



Assisting Practices to Attain Health Equity Part One





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Introduction

The purpose of this toolkit, “Assisting Practices to Attain Health Equity with Quality Improvement, Part One,” is to provide information on health disparities, Culturally and Linguistically Appropriate Services (CLAS) standards, and how to integrate CLAS standards into a Person-Centered Medical Home (PCMH) practice. It provides information on how to gather appropriate ethnic and cultural data from patient populations and understand cultural and health literacy.

Practices face many challenges when providing care to diverse populations. According to The Robert Wood Johnson Foundation’s project, *Finding Answers: Disparities Research for Change*:

“Disparities are inevitable among a diverse population. When access is equal, minority patients are known to receive lesser quality care. When outcomes improve, disparities can remain or grow depending on the specific nature of the intervention, and whether or not it reached minority populations served. In other words, an overall improvement in quality does not assure that quality has improved for people of color.”

Each group of people experiences various obstacles to health associated with socioeconomic disadvantages and historical and contemporary injustices. Beyond this, each group has a set of beliefs or principles that impact how the group may interact with their healthcare providers and health behaviors. When healthcare providers incorporate these differences into care, they connect more deeply with these groups and provide better outcomes.

This toolkit presents the first steps and rationale for promoting and incorporating health equity within a PCMH practice. Our other toolkit, “Assisting Practices to Attain Health Equity with Quality Improvement, Part Two,” provides PCMH practices with information on how to collect and analyze their practice data. The data enables them to identify opportunities to improve the quality of care to their patient populations through the use of the Quality Improvement (QI) process.

If you have any questions or need assistance with the Quality Improvement process, please contact your Community Practice Transformation Specialist (CPTS). You may also call the HUSKY Health program PCMH Administrator at 203.949.4194, or send an email to pcmhapplication@chnct.org.



Racial and Ethnic Disparities in Healthcare: Opportunities to Improve in Connecticut

Quality improvement is a central focus in healthcare delivery today and federal, state and local officials, as well as other stakeholders, are all pushing the envelope. Physicians have been key champions of improved healthcare quality. Other leaders in the efforts to improve quality include the National Committee for Quality Assurance (NCQA), the Institute of Medicine (IOM), and the U.S. Congress. The Affordable Care Act (ACA) as well as state legislation has undeniably pushed the healthcare industry and stakeholders forward to measure and improve quality of care delivery. Preventable medical errors, reducing avoidable readmissions, continuity, person-centeredness, coordination, and prevention are all among care elements that systems and providers are seeking to improve.

While quality itself is a central focus, an important – but less of a top-of mind, yet critically important focus that is part and parcel of quality – is disparities in care delivery among persons of color. The IOM report *Crossing the Quality Chasm* includes equitable care as one dimension of quality among others. Likewise, the Affordable Care Act has numerous references, initiatives, and funding sources to address inequities in care delivery in the United States.

Most healthcare providers assume that they offer comparable care with equal outcomes to all patients, regardless of race or ethnicity. Yet, many may be surprised that, based on national and state-specific data, members of minority populations continue to experience worse healthcare outcomes among a broad set of quality domains than Whites.

According to the National Healthcare Disparities Reports (NHDR), racial and ethnic minorities and low-income people often face more barriers to care and receive poorer quality of care when they can get it. This National Healthcare Disparities Report (NHDR), produced annually by the U.S. Agency for Healthcare Research and Quality, is based on data from more than three dozen databases, with estimates for different population subgroups and across different years.

Among the persistent disparities in care documented by the annual National Healthcare Disparities Reports are:

- African Americans or Blacks received worse care than Whites for 41% of quality measures reviewed.
- Asian Americans, American Indians and Alaska Natives received worse care than Whites for 30% of quality measures reviewed.
- Hispanics received worse care than non-Hispanics for 39% of measures reviewed.
- Low-income people had worse outcomes than high income people for 47% of measures reviewed.

The NHDR report further notes that while quality is improving slowly across the country for all groups, few quality-related disparities related to race, ethnicity or income showed significant improvement. The total number of disparities that decreased was fewer than the number of disparities that grew.



Disparities for which the NHDR documented deterioration in outcomes among racial and ethnic minority populations included:

- Maternal deaths per 100,000 live births
- Breast cancer diagnosed at advanced stage per 100,000 women over age 40
- Children for whom a healthcare provider gave advice about using car safety seats
- Adults age 50 and over who ever received a colonoscopy, sigmoidoscopy, or proctoscopy
- People with difficulty contacting their usual source of care by phone
- Adults who did not have problems seeing a specialist they needed to see in the last year
- People without a usual source of care who indicated a financial or insurance reason for not having regular source of care.

A 2002 report by the Institute of Medicine framed three areas as driving disparities: patient characteristics, processes of care, and the healthcare system itself. While patient characteristics cannot be influenced by healthcare providers, there are interventions that can impact improvements in both the processes of care and the contextual healthcare systems in which individual providers deliver healthcare.

Some providers and stakeholders believe that quality improvement efforts can result in better care for all consumers of care; however, others have demonstrated that even if “all boats rise” disparities may still persist – and remain at the same magnitude. Other researchers have found that quality can improve for some populations and still not improve for racial and ethnic minority populations.

Quality improvement is an essential component of person-centered medical homes. All person-centered medical home practices should be looking at quality of care and, based on data findings, should make efforts to specifically improve care for racial and ethnic minorities.

