and Resources
Diversity and disparities groups included	Members of the task force decide who will complete each of the interviews, and what individual or group interviews should be conducted to explore further some issues identified in the questionnaire or to clarify areas that are ambiguous. Interview questions may also be added or deleted based on particular findings and interests			
Benchmarking	n/a			
Reporting	The task force reviews the data from the questionnaire and the interviews; Drawing on the data and analyses, the team decides where the organization fits along the "spectrum of cultural competence." Depending on the charge given the team originally, the task force discusses its findings with multiple audiences. These findings are often offered in a written report to the CEO or a Board committee. In addition to a self-assessment of overall cultural competence, the report will likely include specific recommendations for actions to be taken, identifying who would be accountable for taking the actions.			

	Cultural Competence Self Assessment Protocol for Health Care Organizations and Systems (Sandy Kick)	Culturally and Linguistically Appropriate Health Care Services for Virginians	Tools for Assessing Cultural Competence (need to go directly to the website for the individual tools)	Summary Report Cultural Competence in Primary Health Care: Perspectives, Tools and Resources
Additional information	Interviews generally last 15 to 45 minutes, and participants should be encouraged to bring along relevant data, materials, etc. Interviews should elicit information about those policies and practices that impact on ethnic/cultural competence. They should identify both support and barriers to ethnic/cultural competence. Additionally they provide the opportunity to learn about individuals' opinions and attitudes about this subject and to explore related areas that may not be covered in the questionnaire. Interview questions may be adapted based on particular findings and interests.			

	Cultural Competence Tools	Cultural Competence Assessment Tool (CCAT) (Sandy Kick)	Organizational Cultural Competence Assessment Profile (Roger Clark)	Cultural Competency Organizational Self-Assessment (OSA) Question Bank (Cheri Wilson)
Website	Dead link	http://www.bphc.org/chesj/resources/Documents/Tools/culturalcompentencyassesstool.pdf	http://www.hrsa.gov/culturalcompetence/healthdlvr.pdf	http://www.aidsetc.org/doc/workgroups/cc-question-bank.doc
Tool Developer/Sponsor	Hogg Foundation	Denise Dodd, PhD from Blue Cross Blue Shield of Massachusetts Foundation in conjunction with the Boston Public Health Commission	HRSA	Organization Self Assessment subgroup of the AIDS Education and Training Centers (AETC) Cultural Competence Care Workgroup

	Cultural Competence Tools	Cultural Competence Assessment Tool (CCAT) (Sandy Kick)	Organizational Cultural Competence Assessment Profile (Roger Clark)	Cultural Competency Organizational Self-Assessment (OSA) Question Bank (Cheri Wilson)
How is the tool administered?		The CC Assessment Tool offers health care organizations a framework for assessing the delivery of culturally and linguistically appropriate services. Asks for commitment of the ED, Board of Directors, and staff members throughout the org. Suggests developing an internal committee structure to administer the assessment. Tool will require a great deal of staff time to complete; suggests the org. may want to complete the assessment in several phases, with each phase focusing on specific sections of the tool. It could also be completed by distinct department rather than for the entire org.	The Assessment Profile can be used in routine performance monitoring, regular quality review and improvement activities.	
Who participates?		Suggested full committee participation includes staff from all departments and employment categories (e.g. management, office support, clinical staff) and inviting board members, patients, and community members to join the committee in order to improve the project's accuracy, validity and credibility. In completing the assessment tool, the committee will collect data and complete worksheets based on internal records and discussions with staff members. For this, annual surveys of community parties, and staff members are encouraged.	Organizational level tool, where the organization is involved in direct delivery of health care services. The profile is most pertinent for organizations that are community oriented.	

	Cultural Competence Tools	Cultural Competence Assessment Tool (CCAT) (Sandy Kick)	Organizational Cultural Competence Assessment Profile (Roger Clark)	Cultural Competency Organizational Self-Assessment (OSA) Question Bank (Cheri Wilson)
On what standards is the tool based?		Introduction to the tool cites CLAS standards as a way to identify elements of culturally and linguistically competent care, explain their 14 specific standards, and are listed in the appendix; and that ongoing self-assessment of an organization's cultural and linguistic competence is an integral part of the standards. It doesn't say, however, that the tool is based on the CLAS standards directly; but it does seem to complement or align with them (would need more detailed comparison to answer this)	The tool builds upon the CLAS Standards	2000 CLAS Standards
Evidence-based/validated		Development of the tool (creation and pilot testing) was funded through Blue Cross Blue Shield of Massachusetts Foundation's program Pathways to Cultural Competence. It included an initial pilot with two community health center review sites, feedback and revisions to the tool before it was reviewed by the Executive Directors of eight Boston community health centers who offered suggestions on improving the clarity of the tool's questions and the utility of the format. An Advisory Board of community health centers guided the process.		

	Cultural Competence Tools	Cultural Competence Assessment Tool (CCAT) (Sandy Kick)	Organizational Cultural Competence Assessment Profile (Roger Clark)	Cultural Competency Organizational Self-Assessment (OSA) Question Bank (Cheri Wilson)
What are the domains?		Three sections, each focusing on a key component in the provision of culturally competent health care: 1) Leadership, Staffing, and Community Involvement; 2) Health Care Planning and Delivery; 3) Cross-Cultural Training and Communication	7 Domains: 1) Organizational Values; 2) Governance; 3) Planning and Monitoring/Evaluation; 4) Communication; 5) Staff Development; 6) Organizational Infrastructure; 7) Services/Interventions	Client and Community Input, Diverse and Culturally Competent Staff, Evaluation and Data Management, Language and Interpreter Services, Organizational Policies and Procedures, and Client and Provider Relations
Length of questionnaires		1) Leadership, Staffing, and Community Involvement: 5 Question sets (7-9 questions each) and corresponding worksheets; 2) Health care Planning and Delivery: 6 Question sets (3-7 questions each) and 2 corresponding worksheets; 3) Cross-Cultural Training and Communications: 6 Question sets (2-10 questions each) and 4 corresponding worksheets		Client and community output domain--13 questions; diverse and culturally competent staff--14 questions; evaluation and data management--16 questions; language and interpreter services--16 questions; organizational policies and procedures--15 questions; client and provider relations--18 questions

