WEBINAR VIDEO TRANSCRIPT

P4C HIV TAC Webinar

Using CLAS Standards to Enhance Cultural Competence in Integrated Care

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STEVE LUCKABAUGH: Good afternoon. My name is Steve Luckabaugh and I'd like to welcome you to the Using CLAS Standards to Enhance Cultural Competence in Integrated Care webinar. This webinar is brought to you by the Partnerships for Care, HIV Training, Technical Assistance and Collaboration Center, HIV TAC.

The Partnerships for Care Project as a three-year, multi-agency project funded by the Secretary's Minority AIDS Initiative Fund and the Affordable Care Act. The goals of the project are to expand provision of HIV testing, prevention, care, and treatment in health centers serving communities highly impacted by HIV, to build sustainable partnerships between health centers and their state health department, and to improve health outcomes among people living with HIV, especially among racial and ethnic minorities. The project is supported by the HIV Training, Technical Assistance, and Collaboration Center, HIV TAC.

Our speaker today is Ms. Kelly Wagner. Ms. Wagner is currently the Senior Technical Vice President for Training and Technical Support, and the Manager of MayaTech Corporation's Center for Technical Assistance Training and Research Support, TARS. Ms. Wagner has over 14 years of experience providing programmatic and evaluation technical assistance and training. Her areas of expertise include HIV/AIDS, substance abuse prevention and treatment, women's health, minority health, epidemiology, and health disparities.

She has managed and implemented large, multi-site, federally-funded TA and training programs, and has served as the project director for Technical Assistance and Training for the SAMHSA Behavioral Health and HIV/AIDS Coordinated Technical Assistance Center, the CSAT Evaluation of Pregnant Post-Partum Women Project, Deputy Project Director for CSAP's Substance Abuse and HIV Prevention Technical Assistance, Coordinating Center, and she is currently the Project Director for the HRSA HIV Training Technical Assistance and Collaboration Center funded to provide innovative, cost-efficient, and culturally-competent training and technical assistance to four state health departments and up to 22 health centers serving high-HIV prevalence areas funded under the SMAIF project. Please join me in welcoming Ms. Wagner.

KELLY WAGNER: Thank you, Steve, and thank you everyone for joining us this afternoon. So today we want to talk about using the CLAS standards to enhance cultural competence in

integrated HIV and primary care. So the objectives for today's session are to go over the purpose and rationale for the National Standards for Culturally and Linguistically Appropriate Services, describe each of the standards, and hopefully describe a number of strategies for implementing each of the standards in an integrated care setting.

Steve, we have the first poll question. So at this point, I want to get an idea of how many participants on the training today are familiar with the CLAS standard. So please select either yes or no, and then we'll go through a few minutes, and then Steve, you can move forward to the results of the poll.

STEVE LUCKABAUGH: OK, this is our first poll question. Are you familiar with the CLAS standards, yes or no?

KELLY WAGNER: OK. So it looks like a third of our participants have heard of the standards and are familiar with them, but the good thing is that we do have a group of participants today that are not familiar with the CLAS standards. Hopefully by the end of this training, you will be, and will understand how you can use them to enhance the cultural and linguistic competence of the care that you're providing for your patients that are impacted by HIV.

What are the CLAS standards? The CLAS standards are a set of national standards that were developed by the Office of Minority Health in 2001 and updated in 2013. The 15 standards are designed to ensure that people entering the health care system receive equitable and effective treatment in a culturally and linguistically appropriate manner.

The use of the class standards are proposed to correct currently existing inequities in the provision of health services and make health services more responsive to the individual needs of patients, consumers, and clients. The standards are especially designed to address the needs of racial, ethnic, linguistic, and other minority population groups that experience unequal access to health services.

So as I mentioned on a previous slide the standards were developed in 2000, 2001, and then revised in 2013. The enhanced standards were developed in response to health and health care disparities, changing demographics in the US, and legal and accreditation requirements. The enhanced standards are intended to advance health equity, improve quality, and help eliminate health care disparities.

So there were changes in four different areas in the CLAS standards between 2000 and 2013. Culture, audience, health, and recipient. So the expansion in 2013, the Revised Standards expanded the definition of culture to include geographical, religious and spiritual, biological, and sociological characteristics. This is specifically important when looking at populations that are affected by HIV/AIDS, because culture-- the expansion of the CLAS standards took into account both gender identity as well as sexual orientation in looking at how to ensure that services are culturally and linguistically appropriate.