Connecticut-specific data from the 2009 Connecticut Health Disparities Report indicated that Hispanic women (23.6%) and Black women (21.8%) received late or no prenatal care as compared to 12.7% of the total population and 7.8% of the White population.

Likewise, from 2001 to 2005, the infant mortality rate for Black Connecticut residents ran three times the rate for Whites (13 vs. 3.9 per 1,000 live births).

Oral health status showed similar trends with people of Hispanic origin showing the worst results for percent with cavities, untreated decay, rampant decay and the percent needing treatment as compared to Whites.

Emergency department visits were significantly higher among Hispanic and Black individuals (169.7 and 151.2 per 10,000 population respectively) as compared to a rate of 32.7 for Whites.



Diabetes prevalence was also significantly higher among Black individuals (12.8 %) and Hispanic individuals (11.4%) as compared to White individuals (5.3%).

Sources:

U.S. Department of Health and Human Services, Agency for Healthcare Research and Quality, National Healthcare Disparities Report 2011, ARHQ Publication No. 12-0006 (2012) www.ahrq.gov/qual/qrd11.htm

Stratton, A., M.M. Hynes, A.N. Nepal. 2009. *The 2009 Connecticut Health Disparities Report*. Hartford, CT: Connecticut Department of Public Health.



A Roadmap for Improving Quality and Reducing Disparities

The Robert Wood Johnson Foundation’s project “Finding Answers: Disparities Research for Change” offers a practical roadmap to decrease racial and ethnic disparities. With a focus on the primary care setting, this roadmap suggests an approach with the following steps that can be applied in any primary care or person-centered medical home practice to review, understand and address disparities in care within a patient population.

Step	Approach	What You Can Do
Link Quality and Equality	Disparities are inevitable among a diverse population. When access is equal, minority patients are known to receive lesser quality care. When outcomes improve, disparities can remain or grow depending on the specific nature of the intervention and whether or not it reached minority populations served. In other words, an overall improvement in quality does not assure that quality has improved for people of color.	Be open to the possibility that disparities exist in your practice. Don’t assume that your practice does not have any disparities in care delivery.
Create a Culture of Equity	It isn’t sufficient to know that disparities are a problem in society; owning that they may exist in your practice is an initial step toward improvement.	Encourage your staff to consider whether disparities may in fact exist. Talk to staff, share literature and discuss the possibility that you can do better for patients of color. Let them know that minorities face special challenges in getting care.
Diagnose the Issue	Understand what is driving disparities in your patient population so that you can take steps to improve.	Review your data by race, ethnicity and language. Seek out or become an “equity champion” in your practice, in your geographic area or elsewhere who can lead this work. If your practice is relatively small, find another practice that may be willing to form a team to address
Get Buy-in within your Practice	Buy-in means action – not just saying you’re on board. Be specific about what you’re asking from physicians, other clinical staff, and front-desk staff.	Talk to your providers, front-desk staff and others about what your data shows and, what you’re trying to achieve to improve. They are part of the solution.
Design the Activity	Link what you learned from studying your data to possible interventions and resources with key stakeholders within your practice.	Once you’ve identified potential disparities drivers, think creatively and carefully about how to eliminate those drivers with key people from your practice. There’s no single right answer and you need to work with whomever, and whatever resources you have available to you. Identify, in as much detail as you can, the steps required to execute the intervention and how each member of your team is needed to participate.



Implement the Change	<p>Be realistic and start small – becoming a person-centered medical home is a lot of work and you can’t do everything at once.</p> <p>Use your initial data as a baseline and measure change (every six months or so) to see if your intervention is working. Create a timeline for evaluation and measurement.</p> <p>Be adaptable to maximize results.</p>	<p>Discuss how the intervention is, or is not, working with your team. Make changes as needed. At the outset, buy-in and participation are especially important.</p> <p>Re-measure, based on a timeline, to see if change is truly occurring.</p> <p>As priorities are addressed, re-inspect your data and select a new priority.</p>
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U.S. Department of Health and Human Services, Agency for Healthcare Research and Quality, *National Healthcare Disparities Report 2011*, ARHQ Publication No. 12-0006 (2012). www.ahrq.gov/qual/qdr11.htm

National Committee for Quality Assurance and Eli Lilly Company, *Toolkit for Multicultural Health Care: A Quality Improvement Guide* (2007). http://www.ncqa.org/Portals/0/HEDISQM/CLAS/CLAS_toolkit.pdf

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Robert Wood Johnson Foundation, Finding Answers: Disparities Research for Change, *The Roadmap to Reduce Disparities*. <http://www.solvingdisparities.org/tools/roadmap>

Weinick, RM, Hasnain-Wynia, R. Quality improvement efforts under health reform: How to ensure that they help reduce disparities – not increase them. *Health Aff.* (2011);30(10):1837-1843. <http://www.ncbi.nlm.nih.gov/pubmed/21976324>

The Roadmap to Reduce Disparities

A GUIDE FOR HEALTH CARE ORGANIZATIONS



The Roadmap's six-step framework helps integrate reducing disparities into all health care quality improvement efforts. It is designed to be flexible: organizations can get on the road where they need to. Its goal is to support a thoughtful and comprehensive approach to achieving equity, even though the causes of disparities may vary across regions or patient populations.