	Cultural Competence Tools	Cultural Competence Assessment Tool (CCAT) (Sandy Kick)	Organizational Cultural Competence Assessment Profile (Roger Clark)	Cultural Competency Organizational Self-Assessment (OSA) Question Bank (Cheri Wilson)
Diversity and disparities groups included		Left up to assessment committee who to include from the organization. In the Guiding Principles thought, under Health Care Planning and Delivery, is included a bullet stating: To achieve systemic cultural competence, action steps to be taken by an organization should include, but not be limited to.....Monitoring disparities in care and satisfaction with care by analyzing and reporting all data by race and ethnicity.		Not mentioned
Benchmarking		not specifically addressed		Not mentioned
Reporting		Once data collection has been completed, the assessment committee group can discuss and respond to the guiding questions. Responses will be used to identify organizational strengths and challenges. The committee can develop a set of recommendations based on the identified strengths and challenges. The last section contains a form to record the committee's suggested action steps. Assessment results and committee recommendations should be presented to the organization's "key decision-makers" who can then assess and prioritize recommendations in light of regulations, staffing, and budget. Once this review occurs, a written action plan and timeline should be developed and shared with staff.		Not mentioned

	Cultural Competence Tools	Cultural Competence Assessment Tool (CCAT) (Sandy Kick)	Organizational Cultural Competence Assessment Profile (Roger Clark)	Cultural Competency Organizational Self-Assessment (OSA) Question Bank (Cheri Wilson)
Additional information		Assessment Tool begins with a statement of Guiding Principles for each of the three domain areas that are intended to guide the questions in the assessment.		"It is important that the team completing an OSA not view it as a quiz with a set of perfect answers. It is, rather, an opportunity to consider candidly the extent to which the healthcare organization is meeting the needs of diverse populations, both clients and those in the work force. The findings will, in themselves, suggest actions an organization may take to improve its cross-cultural competence. The results of this self assessment will help the healthcare organization gain a broad perspective of its policies, programs, and procedures relevant to cultural concerns." (*Conducting a Cultural Competence Self Assessment*, p. 7)

	Toolkit for Assessing Cultural Competence in Peer-Run Mental Health Organizations (Steven Ragsdale)	Bibliography of Cultural and Linguistic Competence Self-Assessment Tools and Supporting Information (Steven Ragsdale)	Making Children's Mental Health Successful: Organizational Cultural Competence: A Review of Assessment Protocols.	Cultural Competence Self-Assessment Questionnaire (CCSAQ) (Steven Ragsdale)
Website	http://www.cmhsrp.uic.edu/download/CulturalCompetencyTool.pdf	http://www.tapartnership.org/docs/NatlEvalBibliographyCLCSelf-AssessmentTools.pdf	Dead Link	http://www.rtc.pdx.edu/PDF/CCSAQ.pdf
Tool Developer/Sponsor	Support, Technical Assistance, and Resource Center (STAR Center)	Substance Abuse and Mental Health Services Administration		Research and Training Center on Family Support and Children's Mental Health Regional Research Institute for Human Services Graduate School of Social Work Portland State University

	Toolkit for Assessing Cultural Competence in Peer-Run Mental Health Organizations (Steven Ragsdale)	**Bibliography of Cultural and Linguistic Competence Self-Assessment Tools and Supporting Information (Steven Ragsdale)**	**Making Children's Mental Health Successful: Organizational Cultural Competence: A Review of Assessment Protocols.**	**Cultural Competence Self-Assessment Questionnaire (CCSAQ) (Steven Ragsdale)**
How is the tool administered?	self administered through inter-organizational group activity	SAMHSA recommends regularly conducted self-assessments of programmatic cultural and linguistic competence practices and policies and utilize the findings to make improvements		The Cultural Competence Self-Assessment Questionnaire (CCSAQ) is a self administered tool that allows for focus on two levels;
Who participates?	Mental health programs, consumer operated groups and self help programs; Suggest that organizations develop and culturally competent lead team with other designated strategic organizational assets	the care grant community		The instrument assist child- and family-serving agencies assess their cross-cultural strengths and weaknesses in order to design specific training activities or interventions that promote greater competence across cultures. There are two versions of the Assessment. One version is for use with direct service providers and the other is for administrative staff.

	Toolkit for Assessing Cultural Competence in Peer-Run Mental Health Organizations (Steven Ragsdale)	**Bibliography of Cultural and Linguistic Competence Self-Assessment Tools and Supporting Information (Steven Ragsdale)**	**Making Children's Mental Health Successful: Organizational Cultural Competence: A Review of Assessment Protocols.**	**Cultural Competence Self-Assessment Questionnaire (CCSAQ) (Steven Ragsdale)**
On what standards is the tool based?	NAMI Multicultural Action Center; Culture race and Ethnicity; A to the Surgeon Generals Report on Mental Health; NCCC; Resource Center to promote Acceptance, Dignity and Social Inclusion Assoc with Mental Health, etc.	SAMHSA reviewed child and mental health care literature and prepared this bibliography of self-assessment inventories, assessment tools, and supplemental materials that mental health communities could use to conduct their own self assessments.		Heavily resources but not standard validation of the tool can be identified.
Evidence-based/validated	Pilot tested in 9 states, including AZ, CA, OR, TX, WI, HA. Showed marked improvements in organizations that implemented the questionnaire. Hard to see strength and correlation in program and models of success	issues a disclaimer that they have not validated any of the tools on the list. Are passing on recommendations validated by the industry.		The CCSAQ provides a general score based on five subscales. When analyzed and ranked, the sub-scales provide information to an organization for establishing training and/or policy and procedural priorities. When examined individually, a subscale can suggest behaviors congruent with the cultural competence model or assess the degree to which specific behaviors routinely occur.

Appendix E: Review of Organizational Assessment Tools and/or Bibliographies of Tools

	Toolkit for Assessing Cultural Competence in Peer-Run Mental Health Organizations (Steven Ragsdale)	Bibliography of Cultural and Linguistic Competence Self-Assessment Tools and Supporting Information (Steven Ragsdale)	Making Children's Mental Health Successful: Organizational Cultural Competence: A Review of Assessment Protocols.	Cultural Competence Self-Assessment Questionnaire (CCSAQ) (Steven Ragsdale)
What are the domains?	1) Administration, policies and guidelines; 2)Peer providers and group leaders; 3)services and supports; 4) program or group environment; 5) communication and language capacity	Recommends a series of tools that cover the following domains; Sec 1) Clinical and Personal Assessment; Sec 2) Cultural Competence of Organizations and Systems; and Sec 3) Cultural Competence of Training and Curricula		KNOWLEDGE OF COMMUNITIES; PERSONAL INVOLVEMENT; and RESOURCES AND LINKAGES
Length of questionnaires	there are five domains with four sections each. Each section has 1-4 questions.	There are several different tools that are recommended. Too many possible questions to calculate. Organizations can determine the level of their own burden?		Each section has 59 questions that vary in length and responsibility