The 2013 standards also expanded the definition of the audience beyond only those health care organizations that are providing direct services, but to any organizations that are involved in health and health delivery. The definition of health was also changed for the 2013 standard. Where as it was an implicit definition in 2000, the 2013 standard explicitly includes physical, mental, social, and spiritual well-being in the definition of health. The 2013 standards also change the recipients of these health care services to only focus on patients and consumers and change them to focus on both individuals and groups. And so that may include families of patients as well as the community in which the health care services are being delivered.

So Steve, I think it's time for the second question, which is, which topics-- for those of you that are familiar with the CLAS standards and those of you that aren't, which topics do the CLAS Standards not address? There are four options here. Communication and language assistance, workforce diversity, cultural celebrations and customs, or conflict and grievance resolution.

STEVE LUCKABAUGH: OK, this is our second poll. If you could take a moment to answer, which topics do the CLAS Standards not address? Select one.

KELLY WAGNER: Few more seconds. If we can get one more response. If you haven't responded, please choose one. OK, Steve, you can launch the results.

So it looks like half of you indicated that the CLAS Standards do not address workforce diversity, and half indicated that they do not address conflict or grievance resolution. In actuality, both of those topics are addressed within the CLAS Standards. What they do not address would be cultural celebrations and customs, but we're going to learn more about the standards and what they address as we move forward through the presentation.

So as I mentioned, there are 15 CLAS Standards, and the 2013 revision organized them into a principal standard and then three different themes. The principal standard frames the essential goal of all of the standards. If all the other standards are adopted, than the principal standard is achieved, and that is to provide effective, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices.

The other 14 standards are organized into three different themes. The first theme emphasizes the importance of CLAS implementation as a systemic responsibility requiring endorsement and investment of leadership, and supportive training of all individuals in the organization. And those are the standards that focus on governance, leadership, and workforce.

The second theme broadens understanding and application of appropriate services to include all communication needs. And those are standards five through eight, which focus on communication and language assistance. The third theme stresses the importance of establishing individual responsibility for ensuring that Culturally and Linguistically Appropriate Services are supported within the health organization, and those are the standards that focus on engagement, continuous improvement, and accountability.

Before we get into the standards, let's just make sure that we're all on the same page in talking about cultural competence. There are many definitions and conceptual frameworks for cultural and linguistic competence, and what I presented here is a framework that's based on the work of Cross which is the most widely adapted definition in the literature. And that states that cultural competence requires that organizations have a clearly defined, congruent set of values and principles, and demonstrate behaviors, attitudes, policies, structures, and practices that enable them to work effectively cross-culturally.

So the definitions and frameworks for cultural competence are based on specific values. So I've indicated on this slide here a number of key values for cultural competence as defined through the National Center for Cultural Competence. So when looking at providing services for people living with HIV/AIDS, consider the values that your health center has in place for serving that patient population, as well as those at risk with HIV/AIDS. Culture greatly influences health seeking behaviors, as well as patient engagement and adherence in maintaining or enhancing their health outcomes.

There are a number of key values for linguistic competence that speak to delivering services in the preferred language and/or mode of delivery for the population served, focused on making sure that written materials are translated and accessible, that interpretation and translation services comply with any government mandate, and that consumers are engaged in the evaluation of language access. Linguistic competence has become much more of a focus in terms of health care delivery in the United States.

There are currently 311 languages that are spoken in the US, and when looking at the patient population or health centers that are funded through the HRSA Bureau of Primary Health, 23% of health center patients are best served in a language other than English. Many individuals living with HIV/AIDS may be less than proficient in English, which makes it doubly important that we focus not only on ensuring cultural competence, but linguistic competence with the services that we're providing to these patients.

So we've talked about cultural and linguistic competence values. There are barriers to being able to provide culturally and linguistically competent care. In most health care settings, when people living with HIV/AIDS or those at high risk-- especially those that are members of a high risk group-- walk into a health care setting, it's not always a given that they'll encounter providers or staff who look anything like them or understand their lifestyle, their experiences, what has brought them to the point where they are in their life. And so it becomes incumbent upon us as service providers to do what we can to address these barriers that I've identified on the screen, such as systems of care that are not well-designed for diverse population, poor cross-cultural communication between providers and patients, concerns of patient and client concerns-- one, around their health, but then also distrust of the medical field, cultural stigma, and lack of diversity in the health care leadership and workforce.

This is our third question. Now, we've talked about high level what the CLAS Standards are. Who's familiar what they focus on? I'd like to find out whether anyone on the training today

has actually used the CLAS Standard in your health center, whether in developing programs or in designing staff recruitment projects. So just an idea of whether these standards have been used in the health centers.