The Roadmap draws upon lessons learned from *Finding Answers'* 33 grantee projects and 11 systematic reviews of the disparities-reduction literature.

www.solvingdisparities.org



LINK CREATE DIAGNOSE DESIGN SECURE IMPLEMENT



FACTS ABOUT HEALTH DISPARITIES IN CONNECTICUT

According to the 2009 Connecticut Health Disparities Report, published by the Connecticut Department of Public Health, the following facts highlight health inequities in Connecticut.

- Health disparities are *avoidable* differences in health that *result from cumulative social disadvantage*. Public health research shows that a wide variety of health outcomes are influenced by social factors like poverty, socioeconomic status, educational attainment, social support, stress, discrimination, and environmental exposures. Health disparities are evidence of inequalities in these social factors.
- Racial and ethnic diversity is increasing in Connecticut. From 2000–2007, the state’s Asian population increased by 38.2% and the Hispanic or Latino population increased by 24.8%. In 2007, the Hispanic or Latino population comprised 11.5% of the Connecticut population, Black or African Americans, 9.3%, and Asians, 3.4%. Whites comprised 74.4 % of the Connecticut population.
- Racial and ethnic minority residents are more likely to be poor compared with the White population in Connecticut. Blacks or African Americans were almost 3.6 times, American Indians or Alaska Natives about 3.3 times, and Hispanics or Latinos about 4.7 times to be living in poverty in 1999.
- Current state data provide a limited picture of the health status of various populations in Connecticut. Health data (e.g., births, deaths, risk factor prevalence) collected on smaller population subgroups, such as American Indians or Alaska Natives and Asians, are limited due to low numbers of reported occurrences.
- The Connecticut Hispanic or Latino population is rapidly increasing in both size and diversity, and more information, particularly on issues related to access to quality healthcare and language barriers, is needed.
- Mortality data show that compared with other racial and ethnic subgroups in Connecticut, Blacks or African Americans suffer disproportionately from the major chronic diseases (heart disease, stroke, diabetes, cancer) and other causes of death such as HIV/AIDS and homicide. Detailed information is lacking on subgroups within the Black or African American population, as well as the influences of poverty, low-income neighborhood environments, and discrimination on health outcomes.
- Lower-income adults in Connecticut are much less likely to obtain recommended screening tests for certain types of cancers such as Pap tests and colonoscopy or sigmoidoscopy screening for colorectal cancer compared with those of high income.
- Cigarette smoking has been linked to numerous chronic diseases including cancer, and cardiovascular and respiratory diseases. Connecticut adult smokers are more likely to be younger and have lower incomes and less education than non-smokers.
- Obesity and overweight have been linked to numerous health problems including high blood pressure, high blood cholesterol, high triglycerides, diabetes, and heart disease, and increased likelihood of developing certain types of cancers. Lower-income adults are more likely to be obese than higher-income adults.



- High blood cholesterol is a major risk factor for heart disease and a moderate risk factor for stroke. Persons without health insurance, and those with lower incomes and less education are more likely to report never having had their blood cholesterol checked.
- Diagnosed cases of HIV/AIDS for 2001–2005 were most prevalent in persons of Hispanic origin and Blacks. These groups experienced 7.4 and 6.6 times the rates of HIV/AIDS diagnoses as Whites, respectively.
- Tuberculosis incidence rates among foreign-born persons and racial and ethnic minorities are higher than the incidence among Whites in Connecticut. The TB incidence rate is highest among Asian residents, about 23 times higher than that of Whites in 2000-2005.
- The infant mortality rate (IMR) is a key measure of population health status. For 2001–2005, the Connecticut IMR was highest for Black or African American infants with 3.3 times the IMR of Whites, followed by Hispanics with 1.7 times the IMR of Whites.
- In 2002-2006, Hispanic women and Black women had the highest percentages of those with late or no prenatal care in the first trimester of pregnancy, at 23.6% and 21.8% of women, respectively. Black women had the highest percentage of low birth weight infants, at 12.9%, compared with 8.5% for Hispanics, and 6.7% for White infants.
- In 2004, Hispanic and Black children 0–17 years old had the highest rate of asthma emergency department visits compared with White children. Connecticut Black and Hispanic residents of all ages had the highest asthma hospitalization rates in 2005.
- In 2006, New Haven had the highest percent of screened children who had a confirmed elevated blood lead level. Likewise, Black children also had high rates of elevated blood lead levels, with 2.7 times that of White children who were screened.
- Lack of health insurance is an urgent health problem facing many state residents. In Connecticut, Hispanic residents are about 5.4 times more likely, and Black residents 2.7 times more likely, to be uninsured than White residents.
- Creation of a more detailed picture of the health status of Connecticut population subgroups is achievable through increased collaboration between local communities and public and private agencies that are committed to providing more in-depth descriptions of the health needs and health status of Connecticut residents. Such an effort would involve use of both qualitative and quantitative methods and GIS (Geographic Information Systems) technology so that accurate and vivid depictions of the health status and needs of smaller, diverse subgroups are captured.

Source: Stratton, A., M.M. Hynes, A.N. Nepal. 2009. *The 2009 Connecticut Health Disparities Report*. Hartford, CT: Connecticut Department of Public Health.



National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health and Healthcare

The National CLAS Standards are intended to advance health equity, improve quality, and help eliminate healthcare disparities by establishing a blueprint for health and healthcare organizations to:

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 healthcare 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.
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.