	Toolkit for Assessing Cultural Competence in Peer-Run Mental Health Organizations (Steven Ragsdale)	Bibliography of Cultural and Linguistic Competence Self-Assessment Tools and Supporting Information (Steven Ragsdale)	Making Children's Mental Health Successful: Organizational Cultural Competence: A Review of Assessment Protocols.	Cultural Competence Self-Assessment Questionnaire (CCSAQ) (Steven Ragsdale)
Diversity and disparities groups included	Diversity expertise is recommended but health equity is not a focus.	The response depends on the tool that an org self selects.		There is an opportunity to subjectively measure your organization against other like organizations.
Benchmarking	There is an opportunity to subjectively measure your organization against other like organizations.			implicit in the tool
Reporting	Self reporting and voluntary submissions to STAR; How is the program working?			No

	Toolkit for Assessing Cultural Competence in Peer-Run Mental Health Organizations (Steven Ragsdale)	**Bibliography of Cultural and Linguistic Competence Self-Assessment Tools and Supporting Information (Steven Ragsdale)**	**Making Children's Mental Health Successful: Organizational Cultural Competence: A Review of Assessment Protocols.**	**Cultural Competence Self-Assessment Questionnaire (CCSAQ) (Steven Ragsdale)**
Additional information	Not very empirical	A clearinghouse of tools for the mental health community. Not very regulatory. The goal is to have organizations determine their own needs and solution oriented tools.		Another helpful self assessment tool to help get the an initiation.

	Organizational Cultural Competence: A Review of Assessment Protocols (Roger Clark)	Organizational Cultural Competence: A Review of Assessment Protocols (Steven Ragsdale)	Build the Field and They Will Come: Multicultural Organizational Development for Mental Health Agencies	Consolidated Culturalogical Assessment Tool (C-CAT) Tool Kit
Website	http://rtckids.fmhi.usf.edu/rtcpubs/CulturalCompetence/protocol/CultCompProtocol.pdf	http://rtckids.fmhi.usf.edu/rtcpubs/CulturalCompetence/protocol/CultCompProtocol.pdf	Dead link	Dead link
Tool Developer/Sponsor	Training Center for Children's Mental Health, Louis, de la Parte Florida Mental Health Institute University of South Florida/Support from SAMHSA	Research & Training Center for Children's Mental Health Department of Child & Family Studies Louis de la Parte Florida Mental Health Institute University of South Florida		

	Organizational Cultural Competence: A Review of Assessment Protocols (Roger Clark)	Organizational Cultural Competence: A Review of Assessment Protocols (Steven Ragsdale)	Build the Field and They Will Come: Multicultural Organizational Development for Mental Health Agencies	Consolidated Culturalogical Assessment Tool (C-CAT) Tool Kit
How is the tool administered?		There are 45 different instruments to choose from in developing an institutional assessment. There are a variety of manners to administer.		
Who participates?	Focused at the organizational level	Any organization associated with increasing service accessibility for racially/ethnically diverse children with serious emotional/behavioral disorders and their families.		

	Organizational Cultural Competence: A Review of Assessment Protocols (Roger Clark)	Organizational Cultural Competence: A Review of Assessment Protocols (Steven Ragsdale)	Build the Field and They Will Come: Multicultural Organizational Development for Mental Health Agencies	Consolidated Culturalogical Assessment Tool (C-CAT) Tool Kit
On what standards is the tool based?	Utilized and assessed 17 organizational level cultural competency assessment instruments. The instruments selected for this review were identified primarily from a search of tools on the National Center for Cultural Competence online database	National Center for Cultural Competence (NCCC)'s online resource database (http://gucchd.georgetown.edu/nccc/), with other sources including Roizner's (1996) review, and tools referenced in the bibliographies of relevant instruments. An online bibliography developed by a contributor to a listserv of CLAS (Gilbert, 2004) was also consulted		
Evidence-based/validated	NA	All instruments are evidence-based and validated.		

	Organizational Cultural Competence: A Review of Assessment Protocols (Roger Clark)	Organizational Cultural Competence: A Review of Assessment Protocols (Steven Ragsdale)	Build the Field and They Will Come: Multicultural Organizational Development for Mental Health Agencies	Consolidated Culturalogical Assessment Tool (C-CAT) Tool Kit
What are the domains?	8 Domains: 1) Organizational Values; 2) Policies/Procedures/Governance; 3) Planning, Monitoring and Evaluation; 4) Communication; 5) Human Resource Development; 6) Community and Consumer Participation; 7) Facilitation of a Broad Service Array; 8) Organizational Resources	All 8 domains measure Access, Availability & Outcome; Domains include: Organizational Values, Policies/ Procedures/Governance Planning/Monitoring/ Evaluation, Communication, Human Resource Development, Community & Consumer Participation, Facilitation of a Broad Service Array, Organizational Resources		
Length of questionnaires		There are several different tools that are recommended. Too many possible questions to calculate. Organizations can determine the level of their own burden?		

	Organizational Cultural Competence: A Review of Assessment Protocols (Roger Clark)	Organizational Cultural Competence: A Review of Assessment Protocols (Steven Ragsdale)	Build the Field and They Will Come: Multicultural Organizational Development for Mental Health Agencies	Consolidated Culturalogical Assessment Tool (C-CAT) Tool Kit
Diversity and disparities groups included		The response depends on the series of tools that an organization self selects.		
Benchmarking		Depends on which instrument is selected		
Reporting		Andrulis et al. (n.d.), CT DCF (2002), CT DMR (2005), La Frontera Center, Inc. (2002), Mason (1995), NCCC (2002)NCCC (2002), NTAC & NASMHPD (2004), NICWA (1991), ODMH (2003), Siegel et al. (2004) and Weiss & Minsky (1996)		

	Organizational Cultural Competence: A Review of Assessment Protocols (Roger Clark)	Organizational Cultural Competence: A Review of Assessment Protocols (Steven Ragsdale)	Build the Field and They Will Come: Multicultural Organizational Development for Mental Health Agencies	Consolidated Culturalogical Assessment Tool (C-CAT) Tool Kit
Additional information		The document provides a organizational assessment tools providing for a very nuanced self study.		

	A Practical Guide for the Assessment of Cultural Competence in Children's Mental Health Organizations	State Mental Health Agency Cultural Competence Activities Assessment	Performance measures of cultural competency in mental health organizations. (Cheri Wilson)	Performance measures and their benchmarks for assessing organizational cultural competency in behavioral health care service delivery. (Cheri Wilson)
Website	Dead link	Dead Link	No website - The authors utilized numerous documents created by advisory groups, expert panels and multicultural focus groups to develop performance measures for assessing the cultural competency of mental health systems. To provide a national perspective, the focus groups--a total of 134 consumers, family members, advocates and providers--met in locations across the country: New York, Florida, South Carolina, South Dakota, and California. Competency was measured within three levels of organizational structure: administrative, provider network, and individual caregiver. Indicators, measures and data sources for needs assessment, information exchange, services, human resources, plans and policies, and outcomes were identified. Procedures for selection and implementation of the most critical measures are suggested. The products of this project are broadly applicable to the concerns of all cultural groups.	No website - These benchmarks were developed in response to a concern among consumers of mental health services that the services offered by behavioral healthcare organizations may not be responsive to the special needs of multicultural populations. It describes a two-phase project to recommend and benchmark performance measures that could make these concerns specific and to measure organizational responses. The project focused on the articulated concerns of the four major racial/ethnic groups in the United States: African American, Hispanic American, Asian American, and American Indian.
Tool Developer/Sponsor				

	A Practical Guide for the Assessment of Cultural Competence in Children's Mental Health Organizations	State Mental Health Agency Cultural Competence Activities Assessment	Performance measures of cultural competency in mental health organizations. (Cheri Wilson)	Performance measures and their benchmarks for assessing organizational cultural competency in behavioral health care service delivery. (Cheri Wilson)
How is the tool administered?				
Who participates?				