So I think, Steve, you can launch the results. OK, so the results are pretty similar to the breakdown between people that were familiar with the standards and those that aren't familiar with the standards. I am excited to see that over a third of the participants have utilized the CLAS Standards in their health center, and hopefully will be able to provide some of their experiences and insight in doing so as we move through the training today.

So for those that haven't utilized them, the question would be, why should your organization implement the CLAS Standards? So there is clear and compelling evidence that cultural and linguistic competence has a significant impact on improving multiple dimensions of health and health care, such as access, satisfaction, outcomes, services, and support. Implementing CLAS will enable your staff to gain knowledge about the cultural values and beliefs of your patients, to interact effectively with those patients whose cultures and belief systems may be different from their own, enhance their ability to provide quality care that is respectful and non-judgmental, allow your health center to deliver health care services and supports in the primary languages spoken by your patients and their families, and be able to identify and respond effectively to the purposes and needs your patient population.

In most cases, you are already implementing activities that support the CLAS Standards whether you knew that or not. But by developing a plan or looking at them as a framework, you're able to identify your goals for meeting them, measure your progress in meeting them, and make adjustments as needed.

So at this point, the remainder of the training today will go through each of the standards and strategies that you might pursue to implement CLAS specifically in providing services to your patient population with and at risk for HIV. Please offer your experiences in implementing the standards, addressing cultural and linguistic competence, and also raise any questions regarding barriers to implementation that you may have.

As Steve mentioned, there is a question feature-- there is a question box where you can type in a question. You may also use the raise your hand feature during the Q&A portion. And there may be times that I actually plan to stop, because I will get tired of hearing my own voice for a minute. Stop to ask if anyone has any questions. And if you would like to ask a question verbally at that point, you can use the raise your hand feature.

Let's move into the CLAS Standards themselves. Standard number one, as I mentioned, is the principal standard, and that frames the essential goal for all of the standards-- to provide effective, understandable, and respectful quality care and services that are responsive to diverse beliefs, practices, languages, health literacy, and communication.

So a few implementation strategies to helping achieve this standard would be really focused on acquiring knowledge about the cultures and languages spoken by your patients. So whether that's collecting data on cultural beliefs and practices, or collecting data on patient experience of care and the extent to which it addresses culture and language, these are ways in which you can help your organization to achieve the principle standard of the number one CLAS Standard.

With speaking specifically around HIV and AIDS, one example may be to collaborate with patients and their advocates to develop or update a glossary of terms for your providers. For those health centers that have not historically provided health services to populations with HIV and AIDS, working with your clients to develop a glossary of terms may be helpful for facilitating better communication between patients and providers. So terms such as slang terms for body parts. Different sexual behaviors. And then at the same time work with clients and providers to develop explanations of some of the more complex medical terms, such as how would you explain a phlebotomy or an x-ray to a patient that has low health literacy, and ensure that they understand what your provider is trying to convey.

So I think this is my last poll question before we get moving, rolling through the standards. So I'm asking this now, because we're about to get into the standards that really focus on service delivery. And so I would like to know for everyone on the webinar today, in what areas has your patient population changed under your P4C project? This is the question where you can actually click more than one option.

So if you've seen changes in either the ages of your patients as you have begun to expand your HIV services, in patient gender identity, sexual orientation, primary language, or racial or ethnic changes. That helps to give me an idea of examples that I might be able to bring up, but then also, I think, helps everyone get an idea of all of the different components that go into providing Culturally and Linguistically Appropriate Services.

So Steve, if you could launch the results. So it looks like two thirds of our participants today have seen a change in the sexual orientation of the patients that are receiving care at their health center. I also see changes in both age of patients gender identity-- and by gender identity, I mean whether patients identify as male, female, or transgender, or another gender option-- as well as race and ethnicity.

So you'll see when thinking about culture, only thinking about race or ethnicity is really not going to get to ensuring that the services that you're providing to your patients and that the environment that you are creating for them to have a safe and secure experience with delivery of health services. It needs to actually really take it to account all of these different areas of culture.

So at this point, we are going to move into the standards that focus on governance, leadership, and workforce. The second CLAS Standard speaks to advancing and sustaining governance in leadership that promotes Culturally and Linguistically Appropriate Services through policy, practice, and allocated resources. This is a new standard that resulted from the enhancement

initiative in 2013 and was added to underscore that CLAS must permeate every aspect of the organization, from the top down and from the bottom up.

So historically, efforts and activities that focus on cultural and linguistic competence have been a grass roots strategy, or have actually been developed through front line staff. However, it's the organizations leadership that establishes the culture of the organization through it's priorities, expectations, and the behavior that it models, and through designing service delivery processes and expectations.

