CONNECTICUT DEPARTMENT OF PUBLIC HEALTH

NATIONAL STANDARDS FOR CULTURALLY AND LINGUISTICALLY APPROPRIATE SERVICES IN HEALTH AND HEALTH CARE (CLAS STANDARDS)

BASELINE ASSESSMENT

Prepared by

Office of Health Equity

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SUMMARY

For over 15 years, the Connecticut Department of Public Health (DPH) has been actively conducting health equity activities, performing surveillance, and producing programs that address health disparities among Connecticut residents. Recent developments in federal law, such as the Patient Protection and Affordable Care Act of 2010 (ACA) and the reaffirmation of President Clinton's Executive Order 13166 of 2000 ("Improving Access to Services for Persons with Limited English Proficiency"), have highlighted the role equal access to health and healthcare plays in reducing health disparities and improving health outcomes for vulnerable and underserved populations.

In September 2013, the DPH Office of Multicultural Health (renamed the DPH Office of Health Equity in 2014) received the federal Office of Minority Health State Partnership Grant to Improve Minority Health (SPG). SPG objectives for 2013-2015 focus on the promotion and implementation of the National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care (CLAS Standards; see Appendix B). According to the federal Office of Minority Health, the CLAS Standards are intended to advance health equity, improve quality, and help eliminate health care disparities by providing a blueprint for individuals and health and health care organizations to implement culturally and linguistically appropriate services. DPH strategies to accomplish these tasks include: 1) conducting a baseline assessment of awareness and adoption of CLAS Standards in selected health and social service sites; 2) assessing barriers to adoption and implementation of CLAS Standards; and 3) developing educational materials and basic training on CLAS Standards for health workers in selected health and social service sites, including onsite presentations and workshops, electronic resources, and a web-based course.

In order to reflect the broader context for health equity activities in Connecticut, DPH Health Equity staff used mixed research methods to compile the information presented in this baseline assessment. These methods included compilation of archival data (e.g., policies, procedures, reports, laws, web pages, and other written communications), qualitative methods

(e.g., key informant interviews, guided discussions, listening sessions, and content analysis), and quantitative data from an agency-wide workforce survey**.**

The *CLAS Standards and Health Equity Activities Prior to 2013* section of this report discusses both the broader federal and state laws and policies affecting health equity and DPH activities related to CLAS Standards during recent years. The section on *CLAS Standards and Health Equity Activities 2013-2014* outlines CLAS-related activities conducted as a direct result of SPG initiatives. Analysis of data compiled for this assessment also revealed *Facilitating Factors to Adopting or Implementing the CLAS Standards* (which positively affect SPG CLAS-related efforts) and *Challenges to Adopting or Implementing the CLAS Standards* (which are perceived barriers to SPG CLAS-related efforts).

In light of the findings from this baseline assessment, the *Recommendations* section reflects on the breadth of work done at the federal, state and program levels, and proposes items for DPH to consider in its continuing efforts to adopt/implement CLAS Standards and to further health equity in Connecticut. These recommendations are to:

- Develop a formal *DPH Language Access Policy*, to be followed by a *DPH Language Access Plan* which will be a publicly-accessible, stand-alone plan consistent with Title VI of the Civil Rights Act, federal CLAS and other guidelines, and Title II of the Americans with Disabilities Act. This plan should delineate DPH practices and protocols staff should use when communicating with persons with limited English proficiency or other natural or artificial barriers to communication.
- Ensure an agency-wide mechanism to provide adequate budgets for telephonic interpretation and document translation by creating guidelines for establishing consistent availability of interpreter and translation services for vital DPH functions (such as the Public Health Hearing Office and the Office of Public Health Preparedness). Requests for funding interpretation and document translation should be included in all grant applications.
- Improve the "public face" of DPH by ensuring regular CLAS Standards training for all staff that interact with the public, including "8000-line" personnel, agency-contracted security guards for DPH facilities, and DPH staff in the field. This would also include compliance with CLAS and ADA Title II guidance for signage in public areas, and ensuring that CLAS

information is easily available on DPH websites, including the DPH Intranet. In addition, provide "I-Speak"[1] cards or other communication tools to staff in public areas, and train staff and agency-contracted security guards how to direct and/or assist clients with their use.

- Revise data collection instruments and databases to reflect ACA reporting requirements to comply with Section 4302 of the ACA.
- Support public health workforce development by providing CLAS Standards trainings in a variety of modalities, including: "how-to" guidance for telephonic interpretation and document translation services; webinar-style trainings posted to TRAIN-CT[2]; in-person trainings; formal CLAS Standards curriculum; and recommendations for monitoring performance of DPH human services contracts. Support workforce initiatives to recruit, promote, and support a diverse workforce that is responsive to the needs of the entire state population.
- Promote DPH intra-agency leadership on CLAS Standards and health equity by conducting periodic meetings with the Affirmative Action/Equal Employment Opportunity Manager, strategic planning, performance management, and workforce development staff, Public Health Hearing Office legal staff, and Office of Communications staff, to review the extent to which culturally and linguistically appropriate practices are integrated throughout DPH's planning and operations.
- Create performance measures for the State Health Improvement Plan (SHIP) by working with Public Health Systems Improvement staff to create performance measures for CLAS Standards-related objectives set forth in the SHIP. Continue to evaluate and compile DPH's successful strategies used to ensure access to public health services.
- Ensure community collaboration and outreach by working with state legislative commissions, state agencies, community-based organizations, and the Connecticut Multicultural Health Partnership in their efforts to assess the health needs of vulnerable and underserved communities, and to communicate DPH progress on CLAS Standards-related activities.

A. INTRODUCTION AND METHODS

Over the past 15 years, the Connecticut Department of Public Health (DPH) has supported several projects and initiatives that highlight health equity, the social determinants of health, and the reduction of health disparities. Since 1999, DPH has published a series of reports that address these issues: *Multicultural Health: The Health Status of Minority Groups in Connecticut* (1999), *Connecticut Women's Health* (2001), *Mortality and its Risk Factors in Connecticut 1989-1998* (2005), and *The 2009 Connecticut Health Disparities Report* (2009).[3]

Numerous other health equity efforts have been made at federal, state, agency and local levels. Two fundamental federal initiatives are: 1) the U.S. Department of Health and Human Services' (DHHS) *Healthy People 2020* [4], the nation's 10-year plan that sets goals for improving Americans' quality of life, health, and well-being; and 2) the federal Office of Minority Health's *National Partnership for Action to End Health Disparities*[5], which focuses on coordinating partnerships to increase the effectiveness of programs that target the elimination of health disparities. These two initiatives provide a basis for the federal Office of Minority Health State Partnership Grant to Improve Minority Health (SPG) 2013-2015, which was awarded to DPH's Office of Multicultural Health (renamed the DPH Office of Health Equity in 2014) on September 1, 2013 (grant no. MP-STT-10-001). In Connecticut, two organizations work on this project – the Office of Health Equity (OHE) and the Connecticut Multicultural Health Partnership (CMHP).[6]

The two-year SPG targets selected health and social service sites throughout the state for the promotion and implementation of the National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care (CLAS Standards). The target is to increase the number of organizations that adopt the CLAS Standards by 10 percent each year of the grant. Strategies to accomplish these objectives include: 1) baseline assessment using a survey, guided small-group discussions, key informant interviews, and archival data collection to assess awareness and adoption of CLAS Standards in selected health and social service sites; 2) an assessment of barriers to adoption and implementation of CLAS Standards; and 3) the development of educational materials and presentations for CLAS Standards training of health

workers in selected health and social service sites, using on-site presentations and workshops, and electronic resources such as a web-based course.

This document is a baseline assessment, representing one strategy to accomplish objectives related to CLAS Standards and health equity. It summarizes initiatives and the institutional contexts within DPH that relate to the CLAS Standards, both in the recent past and in current activities. The *CLAS Standards and Health Equity Activities Prior to 2013* section includes a brief overview of federal and state legislation, and a description of DPH activities related to CLAS Standards in recent years. The *CLAS Standards and Health Equity Activities 2013-2014* section covers those DPH activities related to CLAS Standards implemented during 2013-2014, including activities made possible by SPG funding. The section on *Facilitating Factors for Adopting or Implementing the CLAS Standards* reviews staff capacity and interest, administrative systems, and partnership activities which positively affect CLAS-related efforts at DPH. The *Challenges to Adopting or Implementing the CLAS Standards* section provides analysis of the difficulties that DPH may face in implementing CLAS Standards. The *Recommendations* section reflects on the breadth of the work done at the federal, state and program levels, and proposes items for DPH to consider in its continuing efforts to adopt/implement CLAS Standards and to further health equity in Connecticut.