Source: <https://www.thinkculturalhealth.hhs.gov/pdfs/EnhancedCLASStandardsBlueprint.pdf>



The Case for the National Enhanced CLAS Standards

Of all the forms of inequality, injustice in health care is the most shocking and inhumane.
— Dr. Martin Luther King, Jr.

Health equity is the attainment of the highest level of health for all people (U.S. Department of Health and Human Services [HHS] Office of Minority Health, 2011). Currently, individuals across the United States from various cultural backgrounds are unable to attain their highest level of health for several reasons, including the social determinants of health, or those conditions in which individuals are born, grow, live, work, and age (World Health Organization, 2012), such as socioeconomic status, education level, and the availability of health services (HHS Office of Disease Prevention and Health Promotion, 2010). Though health inequities are directly related to the existence of historical and current discrimination and social injustice, one of the most modifiable factors is the lack of culturally and linguistically appropriate services, broadly defined as care and services that are respectful of and responsive to the cultural and linguistic needs of all individuals.

Health inequities result in disparities that directly affect the quality of life for all individuals. Health disparities adversely affect neighborhoods, communities, and the broader society, thus making the issue not only an individual concern but also a public health concern. In the United States, it has been estimated that the combined cost of health disparities and subsequent deaths due to inadequate and/or inequitable care is \$1.24 trillion (LaVeist, Gaskin, & Richard, 2009). Culturally and linguistically appropriate services are increasingly recognized as effective in improving the quality of care and services (Beach et al., 2004; Goode, Dunne, & Bronheim, 2006). By providing a structure to implement culturally and linguistically appropriate services, the enhanced National CLAS Standards will improve an organization's ability to address healthcare disparities.

The enhanced National CLAS Standards align with the HHS Action Plan to Reduce Racial and Ethnic Health Disparities (HHS, 2011) and the National Stakeholder Strategy for Achieving Health Equity (HHS National Partnership for Action to End Health Disparities, 2011), which aim to promote health equity through providing clear plans and strategies to guide collaborative efforts that address racial and ethnic health disparities across the country. Similar to these initiatives, the enhanced National CLAS Standards are intended to advance health equity, improve quality, and help eliminate healthcare disparities by providing a blueprint for individuals and health and healthcare organizations to implement culturally and linguistically appropriate services. Adoption of these Standards will help advance better health and healthcare in the United States.

Source: <https://www.thinkculturalhealth.hhs.gov/pdfs/EnhancedCLASStandardsBlueprint.pdf>

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Tools to assist with Attaining Health Equity

The following tools are provided to assist your practice with attaining health equity:

- To access the “*Advancing Health Equity – Strategies to change the Way Healthcare is Accessed, Delivered and Managed*” PowerPoint, [click here](#).
- To access the “*Blueprint for Advancing and Sustaining CLAS Policy and Practice*” from the Office of Minority Health with the US Department of Health & Human Services, [click here](#).
- To access the “*Guide to Providing Effective Communication and Language Assistance Services*” that will help you and your organization provide effective communication and language assistance services to culturally and linguistically diverse individuals receiving care and services from your organization, [click here](#).



CLAS Crosswalk to NCQA PCMH 2014 Standards

The table below provides information on how CLAS can be used to meet NCQA 2014 PCMH Standards.

NATIONAL CLAS STANDARDS	DISPARITIES-SENSITIVE NCQA PCMH 2014 STANDARDS	TARGET DATE OF COMPLETION
	PCMH 2: Team- Based Care	
<p>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.</p>	<p>PCMH 2C: Culturally and Linguistically Appropriate Services (CLAS)</p> <p>The practice engages in activities to understand and meet the cultural and linguistic needs of its patients/families by: PCMH 2C1: Assessing the racial and ethnic diversity of its population PCMH 2C2: Assessing the language needs of its population</p>	
<p>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 healthcare and services.</p> <p>6. Inform all individuals of the availability of language assistance services clearly and in their preferred language, verbally and in writing.</p> <p>7. Ensure the competence of individuals providing language assistance, recognizing that the use of untrained individuals and/or minors as interpreters should be avoided.</p>	<p>PCMH 2C3: Providing interpretation or bilingual services to meet the language needs of its population</p>	
<p>Communication and Language Assistance: 8. Provide easy-to-understand print and multimedia materials and signage in the languages commonly used by the</p>	<p>PCMH 2C4: Providing printed materials in the languages of its population</p>	



NATIONAL CLAS STANDARDS	DISPARITIES-SENSITIVE NCQA PCMH 2014 STANDARDS	TARGET DATE OF COMPLETION
populations in the service area.		
<p>Governance, Leadership, and Workforce:</p> <p>4. Educate and train governance, leadership, and workforce in culturally and linguistically appropriate policies and practices on an ongoing basis.</p>	<p>PCMH 2D: The Practice Team</p> <p>The practice uses a team to provide a range of patient care services by:</p> <p>PCMH 2D5: Training and assigning members of the care team to coordinate care for individual patients</p> <p>PCMH 2D6: Training and assigning care teams to support patients and families in self-management, self-efficacy and behavior changes</p> <p>PCMH 2D7: Training and assigning members of the care team to manage the patient population</p>	
<p>Engagement, Continuous Improvement, and Accountability:</p> <p>13. Partner with the community to design, implement, and evaluate policies, practices, and services to ensure cultural and linguistic appropriateness.</p>	<p>PCMH 2D10: Involve patients/families in quality improvement teams or on the practice’s advisory council</p>	
PCMH 3: Population Health Management		
<p>Engagement, Continuous Improvement, and Accountability:</p> <p>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.</p>	<p>PCMH 3A: Patient Information</p> <p>The practice uses an electronic system that records the following as structured (searchable) data for more than 80% of its patients.</p> <p>PCMH 3A3: Race</p> <p>PCMH 3A4: Ethnicity</p> <p>PCMH 3A5: Preferred language</p>	
	<p>PCMH 3A: Patient Information</p> <p>The practice uses an electronic system that records the following as structured (searchable) data for more than 80% of its patients.</p> <p>PCMH 3A3: Race</p> <p>PCMH 3A4: Ethnicity</p>	