So a few implementation strategies on achieving standard number two are on the screen right now. I wanted to ensure that culturally competent care is reflected in the vision, goals, and missions of the organization. Another is to work with developing informed and committed champions for cultural and linguistic competence, and that should be throughout the organization. So champions should not only be with the front staff but also the leadership-- the C-suite, as it may be-- through providers as well as through administrative staff.

And then suggestions or recommendations to develop and actively promote a culture and linguistic competence plan. And I can provide additional resources on developing this type of plan. Following the presentation they'll be posted to the P4C website. But all of these sort of implementation strategies focus on providing the fiscal or the human resource or the knowledge tools to support a culturally and competent organization.

So standard number three focuses on developing a diverse governance, workforce, and leadership in your organization. And by doing this, your organization can create an environment in which culturally diverse individuals, including those people living with HIV/AIDS, feel welcomed and valued, promote trust and engagement with the communities and populations that are being served, and help to increase the knowledge and experience related to culture and language among the staff.

So the first strategy that I have on the screen is to obtain patient feedback on preference for patient-provider concordance. So members of some groups, especially when talking about people that are living with HIV/AIDS, may not want others in their group to be aware of their HIV status. This can be of a particular concern if a number of your providers may be from the surrounding community. If your patients are not open about their HIV status or have not disclosed, then there may be some concerns, and they may not want to be served by certain staff from that group. And so being able to obtain patient feedback on that preference can be very helpful in being able to then match that preference to the degree that you can based on your staff demographics.

One of the second items that I wanted to focus on was around posting notices of job announcements in various forms, venues, and languages to increase the likelihood of attracting diverse applicants. Through our work with a number of your health centers, we've heard about some of the challenges with recruitment, staff recruitment, staff retention, engaging diverse staff, and so my recommendation would be to find out where the groups that you're looking to

engage access information and then utilize these sources. So that may be through websites for minority professional and service organizations, or newsletters of ethnic and HIV service associations, as well as associations or agencies that provide services to LGBT population.

Other strategies for achieving CLAS Standard three include creating benchmarks for diverse representation on your boards of directors. This standard speaks not only to the workforce or leadership but also to the governance of the organization. And to the extent possible, promote continuing education opportunities, whether that's through HIV certification or other opportunities for staff from diverse groups at your organization.

The fourth CLAS Standard, which is the last standard that focuses on governance, leadership, and workforce, speaks to the need to educate and train on culturally and linguistically appropriate policies and practices, and to do this on an ongoing basis. Strategies for achieving this standard would be to periodically query staff about their perceived learning needs around cultural and linguistic competence. This could be through annual evaluations. It could be through focus groups. It could be through having some other form or mechanism for staff to be able to provide information on what their learning needs are.

The third strategy on the screen focuses on providing cross- and discipline-specific training into cultural and linguistic competence. One of the key components of the P4C Project is the development of multi-disciplinary care teams. And so by promoting this sort of cross-discipline as well as discipline-specific training, you're enhancing that multi-disciplinary care team approach and ensuring that everyone on that team is receiving the same training and the same information around providing Cultural and Linguistically Appropriate Services to your patient population.

The fourth bullet-- and you can call it a shameless promotion. Some people may, some people may not-- would be to utilize internal and external resources to educate on cultural beliefs of clients and the target population. The HIV TAC has developed cultural competence curricula for health centers. We have done extensive training and work, and so reach out to us. We are here and able to support you, as well a number of other HIV TAC partners that we work with that may be [INAUDIBLE] funded TA providers, such as the National LGBT Health Education Center.

Those were the three standards they focused on governance, leadership, and workforce. At this point, we're going to move into the standards that focus on communication and language assistance. So the first standard that focuses on communication and language assistance speaks to actively offering language assistance to individuals who have limited English proficiency or other communication needs. And reiterating that this assistance is at no cost to them.

There are a number of strategies that I've indicated on this slide to help achieve this CLAS standard. The first would be to conduct an annual assessment of the languages that are spoken with in the targeted community. So if your health center is serving a broader community, then being able to understand what the language profile of that community looks like will help to ensure that you have services to meet the needs of the client, the potential patient population.

I did want to make a note to include data on people who are deaf or hard of hearing. Oftentimes when we talk about language services or interpretation or translation, we do not always think about the needs of the deaf or hard of hearing patient. And so ensuring that language services for ASL American Sign Language are available are very important. Another strategy is to ensure that the language access services include, as I mentioned, include sign language interpretation.