In order to reflect the broader context for health equity activities in Connecticut, DPH Health Equity staff used mixed research methods to compile the information presented in this baseline assessment. These methods included compilation of archival data (e.g., policies, procedures, reports, laws, web pages, and other written communications), qualitative methods (e.g., key informant interviews, guided discussions, listening sessions, and content analysis), and quantitative data from an agency-wide workforce survey**.**

B. CLAS STANDARDS AND HEALTH EQUITY ACTIVITIES PRIOR TO 2013

1. CLAS Standards and Health Equity: Federal and State Policies, Laws, and Acts

The CLAS Standards (March 2001) and the Enhanced CLAS Standards (April 2013)[7] provide rationale, guidelines, and mandates for culturally competent and linguistically appropriate meaningful access to federally-funded health and health care services and programs. They address demographic changes in the United States, health disparities that are a result of a history of social and health inequities, and challenges for business and workplaces, particularly in health and health care organizations.

Federal and state laws, statutes, and policies form the bases for the CLAS Standards, DPH initiatives, and other nationwide health equity efforts. Title VI of the Civil Rights Act of 1964[8] provides the foundation for many anti-discrimination laws that directly affect CLAS Standards, and it forbids discrimination based on race, color or national origin in federally-funded programs and services. Executive Order 13166 of 2000 (reaffirmed in 2011),[9] directs federal agencies to undertake actions that shall provide meaningful access to their programs and services. Section 4302 of Patient Protection and Affordable Care Act of 2010 (ACA) provides for the "standardization, collection, analysis, and reporting of health disparities data,"[10] including race, ethnicity, sex, primary language, and disability status for all DHHS-supported population-based surveys and programs.

Section 504 of the Rehabilitation Act of 1973, the Americans with Disabilities Act (ADA) of 1990, and the Americans with Disabilities Act Amendments Act of 2008 (ADAAA),[11] provide, in part, for meaningful access to public entities, public accommodations, employment and federally-funded activities and services, and for administration of services or activities. Meaningful access under these Acts cover persons with limited English proficiency (LEP) and persons who may use alternate modes of communication (e.g., D/deaf[12] and hard-of-hearing individuals), and they provide support for the CLAS Standards for language access. Additionally, case law (e.g., *Lau v. Nichols*)[13] established that "national origin" discrimination (under Title VI) should be seen as "discrimination based on language," or as discrimination due to cultural or linguistic characteristics such as accent or fluency. Thus, language access provisions within the CLAS Standards are in conformance with legal mandates to provide equal access to services.

In 1998, the Connecticut State General Assembly Public Act No. 98-250 established the DPH Office of Multicultural Health, responsible for improving "the health of all Connecticut residents by eliminating differences in disease, disability and death rates among ethnic, racial and cultural populations."[14] More recently, House Bill 5537, signed into law by Governor Malloy on June 13, 2014 and effective October 1, 2014, established the Office of Health Equity (OHE) within DPH. The OHE replaced the former Office of Multicultural Health. The responsibility of the Office is "to improve the health of all Connecticut residents by working to eliminate differences in disease, disability and death rates among ethnic, racial and other population groups that are known to have adverse health status or outcomes. Such population groups may be based on race, ethnicity, age, gender, socioeconomic position, immigrant status, sexual minority status, language, disability, homelessness, mental illness or geographic area of residence."[15] These changes to the name and mission statement of the Office reflect federal and state initiatives that emphasize the principle of health as a human right and social good for all people, as well as recognition that Connecticut residents hold multiple social statuses that may predispose them to health inequities.

In 2008, Connecticut State General Assembly Public Act No. 08-171 established a State Commission on Health Equity, with the stated mission of "eliminating disparities in health status based on race, ethnicity and linguistic ability, and improving the quality of health for all of the state's residents."[16] On July 8, 2009, Connecticut began to require cultural competency continuing education for physicians as part of their licensing requirements (Public Act No. 09-232 Sec. 16), and in 2013, Connecticut began to require continuing education in cultural competency for licensed social workers, counselors and therapists (Public Act No. 13-76, June 12, 2013).[17] As of April 14, 2014, the Connecticut Senate was poised to take up the House-passed bill (H.B. No. 5385), which would require acute care hospitals in Connecticut to address interpretation and translation needs of patients in the hospital's service area. The Senate was unable to pass the bill during that session, and this language has not yet been incorporated into future legislative proposals or bills.

2. DPH CLAS Standards Related Activities Prior to Fiscal Year (FY) 2013

From 2011 to 2013, and again from 2013-2015, the OHE has been funded by the SPG in order to assist Connecticut's efforts to eliminate health disparities among its vulnerable populations. However, before and during this time, efforts have been undertaken by committed DPH staff to operationalize federal and state laws for the DPH workplace. This work has provided the context for the DPH policies and initiatives discussed below.

In order to cross-reference the CLAS Standards with DPH activities and policies, the relevant CLAS Standards are included in the narrative surrounded by brackets. In addition, a reference chart is included as Appendix C at the end of this document.

2.a. DPH Policies and Statements

DPH has instituted a number of health equity and CLAS-related policies and statements. While most do not explicitly mention the CLAS Standards, they all address the equitable provision of public health services. Most frequently mentioned is service equity and non-discrimination on the basis of race, ethnicity, and national origin. In addition, DPH's affirmative action and ADA provisions cover not only equitable service provision on the basis of physical or mental disabilities, but also communication differences (e.g., sign language interpreters). DPH policies include:

- DPH Health Equity Policy Statement (signed May 2012) [1, 2, 4, 15]
- DPH Agency Statement of Values and Ethics (created November 9, 2006) [4, 15]
- DPH Affirmative Action/Equal Employment Opportunity Policy Statement (signed July 30, 2014) [2, 3, 4, 9, 14]
- DPH Affirmative Action Contract Compliance Policy Statement (signed July 30, 2014) [2, 3, 4, 9, 14]
- DPH Internal Discrimination Complaint Procedure (created August 29, 2013) [14]
- DPH Non-Discrimination in the Provision of the Department of Public Health Programs and Services Statement (signed July 30, 2014) [1]
- DPH Americans with Disabilities Act Policy Statement (signed July 30, 2014) [1]

- DPH Statement re: Establishment of the DPH Health Equity Research, Evaluation & Policy Initiative (HEREPI) (revised September 4, 2013). HEREPI was created as part of agency realignment for strategic planning, and explicitly notes nondiscrimination clauses, as well as the CLAS Standards. [1, 2, 9, 11]

2.b. Enhancing the State Public Health Infrastructure

Since 2011, DPH has undertaken a series of initiatives and has received grants to enhance the state public health infrastructure with a focus on health equity. These initiatives and funds have supported DPH's readiness for national public health accreditation. The purpose of accreditation activities is, "to help public health departments assess their current capacity to carry out their 3 core functions and 10 essential services, and to guide them to become better by improving service, value, and public accountability"[18] with better health outcomes as a goal. DPH has responded to accreditation guidelines by: 1) creating a strategic plan for DPH; 2) conducting a state health assessment; and 3) developing a state health improvement plan.

i. DPH Strategic Planning. Since 2011, under the leadership of Commissioner Jewel Mullen, DPH has undertaken a strategic planning initiative with "Championing Health Equity" as one of the six goals of the plan. Under the direction of Dr. Margaret Hynes, staff-led work groups have been part of the strategic planning process, operating as five "Promoting Health Equity" teams: 1) Definitions; 2) Data and Surveillance; 3) CLAS Standards; 4) Staff Training; and 5) Partnerships. In December 2012, each work group completed a detailed report and set of recommendations for promoting and integrating concepts of health equity into the workplace. These reports were distributed to DPH leadership in January 2013. [2, 4 ,9, 15]

ii. State Health Assessment and State Health Improvement Plan. In 2012-2013, DPH conducted a comprehensive State Health Assessment (SHA)[19], and by 2014 had developed a State Health Improvement Plan (SHIP)[20] in collaboration with other state agencies and diverse organizations from across the state. These activities are consistent with DPH's mission and its mandated function as the lead agency for health planning in the state. The SHA and SHIP are closely aligned with the goals and objectives of Healthy People 2020 and the National Partnership for Action to End Health Disparities.