NATIONAL CLAS STANDARDS	DISPARITIES-SENSITIVE NCQA PCMH 2014 STANDARDS	TARGET DATE OF COMPLETION
	PCMH 3A5: Preferred language	
	PCMH 4: Care Management and Support	
	<p>PCMH 4E: Support Self-Care and Shared Decision Making</p> <p>The practice has, and demonstrates use of, materials to support patients and families/caregivers in self-management and shared decision making. The practice:</p> <p>PCMH 4E1: Uses an EHR to identify patient-specific education resources and provide them to more than 10% of patients PCMH 4E2: Provides educational materials and resources to patients PCMH 4E3: Provides self-management tools to record self-care results PCMH 4E5: Offers or refers patients to structured health education programs, such as group classes and peer support PCMH 4E6: Maintains a current resource list on five topics or key community service areas of importance to the patient population including services offered outside the practice and its affiliates</p>	
	PCMH 6: Performance Measurement and Quality Improvement	
<p>Engagement, Continuous Improvement, and Accountability:</p> <p>10. Conduct ongoing assessments of the organization’s CLAS-related activities and integrate CLAS-related measures into measurement and continuous quality improvement activities.</p>	<p>PCMH 6A: Measure Clinical Quality Performance</p> <p>At least annually, the practice measures or receives data on:</p> <p>PCMH 6A4: Performance data stratified for vulnerable populations (to assess disparities in care)</p>	



NATIONAL CLAS STANDARDS	DISPARITIES-SENSITIVE NCQA PCMH 2014 STANDARDS	TARGET DATE OF COMPLETION
<p>Engagement, Continuous Improvement, and Accountability:</p> <p>13. Partner with the community to design, implement, and evaluate policies, practices, and services to ensure cultural and linguistic appropriateness.</p>	<p>PCMH 6C: Measure Patient/Family Experience</p> <p>At least annually, the practice obtains feedback from patients/families on their experiences with the practice and their care.</p> <p>PCMH 6C3: The practice obtains feedback on the experiences of vulnerable patient groups</p> <p>PCMH 6C4: The practice obtains feedback from patients/families through qualitative means</p>	
<p>Engagement, Continuous Improvement, and Accountability:</p> <p>9. Establish culturally and linguistically appropriate goals, policies, and management accountability, and infuse them throughout the organization’s planning and operations.</p> <p>10. Conduct ongoing assessments of the organization’s CLAS-related activities and integrate CLAS-related measures into measurement and continuous quality improvement activities.</p>	<p>PCMH 6D: Implement Continuous Quality Improvement</p> <p>The practice uses an ongoing quality improvement process to:</p> <p>PCMH 6D7: Set goals and address at least one identified disparity in care/service for identified vulnerable populations.</p>	



NCQA Multicultural Health Care Resources

To assist you with connecting CLAS to NCQA 2014 PCMH Standards, NCQA offers the following resources.

- Implementing Multicultural Health Care (MHC) Standards Ideas and Examples
<http://www.ncqa.org/portals/0/Publications/Implementing%20MHC%20Standards%20Ideas%20and%20Examples%2004%2029%2010.pdf>
- NCQA's MHC Distinction: *A Roadmap for Addressing Health Care Disparities*
<http://www.ncqa.org/Portals/0/Public%20Policy/2013%20PDFS/NCQA%20MHC%20fact%20sheet.pdf>
- NCQA's MHC Distinction Program
http://www.ncqa.org/portals/0/Public%20Policy/NCQA%20MHC%20fact%20sheet_8.15.12.pdf



Motivational Interviewing

Motivational Interviewing (MI) is a therapeutic treatment strategy used to facilitate behavior or attitude change. It was developed to be used for substance abuse treatment and since then has been applied to many other domains such as health, lifestyle, medical, and behavioral health conditions. MI focuses on those who are ambivalent about change, and is a way of asking questions to help motivate patients toward making a desired change.

MI techniques can help you develop rapport with patients to elicit helpful information.

To access the *“Motivational Interviewing (MI), Self-Management Support in the Person-Centered Medical Home”* PowerPoint, [click here](#).