The last bullet is extremely important-- or I feel it's extremely important with speaking about providing services to patients to people living with HIV/AIDS or those at high risk, and that's to ensure that your medical orders, patient education, and health promotion resources are all translated into languages that are spoken by the patient population. For this translation, it is extremely important to include professional translators to ensure accuracy, paying particular attention to ensure accurate translation of HIV specific terms, such as viral load or anti-retrovirals, as well as other terms that are referring to behaviors and practices.

The National Center for Cultural Competence at Georgetown University has a guide to choosing and adapting cultural and linguistic competence in health promotion materials that provides more information. You can also potentially contact local developmental disability organizations for assistance with making materials available in Braille or in large print.

Standard number six speaks to the need to inform all of your patients around the availability of language assistance. So not just offering or having the services available, but actually how to inform that these types of services are available. Strategies would include posting signage in prominent locations, ensuring that staff provide both verbal and written notification of patients' rights. Making an assumption that patients, regardless of what their ability is to communicate verbally either in English or their language of choice, does not necessarily mean that they are as literate in terms of reading written notifications, so ensuring that those verbal and written notifications are made.

The third strategy is to develop a health promotion program that includes bilingual staff to train community members to share resources. I know a number of the health centers are working with community health workers or promotores to provide additional education and patient support, and so ensuring that that part of your multi-disciplinary team is bilingual if you are working with patient populations that are best served in languages other than English.

Standard number seven speaks to ensuring the competence of the individuals that are providing language assistance. And as you can see from the picture on the screen, there appears to be a medical provider that is speaking with an older woman and who potentially might be her grandson. The use of untrained individuals or minors as interpreters should be avoided at all costs if possible, and so we'll talk about strategies on being able to ensure the competence of individuals outside of minors or their family members.

So as I mentioned previously, the use of professional medical interpreters or trained and qualified bilingual or multilingual staff or volunteers is extremely important, specifically when

looking at a change, a potential change in your population or an expansion in your services. So if you were utilizing bilingual staff previously, but now you have more patients that are coming into your health center that are living with HIV/AIDS are at higher risk, the bilingual or multilingual staff that were previously working as interpreters for you may not be as well-versed about HIV and HIV terms, and so they may need additional training to support the needs of an expanded population living with HIV or AIDS.

There are instances where patients may come in that speak what I have on the slide here as a low incidence language. And so there are alternative options for either video or telephone interpreting technology that can be utilized to ensure that communication with these patients is effective. One way to do this in a lower resource utilization manner would be to develop relationships with local universities to engage language students as potential interpreters or translators.

So there are a number of strategies that I have in place to establish policy and specific procedures to assess the competency of those that are providing language services. So it's not only their proficiency in English as well as whatever the other language is, but their knowledge of health terms and key terms for HIV/AIDS and their comfortability with being able to explain that. So knowing the term for a particular sexual practice and being able to comfortably explain what that may mean is very different, and so competency is not only just the knowledge but also comfortability and ease with which the staff can explain some more complex or sexual practices or behaviors or medical procedures or medications. As well as their awareness of colloquialisms or slang that may be used by particular cultural groups that you have not historically served at your health center.

So the previous slide mentioned developing policies and procedures to assess competencies. This one speaks about strategies to assess quality of language access services. So that's really speaking to the patient and the providers around their satisfaction with the accuracy and the quality of the interpretation services received.

Down at the bottom, if you are utilizing contracts or outside interpreters, one suggestion would be to ensure that any contract that you have with partners or translation service providers include provisions for quality, especially if you are looking at translation of printed material so that if you get a printed material-- you test it with clients. The clients say this doesn't work. These terms don't translate correctly. The literacy level is not quite right-- that you do have provisions within your contract to go back to the service provider for the translation and have them make adjustments.

Standard eight speaks to providing print and multimedia materials as well as signage in languages that are commonly used by the population in your service area. So there are a number of implementation strategies on how your health center can do that. One is to focus on developing or adapting materials that address not only the language but also the literacy and health literacy of the population that are being served, and then test those with your client.

There are literacy and health literacy tools and strategies that are available. I've indicated a number of them underneath the third point on the slide, and so providing training to your staff or access to those literacy tools and strategies will enhance your ability to meet this class standard.

Another strategy is to design alternative approaches to providing information to those patients who may neither be literate in English nor their language of origin. So as an example, for anyone that was at the annual Partners Meeting in May and was able to view the app that was developed by one of your partner health-- one of P4C health centers-- the app is an educational app for patients that provides information on HIV and the need for HIV testing. The app does not have any written words on it. It is a visual, graphical video that has voice over.