The SHA described the health status of Connecticut residents and identified resources that may be mobilized to address health issues. Based on findings from the SHA, the SHIP was developed to provide a roadmap for improving health and health equity in Connecticut over the current decade. The focus of the plan is on "health improvement through prevention, and the promotion of health equity based on age, sex, race, ethnicity, sexual orientation, geography, and social, economic, environmental, and behavioral determinants of health."[21] The planning process was led by DPH and carried out by the Connecticut Health Improvement Planning Coalition, a voluntary partnership of more than 100 individuals representing state, local, and tribal government agencies, community organizations and coalitions, businesses, hospitals and other healthcare providers, academic institutions, and consumers. In addition, the SHA/SHIP process served to increase the number of formal partnerships DPH has with Connecticut stakeholder groups. [4, 9, 10, 13, 15]

iii. Realignment of the DPH Office of Multicultural Health (now OHE). In June 2012, the DPH Office of Multicultural Health was moved from the DPH Planning Branch into the DPH Community Health & Prevention Section (CHAPS) under the umbrella of HEREPI. This realignment is consistent with federal Healthy People 2020 goals and objectives, National Partnership for Action to End Health Disparities goals and objectives, DPH strategic planning efforts, as well as with the health equity focus of the SHA and the SHIP. The changes to Connecticut statute in June 2014 to incorporate the new direction and name of the OHE further supported these realignment initiatives. [2, 4, 9, 15]

2.c. Revision of Human Services Contract Language

In 2009, all human services Purchase of Service (POS) contracts used by DPH were revised to include CLAS Standards-based language. This means that all human services POS contractors with DPH must provide culturally and linguistically appropriate services to clients and must have in place administrative policies that promote such services. DPH Personal Service Agreement (PSA) contracts also contain nondiscrimination clauses, but do not include the CLAS-Standards-based language. [1, 2, 4, 9, 15]

2.d. Document Translation Services (August 2013)

In August 2013, the DPH Office of Multicultural Health supported the translation of 16 documents into Spanish and Chinese for the DPH Environmental Health Section, which is composed of a number of programs that share a common goal of protecting public health and the environment. The Environmental Engineering, Food Protection, and Environmental and Occupational Health and Safety programs have identified specific guidance documents for translation, covering topics such as food safety and foodborne illnesses, clean-up following sewage back-ups, and controlling mold in residential properties. Each of these documents has a broad application to underserved populations, who will benefit from having this public health information more readily available to them. [1, 5, 7, 8]

2.e. DPH Communications Office Activities

The DPH Communications Office has provided guidance related to standardized formats for DPH documents and websites, and has offered recommendations for health literacy, language and cultural access program considerations. In the time leading up to the SPG:

- The Communications Office posted to the DPH Intranet webpage the link to the *State Contracting Portal for State-Approved Vendors for Interpretation and Translation*. This will provide an easy way for DPH staff to view state-approved vendors and their contracts. [5, 7, 8]
- The Communications Office added Google Translate buttons to DPH websites. Launched on June 11, 2013, this option is popular for providing the linguistic "gist" of a given site or web page. In addition, DPH now has the possibility to data-mine the web page hits for language use. [5, 8]
- On February 10, 2014, the Communications Office posted to the DPH Intranet site "Inside DPH" a series of documents comprising DPH's *Communications Guidance and Resources* for DPH employees to use as a reference when communicating with the public to promote our programs and activities. "Language and Cultural Access" links include the CLAS Standards, health literacy, and ADA accessibility-related information. [4]

2.f. DPH Web pages

Several DPH web pages specifically reference or discuss issues related to the CLAS Standards and language and cultural access to health and health care. The DPH Health Disparities web page includes publications and information for the public and providers, and regularly publishes health disparities-related data.[22] The OHE web page serves as the hub for information about health disparities events, networks and resources for the state. Other DPH program web pages include links to CLAS Standards or translations of selected health program information (e.g., Refugee and Immigrant Health Program web page, Office of Emergency Preparedness web page)[23]. [15]

2.g. DPH Office of Affirmative Action and Equal Employment Opportunity (AA/EEO)

In 2012, the State of Connecticut Department of Administrative Services conducted an ADA audit of DPH facilities and procedures. As part of this audit, the AA/EEO Office highlighted CLAS-related issues such as signage as items in need of improvement. In addition, the report identified the need for a DPH Communications Policy to help ensure that written materials would be accessible in various forms for persons with limited English proficiency and persons with sensory disabilities. The AA/EEO Manager convenes an Employee Advisory Committee which serves as a referral vehicle for staff with ADA concerns, questions, or complaints, including communications and cultural access issues. Finally, the AA/EEO Manager provides ongoing training for managers and staff on DPH AA/EEO policies and anti-discrimination laws.

2.h. Data Collection, Database Inventories, and Data Systems Quality Improvement (QI)

In 2007, as part of the two-year Connecticut Health Disparities Project funded by the Connecticut Health Foundation, DPH staff conducted a survey of major databases at DPH to determine if data collection practices complied with federal Office of Management and Budget standards for the collection of race and ethnicity data. The report presenting the survey results, *The Collection of Race, Ethnicity and Other Sociodemographic Data in Connecticut Department of Public Health Databases* [4, 11, 15], led to the publication and approval of DPH's *Policy on Collecting Sociodemographic Data* (September 2008). This Policy sets forth guidelines for the

use of a minimum standard for the collection of data on age, gender, ethnicity and race, and suggests "ideal" standards for additional categories including ancestry, geography, primary language and English proficiency, acculturation, and socioeconomic position. [4, 11, 15]

The 2009 Connecticut Health Disparities Report, the final product of the Connecticut Health Disparities Project, specifically addressed CLAS Standards, LEP populations, refugee and immigrant health concerns, and underserved populations. Subsequent DPH database inventories and compendia (2010, 2012) have not specifically addressed CLAS Standards or the collection of primary/preferred language data, but do continue to ask about race and ethnicity data collection. [4, 11, 15]

Since 2012, DPH has undertaken several QI initiatives, supported by federal ACA – Prevention and Public Health Funds, one of which (April 1, 2012 to November 30, 2012) included improving the collection of race, ethnicity, and other sociodemographic data in DPH databases, to be consistent with both DPH and federal standards. In practice, this project focused on the "minimum standards" set forth in the aforementioned DPH *Policy on Collecting Sociodemographic Data*, and did not explicitly measure or seek to improve preferred/ primary language data collection. This nine-month project, funded by the National Network of Public Health Institutes, was concluded in 2012. The QI project and other data collection monitoring efforts have now been institutionalized through an agency-wide, staff-led data collection QI committee, which held its first meeting in October 2013 (see below). This committee will review the aforementioned DPH *Policy on Collecting Sociodemographic Data* annually, in order to respond to new federal and state mandates and guidelines. [2, 4, 10, 11] Finally, a curriculum to train DPH data entry staff to correctly enter and interpret the DPH *Policy on Collecting Sociodemographic Data* was recently developed with the Yale Public Health Training Center. [1, 4, 9]

2.i. Health Equity QI Training

As part of a series of in-service QI events, DPH hosted a two-day Health Equity QI Training (September 11 and 12, 2012) for approximately 30 DPH staff from across the agency. A presentation entitled "Promoting Health Equity at DPH" was followed by didactic instruction

from a national leader in conjunction with a Public Health Foundation resource publication. A large part of the time was spent in a small group process utilizing the analysis tools presented. The attendees were assembled into four groups. Two groups responded to the question: "How can we incorporate health equity into our work each day at DPH?" and the two remaining groups responded to a second question: "What are the issues faced by DPH in implementing its health equity policy statement?" Results from these workgroups have been used to inform the ongoing efforts of DPH health equity initiatives. Some of the issues identified by work group members addressed CLAS Standards. [2, 4, 9, 10]

2.j. DPH Staff Training on Health Equity, Access to Health Care

While it is beyond the scope of this baseline report to cover every instance of staff training on topics of diversity, equity or health care access, all new DPH employees are required by state law to complete Diversity Training, and employees with supervisory duties are to attend a Sexual Harassment Awareness Prevention Training.

Many federally funded programs may have mandated trainings that include civil rights provisions. For example, as part of their program's federal grant, DPH staff in the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) must complete annual Office of Civil Rights Training, which includes Title VI and an LEP issues component. [4, 9, 10]

When time and resources have allowed, programs such as the Comprehensive Cancer Program (CCP) have conducted cultural competency training, arranged by staff members. In 2013, the DPH Deputy Commissioner and DPH Regulatory Services Branch Chief encouraged and supported all Regulatory Services Branch managers and supervisors to take part in a pilot of the joint Environmental Protection Agency-Office of Civil Rights online training module, components of which included issues with LEP populations. [4, 9, 10]

2.k. DPH Health Disparities Self-Assessment

In 2012, the Connecticut State Commission on Health Equity requested that each state agency conduct a *State Agency Health Disparities Self-Assessment* [4, 10, 12, 15]. From November 2012 to December 2012, a series of small-group conversations with and among 21

senior DPH staff was conducted. Assessment included the following domains: Awareness; Leadership; Health System and Life Experience; Cultural Competency; and Data, Research and Evaluation. The findings were analyzed and written up, and subsequently reviewed by other DPH staff. A total of 37 DPH staff participated in this assessment process, and the final report was released on February 7, 2013 [1, 3, 4, 5, 7, 10, 11, 13, 15]. In 2012, DPH also contributed to a Commission draft *Health Equity Project Report*, which included *"Health Equity Planning Impact Statements"* for each state agency.