	A Practical Guide for the Assessment of Cultural Competence in Children's Mental Health Organizations	State Mental Health Agency Cultural Competence Activities Assessment	Performance measures of cultural competency in mental health organizations. (Cheri Wilson)	Performance measures and their benchmarks for assessing organizational cultural competency in behavioral health care service delivery. (Cheri Wilson)
On what standards is the tool based?				
Evidence-based/validated				

	A Practical Guide for the Assessment of Cultural Competence in Children's Mental Health Organizations	State Mental Health Agency Cultural Competence Activities Assessment	Performance measures of cultural competency in mental health organizations. (Cheri Wilson)	Performance measures and their benchmarks for assessing organizational cultural competency in behavioral health care service delivery. (Cheri Wilson)
What are the domains?				
Length of questionnaires				

	A Practical Guide for the Assessment of Cultural Competence in Children's Mental Health Organizations	State Mental Health Agency Cultural Competence Activities Assessment	Performance measures of cultural competency in mental health organizations. (Cheri Wilson)	Performance measures and their benchmarks for assessing organizational cultural competency in behavioral health care service delivery. (Cheri Wilson)
Diversity and disparities groups included				
Benchmarking				
Reporting				

	A Practical Guide for the Assessment of Cultural Competence in Children's Mental Health Organizations	State Mental Health Agency Cultural Competence Activities Assessment	Performance measures of cultural competency in mental health organizations. (Cheri Wilson)	Performance measures and their benchmarks for assessing organizational cultural competency in behavioral health care service delivery. (Cheri Wilson)
Additional information				

Appendix F: Weighted Scoring Tool

Criteria	Weights	Assessment Tool	
Reviewer			
	Most important to have = 5; Somewhat important to have = 3; Least important to have = 1	Meets or exceed = 5; Addresses but room= 3; inadequately addressed = 1	Weighted Score
Robustness of tool	5		0
Based on national Standards			
Evidence-based/validated			
Includes a qualitative component (interviews)			
Consumer tested/pilot tested in the community			
Participation in assessment tool contributes to recognition program achievement (i.e. NCQA)			
Scope - number of levels it can assess (i.e. system; group; provider; department…)			
Comprehensiveness of domains			
Ability of assessment tool to provide benchmark data/to benchmark performance across organizations			
Low Administrative burden	5		0
Low administrative burden to organization (disruptiveness factor i.e.. Duration overall and survey tool length; participation level, etc.)			
Availability of technical support in administering and/or analyzing data			
Cost to administer/cost associated (both $ and staff time)			
Level of organizational ownership of assessment tool/involvement of direct leadership	5		0
Ease of Use	5		0
Accessibility (live website; easy to navigate and research)			
Quality Improvement Potential/Organizational change Potential	5		0
Ability of assessment to improve quality of care and outcomes			
Ability of results to inform consumers			
Ability of results to inform providers			
Ability of results to inform staff throughout the organization			
Ability of results to change providers' behavior, and ultimately shift organizational culture			
Ability to stratify by the various diversity groups			
Feasibility of Implementation in MD PCMH	5		0
Applicability of assessment to PCMH			
Participation in assessment tool contributes to recognition program achievement (i.e. NCQA)			
TOTAL WEIGHTED SCORE	**30**		**0**

Appendix G: Scoring of Organizational Assessment Tools

Criteria	Weights	Assessment Tools					
Reviewer		Sandy		Sandy		Sandy	
	Most important to have = 5; Somewhat important to have = 3; Least important to have = 1	CAHPS Cultural Competence Item Set: Meets or exceed = 5; Addresses but room= 3; inadequately addressed = 1	Weighted Score	Cultural Competence Assessment Tool (Denise Dodds, Boston PHC)	Weighted Score	Conducting a Cultural Competence Self Assessment (D. Andrulis)	Weighted Score
Robustness of tool	5	5	25	3	15	3	15
Based on national Standards							
Evidence-based/validated							
Includes a qualitative component (interviews)							
Consumer tested/pilot tested in the community							
Participation in assessment tool contributes to recognition program achievement (i.e. NCQA)							
Scope - number of levels it can assess (i.e. system; group; provider; department…)							
Comprehensiveness of domains							
Ability of assessment tool to provide benchmark data/to benchmark performance across organizations							
Low Administrative burden	5	5	25	1	5	1	5
Low administrative burden to organization (disruptiveness factor ie. Duration overall and survey tool length; participation level, etc.)							
Availability of technical support in administering and/or analyzing data							
Cost to administer/cost associated (both $ and staff time)							
Level of organizational ownership of assessment tool/involvement of direct leadership	5	5	25	5	25	5	25
Ease of Use	5	5	25	1	5	1	5
Accessibility (live website; easy to navigate and research)							
Quality Improvement Potential/Organizational change Potential	5	5	25	5	25	5	25
Ability of assessment to improve quality of care and outcomes							
Ability of results to inform consumers							
Ability of results to inform providers							
Ability of results to inform staff throughout the organization							
Ability of results to change providers' behavior, and ultimately shift organizational culture							
Ability to stratify by the various diversity groups							
Feasability of Implementation in MD PCMH	5	5	25	3	15	1	5
Applicability of assessment to PCMH							
Participation in assessment tool contributes to recognition program achievement (i.e. NCQA)							
TOTAL WEIGHTED SCORE	**30**		**150**		**90**		**80**