That is an alternative approach to being able to provide information that does not assume that your patient would be able to read a brochure that you give to them. So that was just one example as I was going through this, and I thought of that specific example. That is a way to make a patient more comfortable with understanding and receiving that information.

So this is the last standard that focuses on communication and language assistance. At the end of the presentation, I have a slide that includes a number of resources. One of the resources I want to mention now is the guide to providing effective communication and language assistance.

This is an online guide that was developed by Think Cultural Health, which is the initiative underneath LMH that supports the CLAS Standards. And the guide provides strategies for communicating in a way that considers the cultural health, literacy, and language needs of your patients and their family. The guide's set up into two different tracks.

So one track is focused more on health care administrators, and that has information on planning, implementing, and evaluating communication and language assistance services. The second track in the guide is focused on the health care providers, those people that are providing direct services or direct care to your patients, and that provides informational cross-cultural communication skills, working with an interpreter, and a number of other areas, looking at ways to enhance effective communication with your patients. And so I wanted to mention that now, but there will be a link to the Think Cultural Health website at the end of the presentation.

We are now moving into the final set of standards, and those are the CLAS standards that focus on engagement, continuous improvement, and accountability. So standard number nine speaks to ensuring that you establish goals, policies, and management accountability that are culturally and linguistically appropriate, and that those things are infused in organization's planning and operations. So this really speaks to how you integrate the expectation, and how your agency hopes to achieve cultural and linguistic appropriateness for their services and integrate that into strategic planning as an organization, being able to involve consumers and the

development of that strategic plan, and then ensuring that the plan includes some sort of work group or team that's responsible for cultural and linguistically competent care.

So ways to involve consumers and their family in doing this is maybe around discussing how to handle topics such as homophobia or how to discuss the use of complimentary medicine. In providing services to patients that are living with HIV/AIDS, there may be certain patient populations that are really looking at complementing traditional medical care with complementary medicine or complementary healing practices. And how does your organization address those things? How do you address that conversation? How do you prepare your providers to initiate that conversation with their patient?

Standard number 10 focuses on ongoing assessment of the organization's activities related to Culturally and Linguistically Appropriate Services, and then how it's integrated into your continuous quality improvement activities as an organization. Potential implementation strategies would be to establish specific resources as available. As available. I know resources are tight-- but establish specific resources to plan to and conduct CLAS-related self-assessment activity.

The National Center for Cultural Competence at Georgetown has a number of tools and instruments and processes to assist organizations with assessing cultural and linguistic competence at both the individual provider level, as well as at the organizational level. And so there is not a need to develop these tools. They are in existence, and they can be extremely helpful for planning, and as I mentioned, continuous quality improvement of service provision at the health centers.

The other key take away I wanted to mention here is to assign a senior staff member to ensure that this work gets done, and that this work is important and that this work is taken seriously by the leadership, by the providers, by the front line staff, and by the administrative staff at your health center. Other strategies for implementing standard number 10 would be to assess the standard of care provided across multiple departments. As I mentioned earlier, the P4C Project is set up to provide services to multi-disciplinary care teams, and so looking across departments to ensure that services are uniformly appropriate and that providers in each department that are interacting with your patients that are living with HIV or that are at high risk are all trained and are equally and uniformly providing Culturally and Linguistically Appropriate Services.

Also, with all of this data collection and assessment, make sure that you share your findings with staff. Patients, staff board members, partners are much more interested in providing information to you on services if they then understand what your findings are. And then how to utilize those findings and integrate them, and what their implications are for policy, practice, and community engagement moving forward.

Standard number 11 focuses on collecting and maintaining accurate demographic data so that you can monitor and evaluate the impact of cultural and linguistically appropriate services on health equity and outcomes, and also to inform service delivery. So one of the implementation

strategies which I know many of you-- just about everyone is doing to a certain degree based on the UDS requirements-- is to include fields in the client record that collect data on race, ethnicity, and language. So while UDS does not require specific language data reporting to HRSA, including fields in your EMR on the client's primary language-- written language, spoken language, and/or sign language-- and then their preferred language for service delivery can be invaluable in ensuring effective patient care.

One of the pieces that is not noted on here but I realized after I develop these slides was around including fields in the client record on gender identity. Based on the UDS manual that's available on the HRSA website, 2016 would be the first year that UDS specifically collects data on gender identity beyond male or female. And so making sure that your client records in your EMR are collecting data at that level, and then also understanding how your providers or whoever is collecting those data on determining gender identity is extremely important for ensuring that the data that you have are accurate and reflect the client's preferences.