2.l. Community Health Needs Assessments

Over the last several years, DPH has supported a number of community health needs assessments to inform health planning efforts for diverse communities. For example, Connecticut received the highly competitive federal Community Transformation Grant (CTG, 2011–2016), to support needs assessment in five rural counties. The CTG highlighted chronic disease prevention, with emphasis on reducing health disparities and inequities by transforming communities through policy, system, and environmental change. (Federal funding for CTG was discontinued in 2014). Other examples include: community needs assessments conducted by hospitals; Maternal, Infant, and Early Childhood Home Visiting Programs; providers contracting with the DPH HIV Prevention Program; and the Office of Health Care Access. DPH program staff often work with and support these efforts, providing funding, technical assistance, and using needs assessment findings to improve programs. [12]

2.m. Connecticut Multicultural Health Partnership Reports and Activities (2011-2013)

The OHE has also supported the work of the CMHP, a coalition of public and private partners working to develop and implement an action plan to identify and address health disparities and multicultural health issues. Membership currently has representation from health, education, government, academia, professional and business associations, health care providers, faith-based organizations, community-based organizations, and advocacy organizations. Currently there are about 350 community partner-members of the CMHP, and its stated focus for this grant cycle is to increase awareness and implementation of the CLAS

Standards and to develop systems to improve access to health care. Two reports completed by the CMHP in recent years with specific CLAS impact are: *Language Needs and Services of Local Health Districts and Community Health Centers* (June 2010), and *Assessing the CMHP's Progress in Strategic Planning and Implementation of the CLAS Standards* (April 2012).[24] [2, 10, 11, 12, 13, 15]

C. CLAS STANDARDS AND HEALTH EQUITY ACTIVITIES 2013-2014

Since October 1, 2013, DPH has undertaken specific activities designed to assist DPH staff and their grantees/ contractors with the adoption and implementation of CLAS Standards in everyday work. Separate agency-wide efforts related to strategic planning, national public health accreditation, championing health equity, addressing health disparities, and improved data collection and communications, have increased the visibility of SPG-funded activities during Grant Year 1. Health Equity staff have leveraged these existing agency initiatives to further advance SPG-funded activities. Accomplishments directly related to SPG funding, but supported by related agency initiatives, are described below.

1. <u>DPH Commissioner Letter of Support</u>

On November 25, 2013, DPH Commissioner Mullen sent a letter to all DPH staff indicating that, "As part of our DPH effort to champion health equity DPH has adopted the National Standards for Culturally & Linguistically Appropriate Services in Health and Health Care (CLAS Standards)." In this letter, Dr. Alison Stratton was formally named DPH CLAS Standards Coordinator. [1, 2, 4, 9, 15]

2. <u>DPH CLAS Standards Staff Workgroup Reconvened</u>

From September 16, 2013 to November 1, 2013, the DPH strategic planning health equity CLAS Standards staff workgroup was reconvened in order to: 1) conduct a review of other states' CLAS Standards resources; 2) draft DPH-specific CLAS Standards awareness survey questions; and 3) make further recommendations as needed. A review of other states' curricula

and self-assessment survey instruments was undertaken. [2, 9, 10] The committee created a set of draft survey questions, reviewed potential methodology, and made recommendations about DPH staff CLAS Standards awareness. The draft survey questions served as the basis for the five questions finalized for inclusion in an agency-wide workforce development survey (see item 4 below). [4, 10]

3. Human Services Contract Language Review (Fall 2013)

The DPH CLAS Standards strategic planning health equity staff workgroup reviewed DPH human services contract language, and confirmed earlier findings that POS contracts include CLAS Standards-based language, and PSA contracts include non-discrimination clauses. An important finding during the review was that many DPH program staff who help execute these contracts—and grantee agents who sign them—may not know or understand the reach or intent of this language. This signals the need for more training opportunities for DPH staff and external grantees/contractors. [1, 2, 4, 9, 10, 12, 13, 15]

4. DPH Workforce Development Survey and Inclusion of CLAS Standards Questions

During 2012-2014, an all-DPH Workforce Development Survey was developed by the Yale Public Health Training Center in cooperation with several DPH staff, including a separate "health equity" team from DPH. Yale University received funding for the development of this survey from the DHHS Health Resources and Services Administration. Five survey questions about DPH staff knowledge of CLAS Standards were incorporated into the demographic section of the survey. The survey was anonymous and voluntary, and was made available online to approximately 800 DPH staff in July 2014. There was an estimated response rate of 70% (N=510) to the survey overall.

Preliminary survey data suggest that 66.6% of respondents agree that "overall DPH is responsive to the health and health care needs of linguistically and culturally diverse populations we serve." When asked about one's own program, however, smaller percentages of staff agreed that data on language, and race and ethnicity are adequately collected by their programs (32.5% and 54.9%, respectively), and that language assistance and written materials

in languages commonly used by people served is available through their programs (57.2% and 64.6% respectively). These findings suggest that there is somewhat of a disjuncture between staff's impression of the agency's overall responsiveness to diverse populations – which is very positive – and the actual services provided to and data collected on diverse populations by their own specific programs – which is not viewed as positively. See Appendix D for the CLAS-related survey questions and results. [2, 4, 10]

5. Qualitative Research Methods

The DPH CLAS Standards Coordinator (hereafter, "the Coordinator") employed several qualitative methods to elicit DPH staff knowledge and experiences with the adoption and implementation of CLAS Standards, and to determine the need for and types of further training.

- The Coordinator conducted key informant interviews with supervisors and management staff from CCP, Tobacco Control, and the AA/EEO Office to better understand what were the issues, needs, and barriers to implementation of CLAS Standards within their programs, and for their outside grantees/partners. [4, 10]
- The CCP key informant interview led to the development of a discussion guide for a semi-structured group discussion about CLAS Standards and their implementation. On December 17, 2013, seven CCP staff (including the program director, health program assistants/grant managers, a nurse consultant, a fiscal liaison, an epidemiologist and administrative staff) participated in a guided small-group discussion. The Coordinator analyzed and compiled the findings, which will provide a basis for a CLAS Standards curriculum (further described in item 6 below) designed specifically for these staff and their outside contractors/grantees. [4, 10]
- The Coordinator conducted a listening session on March 3, 2014 with three DPH Grants and Contracts staff, which provided further important information about awareness and implementation of CLAS Standards within DPH as it pertains to compliance and accountability for grantees and DPH staff alike. Further key informant interviews and guided small-group discussions with other DPH staff will provide needed contextual information

that will make any subsequent training better tailored to the needs of the DPH staff and their community partners/grantees. [4, 10]

- The Coordinator collected qualitative data during these discussions and during "CLAS 101" presentations (described in item 6 below). Staff had many questions and expressed curiosity and anxiety about implementing the standards. For example, staff wondered about their role(s) in monitoring contractors' compliance with CLAS Standards and with DPH human services contracts, and what that would mean for workload and already-stretched resources. Staff noted that they would need training on how to use a telephonic interpreter and did not know that each program has to set up individual accounts for interpreter services using state-approved vendors. Management staff wondered who had responsibility or "ownership" of agency-wide language access plans and interpretation funds. There was general concern about requesting funding for interpretation and translation in grant applications when federal funding was felt to be stretched thin. Another staff member reported that the statewide computer and systems technology agency had mentioned that they were "too busy" to implement ADA and CLAS accommodations. Finally, one staff member noted that staff may fear "a cascading effect" of having something properly interpreted or translated—that if one person received these services, then "people would expect it" all the time. [4, 10]

6. <u>Development of Curricula, Training and Educational Materials</u>

Development of educational and training materials is crucial to further the adoption and implementation of CLAS Standards by both DPH staff and their partners/grantees. Indeed, these materials are acting as both training *and* baseline assessment tools, since so few DPH staff have heard of the CLAS Standards until recently. These training sessions also take the form of "train the trainer" opportunities, as DPH staff may take their newly-acquired CLAS standards knowledge and help their programs' vendors and grantees to improve outreach and access for their service populations. Several in-person, on-site, and electronic material development initiatives are underway, directly as a result of the SPG [1, 4]