Appendix G: Scoring of Organizational Assessment Tools

Criteria								
Reviewer	**Steven**		**Steven**		**Roger**		**Roger**	
	Cultural Competence Self-Assessment Questionnaire (CCSAQ)	Weighted Score	Organizational Cultural Competence: A Review of Assessment Protocols	Weighted Score	PCMH360	Weighted Score	Cultural Competency Assessment Tool for Hospitals (CCATH)	Weighted Score
Robustness of tool	3	15	5	25	5	25	3.125	15.625
Based on national Standards								
Evidence-based/validated								
Includes a qualitative component (interviews)								
Consumer tested/pilot tested in the community								
Participation in assessment tool contributes to recognition program achievement (i.e. NCQA)								
Scope - number of levels it can assess (i.e. system; group; provider; department…)								
Comprehensiveness of domains								
Ability of assessment tool to provide benchmark data/to benchmark performance across organizations								
Low Administrative burden	3	15	3	15	5	25	2	10
Low administrative burden to organization (disruptiveness factor ie. Duration overall and survey tool length; participation level, etc.)								
Availability of technical support in administering and/or analyzing data								
Cost to administer/cost associated (both $ and staff time)								
Level of organizational ownership of assessment tool/involvement of direct leadership	3	15	3	15	5	25	5	25
Ease of Use	3	15	3	15	5	25	0	0
Accessibility (live website; easy to navigate and research)								
Quality Improvement Potential/Organizational change Potential	1	5	5	25	4.66	23.3	2.333	11.665
Ability of assessment to improve quality of care and outcomes								
Ability of results to inform consumers								
Ability of results to inform providers								
Ability of results to inform staff throughout the organization								
Ability of results to change providers' behavior, and ultimately shift organizational culture								
Ability to stratify by the various diversity groups								
Feasability of Implementation in MD PCMH	1	5	3	15	5	25	0	0
Applicability of assessment to PCMH								
Participation in assessment tool contributes to recognition program achievement (i.e. NCQA)								
TOTAL WEIGHTED SCORE		**70**		**110**		**148.3**		**62.29**

Appendix G: Scoring of Organizational Assessment Tools

Criteria								
Reviewer	**Roger**		**Cheri**		**Cheri**		**Cheri**	
	Organizational Cultural Competence Assessment Profile	Weighted Score	Clearview Organizational Assessments-360 (COA360)	Weighted Score	Behavioral Health and Social Services-360 (BHSS360)	Weighted Score	Communication Climate Assessment Toolkit (C-CAT)	Weighted Score
Robustness of tool	3.5	17.5	3	15	3	15	3	15
Based on national Standards								
Evidence-based/validated								
Includes a qualitative component (interviews)								
Consumer tested/pilot tested in the community								
Participation in assessment tool contributes to recognition program achievement (i.e. NCQA)								
Scope - number of levels it can assess (i.e. system; group; provider; department…)								
Comprehensiveness of domains								
Ability of assessment tool to provide benchmark data/to benchmark performance across organizations								
Low Administrative burden	3	15	5	25	5	25	5	25
Low administrative burden to organization (disruptiveness factor ie. Duration overall and survey tool length; participation level, etc.)								
Availability of technical support in administering and/or analyzing data								
Cost to administer/cost associated (both $ and staff time)								
Level of organizational ownership of assessment tool/involvement of direct leadership	3	15	5	25	5	25	3	15
Ease of Use	0	0	5	25	5	25	3	15
Accessibility (live website; easy to navigate and research)								
Quality Improvement Potential/Organizational change Potential	3.333	16.665	5	25	5	25	3	15
Ability of assessment to improve quality of care and outcomes								
Ability of results to inform consumers								
Ability of results to inform providers								
Ability of results to inform staff throughout the organization								
Ability of results to change providers' behavior, and ultimately shift organizational culture								
Ability to stratify by the various diversity groups								
Feasability of Implementation in MD PCMH	2.333	11.665	3	15	3	15	3	15
Applicability of assessment to PCMH								
Participation in assessment tool contributes to recognition program achievement (i.e. NCQA)								
TOTAL WEIGHTED SCORE		**75.83**		**130**		**130**		**100**

Appendix G: Scoring of Organizational Assessment Tools

Criteria						
Reviewer	**Cheri**		**Cheri**		**Cheri**	
	Culture Care Connection CLAS Assessment Survey	Weighted Score	Tailoring Initiatives to Meet the Needs of Diverse Populations: A Self-Assessment Tool	Weighted Score	Cultural Competency Organizational Self-Assessment (OSA) Question Bank	Weighted Score
Robustness of tool	1	5	1	5	3	15
Based on national Standards						
Evidence-based/validated						
Includes a qualitative component (interviews)						
Consumer tested/pilot tested in the community						
Participation in assessment tool contributes to recognition program achievement (i.e. NCQA)						
Scope - number of levels it can assess (i.e. system; group; provider; department…)						
Comprehensiveness of domains						
Ability of assessment tool to provide benchmark data/to benchmark performance across organizations						
Low Administrative burden	1	5	1	5	1	5
Low administrative burden to organization (disruptiveness factor ie. Duration overall and survey tool length; participation level, etc.)						
Availability of technical support in administering and/or analyzing data						
Cost to administer/cost associated (both $ and staff time)						
Level of organizational ownership of assessment tool/involvement of direct leadership	1	5	3	15	3	15
Ease of Use	1	5	1	5	3	15
Accessibility (live website; easy to navigate and research)						
Quality Improvement Potential/Organizational change Potential	1	5	1	5	3	15
Ability of assessment to improve quality of care and outcomes						
Ability of results to inform consumers						
Ability of results to inform providers						
Ability of results to inform staff throughout the organization						
Ability of results to change providers' behavior, and ultimately shift organizational culture						
Ability to stratify by the various diversity groups						
Feasability of Implementation in MD PCMH	1	5	1	5	1	5
Applicability of assessment to PCMH						
Participation in assessment tool contributes to recognition program achievement (i.e. NCQA)						
TOTAL WEIGHTED SCORE		**30**		**40**		**70**

Appendix H: Final Weighted Score Ranking

Assessment Tool	Total Weighted Score
CAHPS Cultural Competence Item Set	150
PCMH360	148
Clearview Organizational Assessments-360 (COA360)	130
Behavioral Health and Social Services-360 (BHSS360)	130
Organizational Cultural Competence: A Review of Assessment Protocols	110
Communication Climate Assessment Toolkit (C-CAT)	100
Cultural Competence Assessment Tool (Denise Dodds, Boston PHC)	90
Conducting a Cultural Competence Self Assessment (D. Andrulis)	80
Organizational Cultural Competence Assessment Profile	76
Cultural Competence Self-Assessment Questionnaire (CCSAQ)	70
Cultural Competency Organizational Self-Assessment (OSA) Question Bank	70
Cultural Competency Assessment Tool for Hospitals (CCATH)	62
Tailoring Initiatives to Meet the Needs of Diverse Populations: A Self-Assessment Tool	40
Culture Care Connection CLAS Assessment Survey	30
Average Score	**92**