Improving Communication with Patients from Diverse Racial and Ethnic Backgrounds

SafetyNetMedicalHome Initiative, Patient-Centered Interactions

This implementation guide was created for use by safety net providers (such as community health centers and small group physician practices) and focuses on provider communication strategies to improve the patient-centered experience. There also are related implementation guides on how providers can engage patients in their health and healthcare and on measuring the patient experience in a patient-centered medical home. The website also has webinars available on patient-centered interactions, transforming primary care, patient self-management support, health consumer engagement, and establishing patient and family advisory councils for a patient-centered medical home. <http://www.safetynetmedicalhome.org/change-concepts/patient-centered-interactions>

National Committee for Quality Assurance and Eli Lilly Company, Toolkit for Multicultural Health Care: A Quality Improvement Guide (2007)

This quality improvement guide includes tools for physician practices to assess, plan, implement, and evaluate improvements in the quality of healthcare provided to multicultural patients. Included are specific tools for assessing and improving linguistic competence, cultural competence, and reduction of healthcare disparities, including obtaining data from multiple sources and through multiple methods, and applying quality improvement tools and techniques to make improvements. The chapter on measurement and evaluation uses an example of a diabetes care program to describe how quality improvements and reductions in disparities can be documented. http://www.ncqa.org/Portals/0/HEDISQM/CLAS/CLAS_toolkit.pdf

Agency for Healthcare Research and Quality, Health Literacy Universal Precautions Toolkit 2nd Ed. (2015)

This toolkit includes tools for providers on understanding health literacy, improving spoken communication (including the teach-back method and brown bag medication review), improving written communication, improving self-management and patient empowerment (including patient action plans and getting patient feedback) and improving health delivery systems to support improved communication with all patients. <http://www.ahrq.gov/professionals/quality-patient-safety/quality-resources/tools/literacy-toolkit/healthlittoolkit2.html>

U.S. Department of Health and Human Services Office of Minority Health, Communication Tools

These tools from the U.S. Department of Health and Human Services Office of Minority Health include a Patient-Centered Guide to Implementing Language Access Services in Healthcare Organizations and a fact sheet on how to work effectively with a healthcare interpreter. <https://www.thinkculturalhealth.hhs.gov/resources/library>



Health History Cultural Assessment Questions

The following interview can be used to collect culturally relevant information from patients. The interview can be completed by clinical or non-clinical staff over multiple visits and can be reviewed by the provider prior to the visit. The collected information can help to inform your treatment decisions and care plans.

It is important to preface the interview with, “The information you provide to me here **will only be used** to create the most effective care plan for you with your care team so that you will get the best care possible. It **will not** be disclosed outside this facility. We use this information to review the treatment all patients receive and make sure that everyone gets the highest quality of care.”

Personal Background, Ethnic Affiliation, and Acculturation

- What would you like to be called (Mr., Mrs., Miss, Ms. or professional title, first and/or last name?)
- Have you always lived in the U.S.?
 - (If no) How long have you lived here?
 - Can you tell me about your journey to the U.S.?
- Is there a particular cultural group or nationality that you identify with, such as... (give examples)?
- With whom do you live now? Do you live near and/or spend time with people in your community?
 - (If yes) What do you do together? (school, work, socialize, worship)
- Do you/your children study your language and culture?

Education and Work

- Can you tell me about your education? How long were you in school?
- Do you work? What do you do? Where do you do it?

Language

- What language do you speak at home? (If non English continue)
 - What language do you feel most comfortable speaking with your doctor/nurse?
 - Are you able to speak and understand English? How well?
 - In which language would you feel most comfortable reading medical or healthcare instructions?

Religion/Spiritual Practices

- Do you/your family attend religious services/gatherings?
 - Where do you go and how often?
- Are there any concerns related to your religious practices that you would like us to know?
- Do you follow any other spiritual or traditional practices?



Physical Examination

- We will need you to change into a gown so we can do a physical examination (may need to explain this term). Is this acceptable with you?
- Would you prefer a male or female doctor?
- Would you like someone from your family to stay in the room during the exam?

Role of Family, Traditional Healers/Spiritual Practitioners

- Do you talk to others in your family or household about your healthcare?
 - Who makes health decisions with you?
 - Who helps you to stay well and cares for you when you are sick?
 - Would you want them to help with your care here?
- Do you consult anyone outside your family regarding your healthcare?
 - Would you like them to be part of your care here?

Access to Healthcare

- Are you able to see a nurse or doctor when you need to?
 - (If yes) Where do you go?
 - (If no) Why not? (insurance, cost, transportation, child care, language barriers)
- Are you comfortable when you go to see a nurse or doctor? (If no, why not?)
- What do you think about medicines that you get from the doctor, nurse, or pharmacy?

Disability (Required by ACA)

- Are you deaf or do you have serious difficulty hearing?
- Are you blind or do you have serious difficulty seeing, even when wearing glasses?
- Because of a physical, mental or emotional condition, do you have serious difficulty concentrating, remembering, or making decisions? (5 years old or older)
- Do you have serious difficulty walking or climbing stairs? (5 years old or older)
- Do you have difficulty dressing or bathing? (5 years old or older)
- Because of a physical, mental, or emotional condition, do you have difficulty doing errands alone such as visiting a doctor's office or shopping? (15 years old or older)

This form is adapted from the Cultural Assessment Questionnaire from Culture Vision
© Cook Ross, Inc. www.crculturevision.com



Illness Cultural Assessment Questions

The following interview can be used to collect information from a patient when a patient presents in the office with an illness.

It is important to preface the interview with, “The information you provide to me here **will only be used** to create the most effective care plan for you with your care team so that you will get the best care possible. It **will not** be disclosed outside this facility. We use this information to review the treatment all patients receive and make sure that everyone gets the highest quality of care.”