- The Coordinator developed and presented "CLAS 101," an introduction and practical approach to the CLAS Standards, with accompanying handouts (e.g., list of CLAS Standards,

Federal Register "four-factor analysis" guideline document,[25] and CLAS-related DPH Purchase of Service contract language[26]). These presentations serve as semi-formal arenas within which to ask questions and share knowledge about the CLAS Standards. Most staff have been unaware of the content and scope of the CLAS Standards, although they may be familiar with concepts such as "cultural diversity" or "cultural competence." Enthusiastically received, these presentations have led to further conversations about more in-depth training as well as incorporation of CLAS Standards into DPH's organizational structures and processes. In addition, the Coordinator has collected comments by presentation attendees for further documentation of the need for training and clarification at DPH of CLAS Standards. [1, 4]. To date, the Coordinator has conducted the following presentations:

  - January 28, 2014: At the invitation of the DPH Commissioner, an in-person PowerPoint presentation to the Commissioner's meeting of Branch Chiefs (14 people).
  - March 7, 2014: At the invitation of the Chief of Administration, an in-person presentation to all DPH Grants and Contracts staff (20 people).
  - April 10, 2014: At the invitation of the Director of Public Health Systems Improvement Office (PHSI), an in-person presentation to the PHSI staff, who assist with implementation of the SHIP and other QI initiatives (5 people).
  - May 19, 2014: At the invitation of the Section Chief for Regulatory Services, a webinar presentation to staff of the Office of Local Health Administration and to local health directors (46 people).
  - June 11, 2014: At the invitation of the AA/EEO Manager, an in-person presentation to the members of the DPH Employee Advisory Committee (6 people).
  - September 4, 2014: At the invitation of the Section Chief for CHAPS, an in-person PowerPoint presentation to all CHAPS staff (47 people).
  - September 18, 2014: At the invitation of the Epidemiology and Emerging Infections Program Co-coordinator, an in-person presentation to the Epidemiology and Emerging Infections and the Healthcare Associated Infections Programs (20 people).

- As a direct result of SPG funding, the OHE has been able to purchase a video of civil rights attorney Bruce Adelson's webinar, "The Legal Case for CLAS." The OHE is now in the

process of converting the webinar to an accessible format in order to post it to TRAIN-CT, the public health training website for Connecticut. Additionally, the "CLAS 101" presentation mentioned above will be converted to a webinar-style format and will be posted to the TRAIN-CT system. Plans are also underway for the production of a short, practical guide about "How to Use Telephonic Interpreters," to be posted to TRAIN-CT.[4, 9]

- The University of Connecticut Health Center and DPH Health Equity staff are collaborating on a series of key informant interviews and guided discussions with CCP contractors/ grantees about understanding and implementing CLAS Standards. These contractors/grantees include employees and volunteers of non-profit community organizations, hospitals, and community health centers. Types of staff include health care providers, patient navigators, nurses, grant administrators, and administrative staff. These qualitative data will be analyzed and incorporated into a CLAS Standards curriculum to be delivered to CCP staff and their contractor-grantees. Plans include conversion of the curriculum to a webinar-style format and posting to TRAIN-CT. [4, 9]
- At the invitation of the Connecticut Public Health Association, the Coordinator will be a panelist for the topic, "Public Policy and the Equity Agenda" at the Association's annual meeting on October 17, 2014.
- At the invitation of the CCP Coordinator, an in-person PowerPoint presentation to the CCP annual grantee meeting on October 14, 2014 (approximately 40-50 people).

7. Document Translation Activities (September 2013-present)

As a direct result of SPG funding, the OHE has been able to invite all DPH programs to apply for the translation of vital program documents that directly reach community members, patients, clients, and grantees of DPH. Approximately $23,400 has been set aside for document translation during the two-year grant period. Health Equity staff identified state-approved vendors, and created the processes for application, ranking, and evaluation. In the first round of applications, the DPH Public Health Hearing Office and the WIC Program had documents translated into at least eight of their most important languages, and the Environmental and Occupational Health Program had a public service announcement script translated into Spanish

for radio messaging about carbon monoxide poisoning. The second round of applications included translations for the Hepatitis C, Diabetes, and Tuberculosis Programs, and the third round included translations for WIC's Vendor Management Unit, and from the Immunizations, Diabetes, and Environmental Health programs. [1, 5, 6, 8]

8. State Agency Meetings

The OHE will hold one state agency sharing session each grant year so that key state social services agencies may compare experiences and best practices related to adopting and implementing CLAS Standards at their agencies and with their contractors. The first meeting was held on August 27, 2014 and was hosted at DPH. Invited state agencies included: the Departments of Correction, Mental Health and Addiction Services, Developmental Services, Social Services, and Energy and Environmental Protection as well as the Office of the Healthcare Advocate. [1, 2, 4, 13, 15]

9. DPH Standing Committee for Implementation of Federal Data Collection Standards

As mentioned above, this Standing Committee was convened on October 1, 2013, in response to recommendations from the 2011-2012 DPH QI Project. This is an agency-wide, staff-led data collection QI committee, meeting quarterly, which will monitor the data collection compliance of most key DPH databases, and will review the aforementioned DPH *Policy on Collecting Sociodemographic Data* annually, in order to respond to new federal and state mandates and guidelines. The DPH Health Equity Director founded and co-chairs this committee, and the Health Equity Epidemiologist is a participating committee member. The Coordinator was invited to be a member of this committee, and is working to ensure that "primary language" or "preferred language" is included as a "minimum standard" in a revised DPH *Policy on Collecting Sociodemographic Data*, so that DPH data collection instruments, data entry processes, and databases may be in compliance with CLAS Standards. [2, 4, 10, 11]

10. DPH Staff Participation in Johns Hopkins CLAS Standards Training

In the spring of 2014, the State Commission on Health Equity contracted with Johns Hopkins Bloomberg School of Public Health, Hopkins Center for Health Disparities Solutions for a four-part training series on CLAS Standards. To date, three of the four workshops have been facilitated. Health Equity and other DPH staff attended, including staff from DPH's AA/EEO Office, Public Health Hearing Office, PHSI Office, and representatives from the CMHP. [4, 10]

11. Systems Change Reflected in Grant Applications

As a direct result of conversations and collaborations between the DPH CLAS Standards Coordinator and the DPH Asthma Program Evaluator, the Program's recent successful application for their program's five-year federal grant included CLAS Standards training, monitoring, and self-assessment for both DPH Asthma Program staff and their outside grantees. In addition, both the federal Office of Refugee Resettlement Refugee Health Promotion grant and the federal Tuberculosis Elimination and Laboratory Cooperative Agreement application required explicit discussion of CLAS Standards. [9]

D. FACILITATING FACTORS FOR ADOPTING OR IMPLEMENTING THE CLAS STANDARDS

DPH has many strengths that have led to success in the promotion and implementation of the CLAS Standards over the years. Staff interest and recent revisions to administrative policies and practices have laid the foundation for targeted CLAS Standards work. This section outlines the thematic areas of strength within DPH.

1. OHE Funding/Staff Resources

From September 2013 through August 2014, there were three full-time equivalent (FTE) state-funded staff, one .20 FTE Coordinator, and one 0.50 FTE Directors of Health Promotion and Education Health Equity and Policy Fellow who worked on the DPH health equity initiative, and thus contributed to the promotion and implementation of the CLAS Standards.

2. Staff Support and Health Equity/CLAS Standards Champions

Strong staff support exists in various sections of DPH to carry out the objectives of the grant. This includes support from the AA/EEO Manager, the Communications Director, the Public Health Hearing Office, the Strategic Planning team, at least three section chiefs, and the Commissioner's Office. There were a variety of staff efforts prior to the SPG which promoted the CLAS Standards, such as the addition of Google Translate buttons to the DPH website, Affirmative Action/equal opportunity policy initiatives, ADA and ADAAA training, and Title VI and cultural competency trainings.

3. DPH Leadership and Administrative Activities

A variety of DPH efforts already in place support the promotion and implementation of CLAS Standards. They include public health accreditation activities, strategic planning (Goal 6: Championing Health Equity), and SHA and SHIP activities. DPH is a member of the Association of State and Territorial Health Officials, which strongly encourages health equity efforts across all programmatic initiatives.

4. CLAS-Related DPH Human Services Contract Language

Since 2009, all POS contracts at DPH have included clearly delineated language that requires contractors to conduct service activities in a culturally and linguistically competent manner. Such contract language is a critical tool that may be used to monitor and encourage the provision of culturally and linguistically appropriate services from health care and community-based organizations.