Appendix I: Committee Participants

Name	Title	Organization
Lead: Cheri Wilson, MA, MHS, CPHQ	Faculty Research Associate and Program Director	Hopkins Center for Health Disparities Solutions, Johns Hopkins Bloomberg School of Public Health
Co-Lead: Thomas LaVeist, PhD	Director and William C. and Nancy F. Richardson Professor in Health Policy	Hopkins Center for Health Disparities Solutions, Johns Hopkins Bloomberg School of Public Health
Co-Lead: Earl Ettienne, PhD, MBA	Assistant Professor	Howard University College of Pharmacy
Salliann Alborn	CEO	Maryland Community Health System, Community Health Integrated Partnership
Cyntrice Bellamy-Mills, MEd, MS	Chief, Community Operations and Quality Assurance Health Programs	Department of Health and Mental Hygiene, Mental Hygiene Administration
Roger Clark, MBA	Chief Operating Officer	Medical Home Development Group
Dianne Houston-Crockett, MEd, MPH, CHES	Associate Vice President, Health Promotion	Amerigroup Maryland, Inc.
Erin Dorrien	Chief, Government Relations and Special Projects	Maryland Health Care Commission
Niharika Khanna, MBBS, MD, DGO	Director	University of Maryland School of Medicine, Maryland Learning Collaborative
Sandra Kick, MSPH	Health Policy Analyst	Maryland Women's Coalition for Health Care Reform
Steven Ragsdale	Consultant	Connecting the Dots
Ben Steffen	Executive Director	Maryland Health Care Commission

Subject: RE: Question re: Assessment of Maryland PCMH Demonstration Project
Date: Thursday, June 13, 2013 10:47:04 PM Eastern Daylight Time
From: Marsteller, Jill A.
To: Wilson, Cheri
CC: Donald Nichols

Hi Cheri,
Here are answers to the committee's questions.

- Are there cultural competency standards incorporated into the assessment?

Yes, we will assess cultural competency from the perspective of the patient using patient surveys (adult and child versions). In addition, we included a question about a potentially related topic, health care disparities reduction, in interviews with representatives of 9 practices selected to represent the range of ownership types and rural-to-urban location.

- If yes, what are they? Please provide a copy.

The cultural competency questions for patients come from the Consumer Assessment of Healthcare Providers Survey (CAHPS). This is a well-validated survey developed for the Agency for Healthcare Research and Quality. Specific questions in the cultural competency group (as designated by the CAHPS developers) that were included in the MMPP evaluation survey are:
ADULT VERSION: a. In the last 12 months, how often did this provider interrupt you when you were talking?; b. In the last 12 months, how often did this provider talk too fast when talking with you?; c. In the last 12 months, how often did this provider use a condescending, sarcastic, or rude tone or manner with you?; d. In the last 12 months, did you and this provider talk about a healthy diet and healthy eating habits?; e. In the last 12 months, did you and this provider talk about the exercise or physical activity you get?; f. In the last 12 months, did anyone in this provider's office ask you if there was a period of time when you felt sad, empty, or depressed?; g. In the last 12 months, did you and anyone in this provider's office talk about things in your life that worry you or cause you stress?; h. Using any number from 0 to 10, where 0 means that you do not trust this provider at all and 10 means that you trust this provider completely, what number would you use to rate how much you trust this provider?
It should be noted that we were not able to include all the questions that are considered cultural-competency-related because of the length of the survey. We did not include Cultural Competency subscales on Politeness and Caring (although we kept the overall trust scale). Questions on Cultural Competency are similar for the children's survey.
The patient surveys do include several PCMH-specific questions in regard to shared decision-making, which also could be used to look for differences between vulnerable and non-vulnerable groups.
The health care disparities reduction item in the interviews with practitioners at the 9 selected sites are:
Do you expect that the PCMH program will have an impact on health disparities (racial/ethnic, rural vs. urban, income/wealth)?

a. In what direction?
b. What will be the mechanism or why expect to have impact?
c. Have you observed any impact? If so what?

- How are the cultural competency standards evaluated/assessed?

Patient surveys will be collected by telephone at two time points, baseline (presently being collected) and late in the intervention. We will sample 1000 patients at each time point. We will analyze the cultural competency and other patient survey questions in bivariate analyses to examine whether there are significant differences in responses by race, ethnicity, or other indicators of potential vulnerability (e.g. Medicaid insurance status; rural residence). In addition, once two time points are available, we will look at changes over time using a pre-post evaluation strategy and will look for differences between vulnerable and non-vulnerable populations using a difference-in-difference regression analysis approach (which compares over-time changes between 2 or more groups).

Site visits and interviews of participating clinicians and staff will be conducted twice during the evaluation project. The first round of interviews has been completed and data from site visits at the 9 practices have been summarized in a report. Qualitative analysis of the themes surrounding the disparities question did not reveal much contemplation of the issue among respondents. However, further analysis of responses is possible if requested.

Hope this will suit your purpose, Cheri? I did not attach the instruments themselves since most of the questions are irrelevant to the committee's specific interests. Let me know if you need anything else!
Thanks,
Jill

Jill A. Marsteller, PhD, MPP
Associate Professor
410-614-2602/ FAX 410-955-6959

Mary Wisniewski
Senior Administrative Coordinator
410-955-5315/FAX 410-955-6959
mwisniew@jhsph.edu

From: Wilson, Cheri
Sent: Thursday, June 13, 2013 8:38 AM
To: Marsteller, Jill A.
Cc: Donald Nichols
Subject: Re: Question re: Assessment of Maryland PCMH Demonstration Project

Hi Jill,

Our next conference call is scheduled for this Friday at 2. Is there any changes that you and Donald could have a response by then? We will be completing our fact finding as of tomorrow so that we can move to the analysis stage of our Subcommittee's charge.

Thanks in advance,

Cheri

From: <Marsteller>, "Jill A." <jmarstel@jhsph.edu>
Date: Monday, June 10, 2013 11:28 AM
To: Cheri Wilson <chwilson@Jhsph.edu>
Cc: Donald Nichols <dnichols@impaqint.com>
Subject: RE: Question re: Assessment of Maryland PCMH Demonstration Project

Hi Cheri,
Yes, we are indeed. Let me discuss this with Donald Nichols, the IMPAQ lead, so we can be as comprehensive as possible in our response.

Hope you are doing well!

Thanks! Jill

Jill A. Marsteller, PhD, MPP
Associate Professor
410-614-2602/ FAX 410-955-6959

Mary Wisniewski
Senior Administrative Coordinator
410-955-5315/FAX 410-955-6959
mwisniew@jhsph.edu

From: Wilson, Cheri
Sent: Friday, June 07, 2013 2:44 PM
To: Marsteller, Jill A.
Subject: Question re: Assessment of Maryland PCMH Demonstration Project

Hi Jill,

I hope all is well. I currently sit on the Maryland Health Quality and Cost Council Cultural and Linguistic Competency Workgroup and staff one of the subcommittees that is working on health equity standards for the PCMH. Ben Steffen mentioned that you were conducting an assessment of the program and suggested that I follow up with you regarding the following questions:

- Are there cultural competency standards incorporated into the assessment?
- If yes, what are they? Please provide a copy.
- How are the cultural competency standards evaluated/assessed?