Other strategies for achieving standard 12 focus on confidentiality, specifically when talking about populations that are impacted by HIV/AIDS. Stigma is so pervasive, and concerns about confidentiality, enforced or inadvertent disclosure can be very strong. There is never enough reassurance that you as health providers can give around patient health confidentiality. And so aside from the written forms and confidentiality and consent forms, having verbal assurances from multiple levels of providers from the physician to the medical assistant to the nurse to the phlebotomists that confidentiality is key and of utmost importance will enhance client engagement in and their comfort with receiving services at the health center.

Standard number 12 speaks to assessing community health assets and needs and then using those to plan and implement services to respond to the diversity of your patient population. One of the key implementation strategies would be to ensure that you have policies and procedures in place not only to monitor changes in or projections for HIV/AIDS in your service area, but then also looking at current or emerging demographic trends in the service area that your patients are coming from. So if there has been an influx or an increase in a specific immigrant population in your community, then that may speak to the need to diversify or expand language assistance services.

Also, if there have been changes in the service providers in your community-- let's say, for example, that an organization that previously provided services to the LGBT population has closed, they shuttered their doors-- that may speak to projecting or anticipating an increase in LGBT patients at your health center. And so that allows you to plan services, plan resources in advance of actual changes in the patient population. That's basically the second point, which is to analyze the data and then determine their implications for planning and evaluating services moving forward.

One of the other important strategies for regularly being able to assess community health needs and assets speaks to data sharing and how data are shared between your health center and your partner agencies, including the health department. And while often data sharing

agreements speak to clinical data. To the best of your ability be able to include cultural and linguistic data in your data sharing agreements. So that whether it is a source that are referring clients to your health center, or a partner that is providing services to your health center clients where you're referring out, that everyone will be as informed as possible around the cultural and linguistic needs of the patients that they're providing services to.

There is a resource at the bottom of the page-- the National Minority Quality Forum website provides epidemiological data based on zip code. So if you're interested in information, epidemiological information, or changes or trends in your community, that is one area of resource that you can utilize if you were not already aware of it.

Standard number 13 speaks to partnering with the community to design and implement and evaluate services to ensure cultural and linguistic appropriateness, and so there are a number of strategies here. One is to incorporate community and consumer participation, specifically in planning and evaluating services for people impacted by HIV and AIDS. Identify and collaborating with informal networks within the culturally diverse community to support people impacted by HIV/AIDS is key. There are often cultural gatekeepers that are sort of leaders of informal networks, and being able to identify them and collaborate with them to include their feedback and input as you develop and provide services and then evaluate how those services are received by your patients.

Standard number 14 speaks to conflict and grievance resolution processes, and ensuring that they are culturally and linguistically appropriate. Some of the strategies to achieve that specifically in working with HIV-- people that are living with HIV/AIDS are to provide cross-cultural communication training, including how to work with an interpreter. A potential reason for a grievance could be that a provider who is working with a patient that requires an interpreter is speaking at and looking at the interpreter as opposed to the patient when having the conversation. And so understanding and being able to train providers on how to work with interpreters, specifically with changing racial or ethnic populations, changing linguistic populations in your health center can be key to achieving more linguistically appropriate services.

The first bullet on this slide speaks to potentially considering using an ombudsperson, which is a very strange word and a hard word to say, but basically an independent third party who is knowledgeable of cultural and linguistic context and with services being delivered, as well as the populations that are served in the resolution of grievances for your patient population. When speaking with clients that are living with HIV/AIDS or at high risk, potentially identifying an ombudsperson that is also living with HIV/AIDS maybe extremely important, because they have a different perspective on interactions with-- or understanding of the medical care needs, the care needs or treatment needs of that population, and may be able to provide a new perspective while still independent in terms of resolving any grievances.

We are on to the last standard, which is standard 15. And standard 15 focuses on communicating your progress in implementing and sustaining CLAS to all stakeholders,

constituents, and the general public. So after all of this work that you've done with standards 1 through 14, being able to communicate what your organization is doing to ensure that the services that you're providing to your patient are culturally and linguistically appropriate can make an enormous difference in the engagement of your target community in the services provided at your health center.

During the readiness reviews that we conducted last year and through our continuing conversation with a number of the health centers, we've understood that there are health centers that may have been very well-known in the community for a certain type of service, but may not have been as well-known for being able to provide services to people living with HIV and AIDS. Or the health center may not necessarily be seen in the community as an organization that has provided services historically to a specific racial or ethnic population. And so taking the time to communicate what you have done and the work that you've done to increase the cultural and linguistic competence of your services tells the community that you're listening to their needs, and indicates to those patients that may need to be seen at a health center that your health center is a welcoming environment, and that your health center is an environment that values their culture, values their beliefs, and values their input and designing and engaging in health care delivery.