5. Governmental Structures

As noted above, the State Commission on Health Equity works to promote policies and legislation to improve the health outcomes of residents based on race, ethnicity, gender and linguistic ability. Other state legislative Commissions (e.g., African-American Affairs Commission, Asian Pacific American Affairs Commission, Commission on Aging, Latino and

Puerto Rican Affairs Commission, and the Permanent Commission on the Status of Women) are allies at the state legislative level which promote activities and policies to eliminate health disparities, and help to promote the CLAS Standards. Connecticut state laws that require continuing education in cultural competency for health care providers are yet another way to promote the critical importance of culturally and linguistically appropriate service provision.

Finally, Health Equity staff participate with representatives from other states and regions on health equity issues through teleconference meetings with State Offices of Minority Health representatives, New England State Offices of Minority Health directors, and All Regions Health Equity Council members. Health Equity staff have also participated in conference calls and in-person meetings of the Region I New England Regional Health Equity Council. Each of these partner groups supports strategic planning and coordination related to achieving health equity, promoting and implementing evidence-based approaches, implementing programs to address priority minority health problems, and disseminating and sharing information focused on achieving health equity.

6. Other Federal Funding Sources

Other federal funding sources have been leveraged to support CLAS Standards. For example, in FY 2013-2014, U.S. Preventive Health & Health Services Block Grant funds were used to support curriculum development for staff and community partners for both the CLAS Standards (for the CCP) and for the collection of race, ethnicity, and other sociodemographic data. These funds amounted to approximately $50,000.

E. CHALLENGES TO ADOPTING OR IMPLEMENTING THE CLAS STANDARDS

While DPH has many strengths that have led to success in the promotion and implementation of the CLAS Standards over the years, many challenges remain. This section outlines the main areas of concern.

1. Data Collection and Database Parameters

The CLAS Standards and Section 4302 of the ACA recommend that certain sociodemographic data be collected on clients, in order to better understand and appropriately serve the service population, and to properly allocate resources. However, many DPH databases use systems, templates and/or software provided by federal agencies—many of which are not in compliance with the federal sociodemographic data collection guidelines established by the federal Office of Management and Budget. In addition, many primary data sources are not in compliance with federal guidelines when they supply data to DPH, and may require assistance to reach this goal. This is a large, resource-heavy, systemic challenge for DPH, which includes updating data collection instruments, training staff, and working on interactions between federal and state data reporting requirements.

2. DPH Staff Unfamiliarity with CLAS Standards

Recent qualitative data have shown that many DPH staff do not know what the CLAS Standards are. And many people who *do* know, still do not know how to implement them in their daily work. When this is the case, DPH staff will not be able to train contractors/grantees about implementing CLAS Standards in the field. In addition, DPH staff will be unable to appropriately monitor human services contracts which call for cultural and linguistic competence in the delivery of contracted services.

3. Interpretation and Translation

In general, there is a lack of awareness of the importance and benefits of interpretation and translation services among DPH staff. Many DPH staff members interact with the public and with program clientele, either in person or during telephone communications. However, many staff have never heard of telephonic interpretation, and/or do not know how to use it. In addition, staff do not know the mechanisms for contracting with interpretation or translation vendors. Health Equity staff also have found that, when applying for grants, many DPH programs do not set aside funds for interpretation and translation—even when the grant targets LEP clients.

4. Public Face of DPH

While a number of activities are being undertaken to improve DPH public spaces, attention has only recently turned to appropriate or engaging bilingual signage in public areas. Until recently, Spanish language messaging was confined to statewide weapons-ban signage posted in public entrances and lobbies, small messages for practitioner licensing drop boxes, and Vital Records procedural signage. While directional signage was ADA-compliant on basement and first floors of the DPH building complex at 410-450 Capitol Avenue in Hartford, CT, ADA-compliant signage was not present in public areas of the second and third floors of the building.

As far as Health Equity staff can determine, agency-contracted security guards for DPH facilities have not been trained in the CLAS Standards, and do not have the tools for directing persons with limited English proficiency in languages other than Spanish. In addition, DPH's "8000-line" main reference phone number operators appear not to have been trained in the CLAS Standards, and also may not know how to appropriately assist persons with limited English proficiency.

F. CONCLUSION AND RECOMMENDATIONS

For years, DPH has been actively conducting health equity activities, and has supported several projects and initiatives that address health disparities among Connecticut residents. The federal SPG, awarded to the DPH Office of Multicultural Health effective September 1, 2013 has focused on the promotion and implementation of the CLAS Standards. This baseline document has highlighted the policies and products of dedicated health equity champions, and has outlined the challenges DPH and Connecticut health and health care organizations still face in order that every resident have equal access to health and health care. DPH leadership–and increasingly, rank-and-file staff—recognize that the adoption and implementation of the CLAS Standards are important to state public health systems improvement, accreditation processes, social justice, and compliance with civil rights law. Below, DPH offers recommendations for building on the legacy of hard work in the area of health equity, focusing on this baseline assessment of CLAS Standards-related activities.

1. Develop a formal *DPH Language Access Policy*, to be followed by a *DPH Language Access Plan* which will be a publicly-accessible, stand-alone plan consistent with Title VI of the Civil Rights Act, federal CLAS and other guidelines, and Title II of the ADA. [1,2] This plan should delineate DPH practices and protocols staff should use when communicating with persons with limited English proficiency or other natural or artificial barriers to communication.
2. Ensure an agency-wide mechanism to provide adequate budgets for telephonic interpretation and document translation by creating guidelines for establishing consistent availability of interpreter and translation services for vital DPH functions (such as the Public Health Hearing Office and the Office of Public Health Preparedness). Requests for funding interpretation and document translation should be included in all grant applications. [1,5,7]
3. Improve the "public face" of DPH by ensuring regular CLAS Standards training for all staff that interact with the public, including "8000-line" personnel, agency-contracted security guards for DPH facilities, and DPH staff in the field. [8] This would also include compliance with CLAS and ADA Title II guidance for signage in public areas, and ensuring that CLAS information is easily available on DPH websites, including the DPH Intranet. In addition, provide "I-Speak" cards or other communication tools to staff in public areas, and train staff and agency-contracted security guards how to direct and/or assist clients with their use.
4. Revise data collection instruments and databases to reflect ACA reporting requirements to comply with Section 4302 of the ACA. [11]
5. Support public health workforce development by providing CLAS Standards trainings in a variety of modalities, including: "how-to" guidance for telephonic interpretation and document translation services; webinar-style trainings posted to TRAIN-CT; in-person trainings; formal CLAS Standards curriculum; and recommendations for monitoring performance of DPH human services contracts. [14] Support workforce initiatives to

recruit, promote, and support a diverse workforce that is responsive to the needs of the entire state population. [3]

6. Promote DPH intra-agency leadership on CLAS Standards and health equity by conducting periodic meetings with the AA/EEO Manager, strategic planning, performance management, and workforce development staff, Public Health Hearing Office legal staff, and Office of Communications staff, to review the extent to which culturally and linguistically appropriate practices are integrated throughout DPH's planning and operations. [9]
7. Create performance measures for the SHIP by working with PHSI staff to create performance measures for CLAS Standards-related objectives set forth in the SHIP. Continue to evaluate and compile DPH's successful strategies used to ensure access to public health services. [10]
8. Ensure community collaboration and outreach by working with state legislative commissions, state agencies, and the CMHP in their efforts to assess the health needs of vulnerable and underserved communities, and to communicate DPH progress on CLAS Standards-related activities. [2, 13, 15]

APPENDIX A: List of Selected Acronyms

AA/EEO	Affirmative Action/Equal Employment Opportunity
ACA	The Patient Protection and Affordable Care Act (2010)
ADA	Americans with Disabilities Act (1990)
ADAAA	Americans with Disabilities Act Amendments Act (2008)
CCP	Comprehensive Cancer Program
CHAPS	Community Health and Prevention Section
CLAS; CLAS Standards	National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care
CMHP	Connecticut Multicultural Health Partnership
CTG	Community Transformation Grant
DHHS	United States Department of Health and Human Services
DPH	Connecticut Department of Public Health
FY	Fiscal year
HEREPI	DPH Health Equity Research, Evaluation & Policy Initiative
LEP	Limited English proficiency
OHE	Office of Health Equity (DPH)
PHSI	Public Health Systems Improvement
POS	Purchase of Service contract
PSA	Personal Service Agreement contract
QI	Quality Improvement
SHA	State Health Assessment
SHIP	State Health Improvement Plan
SPG	Office of Minority Health State Partnership Grant to Improve Minority Health
WIC	Special Supplemental Nutrition Program for Women, Infants, and Children