All the best,

Cheri
--
Cheri C. Wilson, MA, MHS, CPHQ
Faculty Research Associate, Health Policy and Management Department
Program Director, Culture-Quality-Collaborative (CQC) and
Clearview Organizational Assessments-360 (COA360)
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Hopkins Center for Health Disparities Solutions
http://www.hopkinshealthdisparities.org

Learn more about the:
Culture-Quality-Collaborative (CQC)
Clearview Organizational Assessments-360 (COA360)
http://www.clearview360.org

Follow the Center on Facebook at:
http://www.facebook.com/pages/Baltimore-MD/Hopkins-Center-for-Health-Disparities-Solutions/71907077462

Health Care Disparities Blog: Raising Awareness, Making Connections, Creating Solutions
http://healthcaredisparities.com/

Appendix C

Charge 3 Report

Criteria for Continuing Education in Multicultural Health Care

June 2013

Charge 3 - Cultural Competency and Health Literacy Workgroup

SubCommittee Members:
Co-Chairs: Linda Aldoory, Daniel Teraguchi
Margot Aronson
Brandon Batiste
Janice Berry-Edwards
Olivia Carter-Pokras
Diane Collins
Keith Colston
Doris Dzameshie
Katherine Garcia
Columbus Giles
Larry Gourdine
Leslie Grant
Darci Graves
Laurie Hedlund
Cheryl Jones
Chimene Liburd
Yolanda Maria Welch Martinez
Monica McCann
Steven Ragsdale
Lorraine Smith
Ray Winbush
Mohammed Younus

Purpose of this Report
The Charge 3 Subcommittee is recommending criteria for health care professionals in the State to receive continuing education in multicultural health care, including cultural and linguistic competency and health literacy training. Continuing Education efforts are ongoing, formal learning activities that are mandated in order to renew a professional license.

As stated in the Maryland Health Improvement and Disparities Reduction Act of 2012, "cultural and linguistic competency" means cultural and linguistic abilities that can be incorporated into therapeutic and medical evaluation and treatment, including:

1) Direct communication in the patient's primary language;
2) Understanding and applying the roles that culture, ethnicity, and race play in diagnosis, treatment, and clinical care; and
3) Awareness of how the attitudes, values, and beliefs of health care professionals and patients influence and impact professional and patient relations.

Demonstration of cultural and linguistic competencies is most effective when health literacy is taken into consideration during each patient-provider encounter. Health literacy refers to the degree to which individuals have the capacity to obtain, process, and understand basic health

information and services needed to make appropriate health decisions (U.S. Department of Health and Human Services).

Cultural, linguistic, and health literacy considerations are best addressed by a health care professional workforce that is appropriately trained to provide health care services to diverse communities. A formal process for continuing education in multicultural health care for health care professionals would help to reinforce the implementation of organization-level standards for cultural and linguistic competency and health literacy.

Organizational standards for cultural and linguistic competency and health literacy are becoming increasingly desired for purposes of accrediting health care organizations. The significance and purpose of such standards at both the organizational and individual practitioner level can be summed up by the overarching principal standard of the enhanced *National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health and Health Care*:

> "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."

Target Audience
All health care professionals who hold an active license to practice in Maryland.

Goals of Continuing Education in this area

- To increase health care professionals' knowledge and understanding of different cultural practices and health literacy;

- To maintain, develop, and increase cultural and linguistic competencies and address health literacy in order to improve service outcomes for limited-English speaking patients and patients from cultures who are English-speaking;

- To heighten health care professionals' own awareness and perception of cultural assumptions, stereotypes, and health literacy issues and to understand the impact of these constraints on service delivery;

- To foster health care professionals to incorporate knowledge of health beliefs and practices in the diagnosis and treatment of patients;

- To equip health care professionals with effective health literacy and cross-cultural skills to improve patient-provider communication that enhances patient's ability to obtain, process, and understanding health information and services to make appropriate health care decisions.

- To recognize and understand that cultural competency will inform and drive action to ensure equitable access and accountability for excellent health care delivery for all.

Suggested Guidelines for Administering CE programs

The range of licensing boards varies greatly, as do their required continuing education credits/units. This poses a particular challenge in providing guidelines for administering continuing education programs that are fair, equitable, and appropriate across all licensing boards. However, it seems that certain components must be taken into account in order to ensure adequate attention to cultural competency for all licensees under the purview of each individual board. Outlined below are the key components with suggested guidelines on how to tailor cultural competency requirements for individual boards:

- *Amount:* Each board should identify the most critical and relevant learning objectives for their licensees using the list below. Once these learning objectives are identified, boards should determine the competency level needed for their licensees and identify existing required credits/units that attend to these objectives. Based on results of a survey of existing licensing board requirements, boards should consider a minimum ten percent dedication to cultural competency or 2 hours of continuing education credits/units for each licensing period. Depending on the assessment outcomes, many boards may determine that a higher percentage is required to meet their learning objectives.

- *Approval of Acceptable Credits/Units:* It is important that educational activities for continuing credits/units be vetted and evaluated to ensure they are of the highest quality and are proven effective in achieving identified learning objectives. Boards should develop a mechanism or process for approval of acceptable credits/units using these guidelines. We recommend that a reputable external agency or non-board affiliated representative be part of the process to provide a critical perspective that may be more difficult to do for personnel directly associated with the licensing agency. The type of acceptable activities should be discussed to determine the type of activity that best attends to the learning objective. Types of acceptable activities might include attending a workshop, publishing a paper, or participating in a webinar.

- *Curricular Structure/Navigation:* Depending on which learning objectives the board identifies as critical and appropriate for the licensees, a user-friendly structure should be provided to identify which approved educational activities attend to specific learning objectives and how many credits/units are needed to achieve the level of competency for that objective. Included in this structure should be determinations of whether continuing education training can be taken on-line or in person (e.g., CPR certification), attention to the accessibility of approved activities for licensees regardless of their location, and affordability.

- *Compliance*: In surveying boards, compliance is generally monitored by randomly auditing 5% to 20% of licensees. In addition to this monitoring, it is recommended that the curricular structure develop a specific system to track continuing education credits/units for cultural competency for its licensees.

- *Frequency*: For each licensing cycle, the board should implement these recommendations.

Suggested Learning Criteria for CE curriculum

Suggested learning objectives to be addressed in continuing education activities are listed below. This list derives from various sources including the report of the Maryland Health Disparities Collaborative Cultural and Linguistic Competency Workgroup, and the *Cultural and Health Literacy Competency Primer d*eveloped by the DHMH Office of Minority Health and Health Disparities, the University of Maryland School of Public Health and the Herschel S. Horowitz Center for Health Literacy. The learning objectives contained in the Primer incorporate input from 31 national experts in cultural competency, health literacy, healthcare communication, and minority health, as well as an additional group of 30 educators representing 23 health profession schools in Maryland.