Patient’s Explanation of Illness

- Can you tell me about your problem? What do you call it?
 - When did it start?
 - What are the symptoms and how bad are they?
- What do you think has caused this problem? (*use patient’s own words*)
- What are you doing or taking to get better?
 - Are you taking any food, drinks, or medicines for this problem? (*If yes*) What? Helping?
 - Have you seen anyone else about this problem?
- What difficulties has it caused you?
- Has your problem changed over the past week/month/year?
- What do you think I can do to help solve this problem?

This form is adapted from the Cultural Assessment Questionnaire from Culture Vision
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Culture Vision™ Cultural Competence at Your Fingertips

Today's healthcare professionals are seeing a growing number of patients with diverse cultural backgrounds, and understanding their particular needs is critical. The more you know about someone's healthcare beliefs or practices, the more your care and treatment plans can be designed for the best health outcomes possible, taking into account your patients' world view.

CultureVision™ is the first comprehensive, user-friendly database that gives healthcare professionals access to culturally competent patient care.

Instructions on how to access CultureVision™ through the HUSKY Health website can be found below

Source: <http://www.crculturerevision.com/>



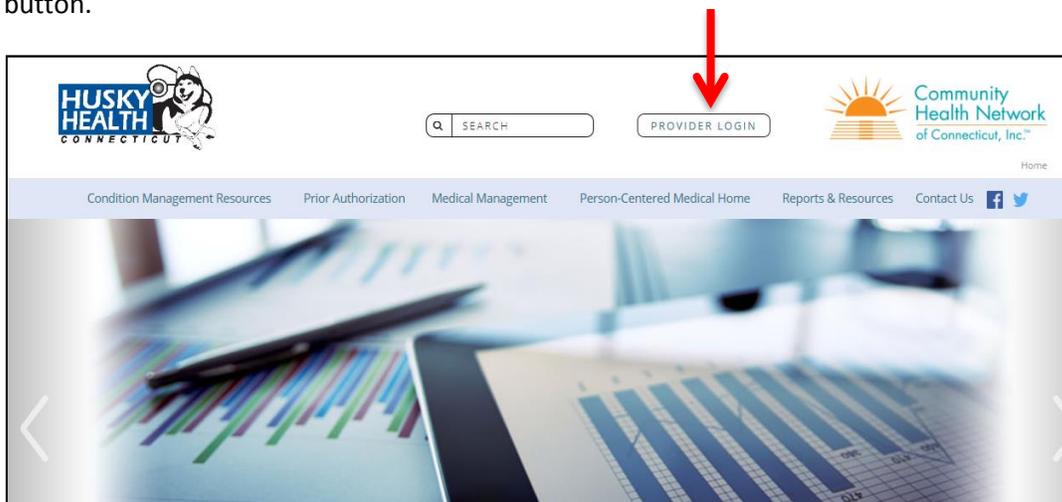
How to Sign Up for the Secure Provider Portal & Login to CultureVision™

Go to www.ct.gov/husky

Click **“For Providers”** from the left-hand navigation column.



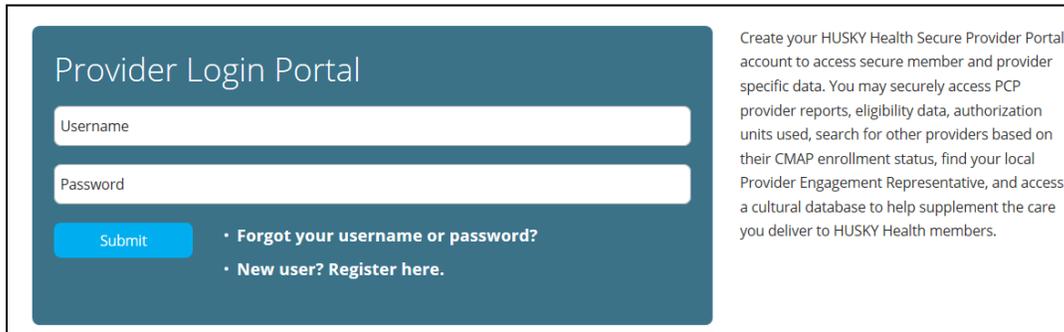
You will be directed to the **“HUSKY Health Provider Home Page.”** Click the **“Provider Login”** button.



Secure Provider Login

To log in, enter the Username and Password that you chose when you signed up. If you forgot your password, you can click ***“Forgot your username or password?”*** to have your password reset.