APPENDIX B: National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care

Principal Standard:
1. Provide effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs.
Governance, Leadership and Workforce:
2. Advance and sustain organizational governance and leadership that promotes CLAS and health equity through policy, practices, and allocated resources.
3. Recruit, promote, and support a culturally and linguistically diverse governance, leadership, and workforce that are responsive to the population in the service area.
4. Educate and train governance, leadership, and workforce in culturally and linguistically appropriate policies and practices on an ongoing basis.
Communication and Language Assistance:
5. Offer language assistance to individuals who have limited English proficiency and/or other communication needs, at no cost to them, to facilitate timely access to all health care and services.
6. Inform all individuals of the availability of language assistance services clearly and in their preferred language, verbally and in writing.
7. Ensure the competence of individuals providing language assistance, recognizing that the use of untrained individuals and/or minors as interpreters should be avoided.
8. Provide easy-to-understand print and multimedia materials and signage in the languages commonly used by the populations in the service area.
Engagement, Continuous Improvement, and Accountability:
9. Establish culturally and linguistically appropriate goals, policies, and management accountability, and infuse them throughout the organization's planning and operations.
10. Conduct ongoing assessments of the organization's CLAS-related activities and integrate CLAS-related measures into measurement and continuous quality improvement activities.
11. Collect and maintain accurate and reliable demographic data to monitor and evaluate the impact of CLAS on health equity and outcomes and to inform service delivery.

Engagement, Continuous Improvement, and Accountability:
12. Conduct regular assessments of community health assets and needs and use the results to plan and implement services that respond to the cultural and linguistic diversity of populations in the service area.
13. Partner with the community to design, implement, and evaluate policies, practices, and services to ensure cultural and linguistic appropriateness.
14. Create conflict and grievance resolution processes that are culturally and linguistically appropriate to identify, prevent, and resolve conflicts or complaints.
15. Communicate the organization's progress in implementing and sustaining CLAS to all stakeholders, constituents, and the general public.

From: U.S. Department of Health and Human Services, Office of Minority Health. Electronic document, accessed July 25, 2014. https://www.thinkculturalhealth.hhs.gov/Content/clas.asp.

APPENDIX C: DPH Activities Referencing Relevant CLAS Standard (in order found in text)

EXISTING DPH EFFORTS, CLAS STANDARDS AND LANGUAGE ACCESS INFO	RELEVANT CLAS STANDARD(S)
DPH HEALTH EQUITY POLICY STATEMENT	1, 2, 4, 15
DPH AGENCY STATEMENT OF VALUES AND ETHICS	4, 15
DPH AFFIRMATIVE ACTION/ EQUAL EMPLOYMENT OPPORTUNITY POLICY STATEMENT	2, 4, 3, 9, 14
DPH AFFIRMATIVE ACTION CONTRACT COMPLIANCE POLICY STATEMENT	2, 3, 4, 9, 14
DPH INTERNAL DISCRIMINATION COMPLAINT PROCEDURE	14
DPH NON-DISCRIMINATION IN THE PROVISION OF THE DEPARTMENT OF PUBLIC HEALTH PROGRAMS AND SERVICES STATEMENT	1
DPH AMERICANS WITH DISABILITIES ACT POLICY STATEMENT	1
DPH STATEMENT RE: ESTABLISHMENT OF THE DPH HEALTH EQUITY RESEARCH, EVALUATION & POLICY INITIATIVE	1, 2, 9, 11
DPH STRATEGIC PLANNING	2, 4, 9, 15
DPH STATE HEALTH ASSESSMENT	4, 9, 10, 15
DPH STATE HEALTH IMPROVEMENT PLAN	4, 9, 10, 13, 15
REALIGNMENT OF OFFICE OF MULTICULTURAL HEALTH	2, 4, 9, 15
REVISION OF HUMAN SERVICES CONTRACT LANGUAGE	1, 2, 4, 9, 15
DOCUMENT TRANSLATION SERVICES	1, 5, 7, 8
DPH COMMUNICATIONS OFFICE: POSTED STATE-APPROVED LIST OF INTERPRETATION AND TRANSLATION VENDORS ON DPH INTRANET WEBSITE	5, 7, 8
DPH COMMUNICATIONS OFFICE: ENABLED GOOGLE TRANSLATE BUTTONS FOR ENTIRE DPH WEBSITE	5, 8
DPH COMMUNICATIONS OFFICE: POSTED “DPH COMMUNICATION GUIDANCE AND RESOURCES” ON DPH INTRANET WEBSITE	4
DPH WEBSITES	15
DPH OFFICE OF AFFIRMATIVE ACTION AND EQUAL EMPLOYMENT OPPORTUNITY	1, 2, 4, 5, 6, 7, 8, 9, 14
COLLECTION OF RACE, ETHNICITY AND OTHER SOCIODEMOGRAPHIC DATA IN CT DPH DATABASES (2007)	4, 11, 15

EXISTING DPH EFFORTS, CLAS STANDARDS AND LANGUAGE ACCESS INFO	**RELEVANT CLAS STANDARD(S)**
DPH POLICY ON COLLECTING SOCIODEMOGRAPHIC DATA (SEPTEMBER 2008)	4, 11, 15
THE 2009 CT HEALTH DISPARITIES REPORT	4, 11, 15
DPH DATA QUALITY IMPROVEMENT PROJECT: NATIONAL NETWORK OF PUBLIC HEALTH INSTITUTES	2, 4, 10, 11
DPH DATA ENTRY CURRICULUM PROJECT	1, 4, 9
HEALTH EQUITY QUALITY IMPROVEMENT TRAINING (2012)	2, 4, 9, 10
DPH STAFF TRAINING ON HEALTH EQUITY, ACCESS TO HEALTH CARE	4, 9, 10
DPH HEALTH DISPARITIES SELF-ASSESSMENT (2012)	1, 3, 4, 5, 7, 10, 11, 13, 15
COMMUNITY HEALTH NEEDS ASSESSMENTS	12
CONNECTICUT MULTICULTURAL HEALTH PARTNERSHIP REPORTS AND ACTIVITIES (2011-2013)	2, 10, 11, 12, 13, 15

POST-SPG DPH EFFORTS REGARDING CLAS STANDARDS AND LANGUAGE ACCESS	**RELEVANT CLAS STANDARD(S)**
DPH COMMISSIONER LETTER OF SUPPORT	1, 2, 4, 9, 15
DPH CLAS STANDARDS WORKGROUP RECONVENED	2, 4, 9, 10
HUMAN SERVICES CONTRACT LANGUAGE REVIEW (Fall 2013)	1, 2, 4, 9, 10, 12, 13, 15
DPH WORKFORCE DEVELOPMENT SURVEY AND INCLUSION OF CLAS STANDARDS QUESTIONS	2, 4, 10
KEY INFORMANT INTERVIEWS	4, 10
SEMI-STRUCTURED GROUP DISCUSSIONS	4, 10
LISTENING SESSIONS	4, 10
QUALITATIVE DATA COLLECTION: CLAS 101 SESSIONS	4, 10
CLAS 101 PRESENTATIONS FOR DPH STAFF AND CONTRACTORS/GRANTEES	1, 4
BRUCE ADELSON WEBINAR POSTED ON TRAIN-CT	4, 9
UNIVERSITY OF CONNECTICUT HEALTH CENTER-DPH COLLABORATION ON CLAS STANDARDS CURRICULUM FOR COMPREHENSIVE CANCER PROGRAM STAFF AND CONTRACTOR-GRANTEES	4, 9
DOCUMENT TRANSLATION ACTIVITIES	1, 5, 6, 8
STATE AGENCY MEETINGS	1, 2, 4, 13, 15

POST-SPG DPH EFFORTS REGARDING CLAS STANDARDS AND LANGUAGE ACCESS	**RELEVANT CLAS STANDARD(S)**
DPH STANDING COMMITTEE FOR IMPLEMENTATION OF FEDERAL DATA COLLECTION STANDARDS	2, 4, 10, 11
DPH STAFF PARTICIPATION IN JOHNS HOPKINS CLAS STANDARDS TRAINING	4, 10
SYSTEMS CHANGE REFLECTED IN DPH GRANT APPLICATIONS	9

APPENDIX D: Connecticut DPH Workforce Development Survey, July 2013: Responses to Survey Questions on Culturally and Linguistically Appropriate Services [(a)]

1. My program or unit provides free language assistance services to people we serve (including members of the public) who do not speak English well.