Following the completion of the CE program, it is recommended that a health care professional possess the following knowledge and skills:

<u>Objectives for Health Care Professional Knowledge:</u>

1. To understand how culture (e.g., race, ethnicity, gender, lifestyle, life stage) and health literacy impact health outcomes and can contribute to health disparities.
2. To define health literacy and its impact on health outcomes.
3. To understand their role in and the relationship between health literacy and cultural competency.
4. To understand the epidemiology of disparities, and acknowledge barriers to achieving health equity.
5. To recognize disparities amenable to intervention.
6. To describe challenges in cross-cultural communication.
7. To identify personal bias and stereotyping through self-assessment.
8. To understand models and strategies to increase patients' understanding of their health and empower them to be active participants in their care.
9. To identify current resources in health literacy and cultural competency available to health care professionals to improve patient communication experiences in health care settings.
10. To identify community and state resources for helping patients improve health literacy and health status.

<u>Objectives for Health Care Professional Skills:</u>

1. To demonstrate communication strategies that are sensitive to low health literate patients.

2. To demonstrate strategies to reduce bias in communication and care.
3. To demonstrate communication skills with patients in a non-shaming, non-judgmental manner.
4. To demonstrate understanding of and ability to use a “universal precautions” approach to patients.
5. To demonstrate ability to discuss with patients their health beliefs.
6. To demonstrate ability to elicit from patients their concerns and questions regarding health care decisions.
7. To demonstrate understanding of the differences between individualistic and collective cultural dynamics.

Attachment 1

Template for Research on Continuing Education in Multicultural Health Care
(Multicultural health care includes cultural competency, health literacy, and linguistic competency)

Responses to Questions 7-13, and 18 may require additional research beyond the legislative text. Other potential sources could include *State occupational licensing boards* (http://www.hwic.org/experts/browse/xa20), *State health departments* (http://www.hwic.org/experts/browse/xa10), *health professional associations* (http://www.hwic.org/experts/browse/xa23), or other reliable information resources.

1.	**State**	
2.	**Bill Number and Year Introduced**	
3.	**Bill Title**	
4.	**Did Bill Pass? (If so, what year was it signed into legislation?)**	
5.	**What are the target health professions?**	
6.	**Does the Bill (1) require or (2) make voluntary the pursuit of multicultural health care continuing education?**	
7.	**What number of multicultural health care continuing education hours is required?**	
8.	**How frequently must the hours be obtained?** (i.e., only one time; every year; every 2 years, etc.)	
9.	**Does the continuing education requirement pertain to new health professional licensees, existing licensees, or both?**	
10.	**What types of training topics can be counted toward the multicultural health care continuing education hours?**	

11.	**What entity is responsible for overseeing implementation of the requirement?** (i.e., State health department; health occupation board; etc.)	
12.	**Are other entities designated to play a role in implementing the requirement? If so, please describe their role.** (e.g., the role for entities such as academic institutions, health professional associations, etc.)	
13.	**What entity or entities are responsible for developing curriculum for multicultural health care continuing education?**	
14.	**Does the Bill specify any multicultural health care curriculum requirements for current health professional <u>students</u> (not yet licensed)? If so, please describe.**	
15.	**Are there any funding sources identified in the Bill? If so, please describe.**	
16.	**Does the Bill require an evaluation of the effectiveness of multicultural health care continuing education?** (i.e., impact on health outcomes or other performance measures)	
17.	**What other useful information should be noted about the Bill?**	
18.	**What other useful information was found about implementation of the multicultural health care continuing education requirement?** (i.e., information from the State health department; health occupation board; etc.)	

Attachment 2

Summary Highlights: Analysis of State Legislation on Cultural Competency Continuing Education

- Between 2003 and 2013, there were 51 legislative bills introduced in state legislatures across the U.S. to implement cultural competency continuing education requirements for licensed health care professionals.

- More than a quarter (27.5%) of bills that were introduced were ultimately signed into law in the respective states; while 50% (N=7) of the bills that became law require (rather than make voluntary) cultural competency continuing education for the designated health care professionals.

States with Requirement for Cultural Competency Continuing Education	Year of Statute
California	2005; 2012
Connecticut	2009; 2013
New Jersey	2005
Oregon	2013
Washington	2006

- Among bills that became law, the physician workforce was the most frequent target audience, whether for voluntary or required continuing education.

- The majority of legislation that was introduced did not specify how frequently health care professionals would be expected to obtain cultural competency training. However, among the bills that provide specifications, the most frequent requirement is 2 hours of cultural competency continuing education every 2 years for both new and existing licensees.

- Among all the legislation, responsibility for developing the continuing education curriculum most frequently lies with the respective state's health profession schools, health occupation boards, health professional associations, and/or the State health department. The most prevalent training topics included in the legislation were:
  - Gender
  - Race and Ethnicity
  - Health Disparities
  - Minority Communities
  - Diversity

- Among bills that became law, the entity most frequently designated with responsibility for overseeing the implementation of the continuing education requirement is the respective Health Occupation Board in the state. Other entities frequently cited in the legislation to play a supporting role in implementation are the following:
    - Colleges and universities
    - Health professional associations and societies
    - Hospitals and other health care facilities

- The majority of legislation that was introduced did not specify funding sources for implementing the legislation. Below are examples of funding provisions that were included in legislation introduced in New York:

    - Training would be funded jointly by the State and the HMOs. The statutory reserve fund of each HMO would be increased at the end of the calendar year to the extent deemed necessary by the superintendent, in consultation with the Commissioner of Health, to provide capital necessary to establish and maintain the health care provider training program in cultural awareness and competence. [New York A057661 (2011); A06388 (2007); S07779 (2010)]

    - $100,000 from the State Treasury General Fund would be allocated for the New York Department of Health to conduct a statewide, community-based public education program on root causes of disparities in minority health care. Target audience is health professionals, patients, and patient advocates. Department of Health may consult with professionals in developing and implementing the program. [New York A02471 (2013); A057661 (2011); A06388 (2007); S00793 (2013); S07779 (2010); S00765 (2007)]

    - At the beginning of each license registration period, a mandatory continuing education fee of five dollars would be collected from all persons required to complete cultural competency course work and training. This fee would be in addition to all other existing registration fees. [New York A06449 (2011); S2743A (2011)]

- None of the 51 bills in the analysis required an evaluation of the effectiveness of the continuing education, such as its impact on health outcomes or other performance measures.

- 20% of the bills analyzed included provisions pertaining to cultural competency curriculum requirements for undergraduate and graduate health profession training programs; and two such bills became law in New Jersey and Washington.