And so there are a number of strategies here on how to disseminate that information. Reports that may be tailored not only just for your staff, but to patients, to other community partners. If you have a multimedia display in your waiting area, you may be able to put up a slide or two or an infographic or a chart that talks about ways in which your organization is addressing cultural and linguistic competence.

For those that are working with multiple community partners, conducting joint forums to discuss the services provided and progress made, or engaging your community health workers or promotores to craft and deliver messages to the target population. We want the effort by your agency to increase the cultural and linguistic competence of your services.

I have come to the end of my thoughts at this point. That's been a lot of information I think that I've provided in the past hour. I did mention previously that there are a number of resources. Many of these resources I utilized to develop this presentation today. As I mentioned, Think Cultural Health is the initiative sponsored by the Office of Minority Health that promotes and supports the CLAS Standards.

The AETC National Multicultural Center website is still live. The website has not been updated since 2014, and that notice is made on the website, but there are a lot of invaluable resources around cultural competence and linguistic competence that may have utilities for your health center. Also, the Office of Minority Health Resource Center website, the National Center for Cultural Competence at Georgetown, and the National Minority Quality Forum.

At this point, I would like to thank everyone that has participated today and open up the floor to questions or comments.

STEVE LUCKABAUGH: OK. We have a few minutes here where we can take some questions. If you have a question, please enter it into the questions pane on the GoToWebinar toolbar, or you can raise your hand and I will un-mute you. We have one that says thank you.

KELLY WAGNER: I had a question for the participants today. What are some of the barriers that you may have encountered with changes in your target population since the implementation of your P4C Project? Because I know that through our discussions that cultural competence has come up a number of times in terms of either need for staff training or technical assistance, and so I would like to hear from anyone on what are some of those challenges that you may have experienced, as well as if you have been able to address them through specific resolutions. Please share those with the group.

STEVE LUCKABAUGH: OK, if you'd like to speak to that, please raise your hand and I will un-mute you.

KELLY WAGNER: Anyone?

STEVE LUCKABAUGH: Yeah. We have a question. Barriers sometimes include collecting demographic info accurately due to homelessness.

KELLY WAGNER: OK. So I"m going to actually ask a question back. So in which way would the barrier be demographic information outside of racial ethnic information? Would it be more sort of geographic demographic information?

STEVE LUCKABAUGH: OK. Defining service eligibility for our population.

KELLY WAGNER: Ah. OK. That I definitely see as being a barrier or challenge. And so at the moment, I probably don't have a strategy for how to actually address that.

However, I would say that if that continues to be a challenge that we can provide technical assistance and recommendations on ways to do that. I'm not sure where you're located, and so a lot of that has-- a lot of the recommendations or strategies may have to do with local requirements or other local resources that could be used to assess service eligibility for the population.

STEVE LUCKABAUGH: OK. Ina Dorsey has a question. You have your hand raised. I'm unmuting you now. Go ahead.

INA DORSEY: Hi. I'm just not able to access a lot of the information. I need the websites again that were on the previous page, and I was just having a hard time to come back to this question and answer. But thank you for the information. I'm here in Baltimore.

KELLY WAGNER: OK. You are more than welcome. And as we mentioned, we will provide-- these slides will be up on the P4C website, hopefully within about a week, week and a half, as

well as the recording. But you can send an e-mail to webinars@mayatech.com, which is who you got your registration information from, and we can send you these resources. But hopefully you can access these, and if you need to take a screenshot or write them down, you'll be able to do that.

INA DORSEY: OK. Thank you.

STEVE LUCKABAUGH: OK, any other questions, comments?

KELLY WAGNER: Well, if you have any other questions that you think of, if you are interested in more information or more specific technical assistance or training around your patient population changes and your patient population, how to further engage or better engage with them from a cultural and linguistic perspective, please do not hesitate to reach out to us at the P4C HIV TAC. There is the email addresses on the website, which is p4chivtac@mayatech.com.

You can also submit questions directly through the P4C website, which is p4chivtac.com. You can also contact your P4C liaison or coordinator, whether that's Chelsea White or Shelly Kowalczyk directly and speak to them around any means that you have regarding technical assistance or training at your health center or cultural or linguistic competence.

I would like to thank you all for your participation and time this afternoon. I know it's late on a Wednesday. Hump day. Hopefully, we're all over the hump at this point. And I look forward to speaking with you and interacting with you on future P4C trainings.

STEVE LUCKABAUGH: Take care everybody, and we'll see you next time.

KELLY WAGNER: Take care and happy holidays.