Response	N	Adjusted Percent
Strongly Agree	59	15.8
Agree	155	41.4
Disagree	56	15.0
Strongly Disagree	40	10.7
Don't Know	64	17.1
Not Applicable	136	___
Total	**510**	**100**

2. My program or unit provides written materials in languages commonly used by people we serve (including members of the public).

Response	N	Adjusted Percent
Strongly Agree	75	18.9
Agree	181	45.7
Disagree	58	14.6
Strongly Disagree	29	7.3
Don't Know	53	13.4
Not Applicable	114	___
Total	**510**	**100**

3. My program or unit collects and maintains data from people we serve (including members of the public) about their preferred language.

Response	N	Adjusted Percent
Strongly Agree	40	10.5
Agree	84	22.0
Disagree	94	24.6
Strongly Disagree	63	16.5
Don't Know	101	26.4
Not Applicable	128	___
Total	**510**	**100**

4. My program or unit collects and maintains data from people we serve (including members of the public) about their race and ethnicity.

Response	N	Adjusted Percent
Strongly Agree	112	26.3
Agree	106	24.9
Disagree	49	11.5
Strongly Disagree	46	10.8
Don't Know	84	19.7
Not Applicable	113	___
Total	**510**	**100**

5. Overall, DPH is responsive to the health and health care needs of linguistically and culturally diverse populations we serve.

Response	N	Percent
Strongly Agree	95	18.6
Agree	245	48.0
Disagree	51	10.0
Strongly Disagree	18	3.5
Don't Know	101	19.8
Total	**510**	**100**

(a) Due to rounding, percentages may not add up to 100.

ENDNOTES

[1] "I-Speak" cards or posters are language identification tools that persons with limited English proficiency may use to let others know that they need an interpreter in their preferred language.
[2] The Public Health Foundation national TrainingFinder Real-time Affiliate Integrated Network (TRAIN) is an online learning management system. DPH is a state affiliate and has access to its own unique Connecticut portal to TRAIN.
[3] All four of these reports (Multicultural Health: The Health Status of Minority Groups in Connecticut, Connecticut Women's Health, Mortality and its Risk Factors in Connecticut 1989-1998, and The 2009 Connecticut Health Disparities Report) are available on the DPH Health Disparities web page: http://www.ct.gov/dph/cwp/view.asp?a=3132&q=388116&dphNav_GID=1601. Electronic document, accessed 8/1/2014.
[4] U.S.DHHS. Healthy People 2020. http://www.healthypeople.gov/2020/about/default.aspx. Electronic document, accessed 3/31/2014.
[5]U.S. DHHS. National Partnership for Action to End Health Disparities. http://minorityhealth.hhs.gov/npa/templates/browse.aspx?lvl=1&lvlid=11. Electronic document, accessed 3/31/2014.
[6] The CMHP is a partnership founded in 2008 which includes approximately 350 individual members and 200 member organizations.
[7] U.S. DHHS. National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care. Available on the federal Office of Minority Health web page. https://www.thinkculturalhealth.hhs.gov/Content/clas.asp#clas_standards. Electronic document, accessed 8/1/2014.
[8] Title VI of the Civil Rights Act of 1964. http://www.justice.gov/crt/about/cor/coord/titlevistat.php. Electronic document, accessed 8/1/2014.
[9] Executive Order 13166 of 2000, "Improving Access to Services for Persons with Limited English Proficiency." http://www.lep.gov/13166/eo13166.html. Electronic document, accessed 8/1/2014.
[10] Patient Protection and Affordable Care Act, Section 4302. http://www.gpo.gov/fdsys/pkg/CREC-2009-11-19/pdf/CREC-2009-11-19-pt1-PgS11607-3.pdf#page=127. Electronic document, accessed 8/1/2014.
[11] U.S. Department of Labor. Section 504, Rehabilitation Act of 1973. http://www.dol.gov/oasam/regs/statutes/sec504.htm; Americans with Disabilities Act of 1990, as Amended. http://www.ada.gov/pubs/ada.htm. Electronic documents, accessed 8/1/2014.
[12] "D/deaf" indicates both persons who identify themselves as having a cultural identity as Deaf, as well as those persons who have severe enough hearing loss to be considered audiologically deaf. In both cases, people may use a sign language or a form of communication other than speech.
[13] Lau v. Nichols 414 U.S. 563 (1974). http://scholar.google.com/scholar_case?case=5046768322576386473&hl=en&as_sdt=6&as_vis=1&oi=scholarr. Electronic document, accessed 8/1/2014.
[14] Connecticut General Statutes, Title 19a, Public Health and Well-Being, Chapter 368a, Department of Public Health, Sec. 19a-4j, Office of Multicultural Health. http://www.cga.ct.gov/2011/pub/chap368a.htm#Sec19a-4j.htm, effective July 1, 1998. Electronic document, accessed 11/26/ 2014. Public Act No. 11-242, An Act Concerning Various Revisions to Public Health Related Statutes. http://www.cga.ct.gov/2011/act/pa/pdf/2011PA-00242-R00HB-06618-PA.pdf, effective October 1, 2011. Electronic document, accessed 11/26/2014.
[15] Connecticut General Assembly Amendment February Session, 2014 LCO No. 5588. *HB0553705588HDO*. To: Subst. House Bill No. 5537 File No. 516 Cal. No. 340 "An Act Concerning the Department of Public Health's Recommendations Regarding Various Revisions to the Public Health Statutes." http://www.cga.ct.gov/2014/amd/H/2014HB-05537-R00HA-AMD.htm. Electronic document, accessed 7/31/2014.
[16] Public Act No. 08-171, An Act Establishing a Commission on Health Equity. http://www.ct.gov/cche/lib/cche/Public_Act_No_08-171.pdf. Electronic document, accessed 8/1/2014.
[17] Public Act No. 09-232, An Act Concerning Revisions to Department of Public Health Licensing Statutes. http://cga.ct.gov/2009/ACT/PA/2009PA-00232-R00HB-06678-PA.htm; Public Act No. 13-76, An Act Requiring Licensed Social Workers, Counselors and Therapists to Complete Continuing Education Course Work in Cultural

Competency. http://www.cga.ct.gov/2013/act/pa/pdf/2013PA-00076-R00SB-00366-PA.pdf. Electronic documents, accessed 8/1/2014.

[18] Adapted from Centers for Disease Control & Prevention, Public Health in America. http://www.ct.gov/dph/cwp/view.asp?a=3130&q=472122. Electronic document, accessed 7/25/2014.

[19] Connecticut State Health Assessment. http://www.ct.gov/dph/lib/dph/state_health_planning/ship/hct2020/hct2020_state_hlth_assmt_032514.pdf. Electronic document, accessed 8/1/2014.

[20] Connecticut State Health Improvement Plan. http://www.ct.gov/dph/lib/dph/state_health_planning/ship/hct2020/hct2020_state_hlth_impv_032514.pdf. Electronic document, accessed 8/1/2014.

[21] Connecticut State Health Assessment and Health Improvement Plan. http://www.ct.gov/dph/cwp/view.asp?a=3130&q=509550. Electronic document, accessed 8/1/2014.

[22] DPH: Health Disparities. http://www.ct.gov/dph/cwp/view.asp?a=3132&q=388116&dphNav_GID=1601. Electronic document, accessed 8/1/2014.

[23] DPH: Topics A-Z. http://www.ct.gov/dph/cwp/view.asp?a=3115&q=387268&dphNav_GID=&dphNav_GID=1601. Electronic document, accessed 8/1/2014.

[24] Language Needs and Services of Local Health Districts and Community Health Centers. http://www.ctmhp.org/wp-content/uploads/2010/06/Final-Report-Language-Services-Project.pdf; Assessing the Connecticut Multicultural Health Partnership's (CMHP) Progress in Strategic Planning and Implementation of the CLAS Standards. http://www.ctmhp.org/wp-content/uploads/2012/12/CMHP-Evaluation-Report_April-2012_Final.pdf. Electronic documents, accessed 8/1/2014.

[25] U.S. DHHS. Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition against National Origin Discrimination Affecting Limited English Proficient Persons. Federal Register Vol. 68, No. 153, August 8, 2003. http://www.justice.gov/crt/about/cor/lep/hhsrevisedlepguidance.pdf. Electronic document, accessed September 16, 2014.

[26] State of Connecticut Purchase of Service Contract, Revised August 2011. Refer to: Section A, subsection A.1. General Terms and Conditions: 8) Cultural Competence, 9) Respect and Dignity, and 10) Client Satisfaction.