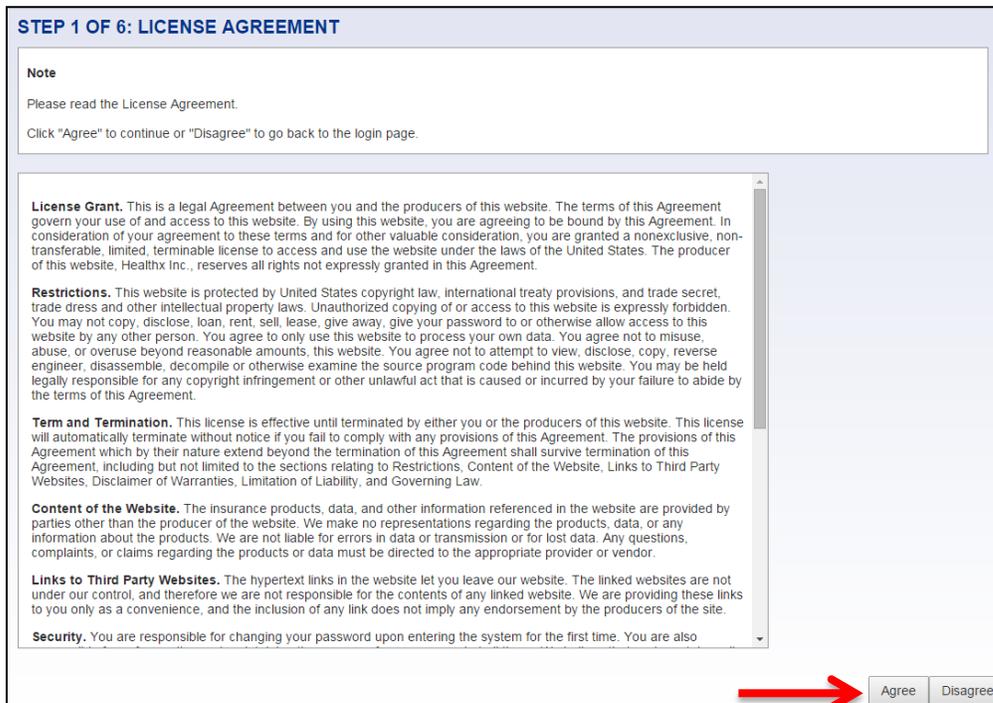
If you do not have an account yet, click ***“New user? Register here”*** to create a new user account.



The screenshot shows a login form titled "Provider Login Portal" with fields for "Username" and "Password", a "Submit" button, and two links: "Forgot your username or password?" and "New user? Register here." To the right of the form, there is a text block explaining the purpose of the account: "Create your HUSKY Health Secure Provider Portal account to access secure member and provider specific data. You may securely access PCP provider reports, eligibility data, authorization units used, search for other providers based on their CMAP enrollment status, find your local Provider Engagement Representative, and access a cultural database to help supplement the care you deliver to HUSKY Health members."

Registering as a New User

Step 1. Read the license agreement and click ***“Agree.”*** If you select ***“Disagree,”*** you will be sent back to the ***“Secure Provider Login”*** page.



The screenshot shows "STEP 1 OF 6: LICENSE AGREEMENT". It includes a "Note" section with instructions to read the license agreement and click "Agree" to continue. Below is a scrollable text area containing the full license agreement, including sections on "License Grant", "Restrictions", "Term and Termination", "Content of the Website", "Links to Third Party Websites", and "Security". At the bottom right, there are "Agree" and "Disagree" buttons, with a red arrow pointing to the "Agree" button.

Step 2. Fill in all of the required fields that are designated by a red asterisk. When completed, choose **“Next.”**

- The information fields reflect the information of the User that will be logging in to the website. This is not necessarily the provider.
- The **“First Name”** and **“Last Name”** should be the names of the person completing the form.
- For **“Address,”** please list your office location.
- **“Contact Phone”** must be in ###-###-#### format.

STEP 2 OF 6: PERSONAL INFORMATION

Note

Fields indicated with a * are required.

Enter the official name of the user signing up for the account.

Address should be the practice/facility address.

*First Name:

*Last Name:

*Address Line 1:

Line 2:

*City:

*State:
Please Select

*Zip:

*Country:
United States

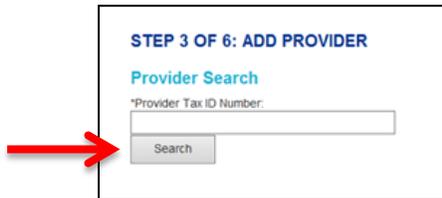
*Contact Phone:

Department:

*Practice Name:

Previous Next Cancel

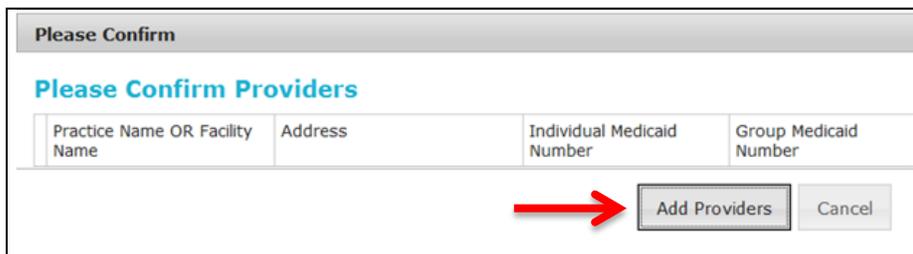
Step 3. To view the list of providers associated with a Tax ID, enter a valid provider Tax ID Number (TIN), and click **“Search.”**



Choose the provider(s) you would like to add to your account by clicking in the box next to their name(s). To select all providers associated with the Tax ID, click the **“Select All Providers”** button. To confirm the selected providers, click **“Add Providers.”**



“Provider Confirmation” page will be displayed, showing the selected providers. Review the list to ensure all appropriate providers have been selected. Once reviewed, click **“Add Providers.”**



You will see the providers you have chosen to add to your account listed beneath the **“Added Providers”** section. To add another provider, enter another Tax ID and repeat the steps outlined above, or click **“Next”** to continue.



Step 4. Identify the role of the person who is completing the sign up process (your role) by selecting the appropriate value from the “*I am a(n)*” drop-down list. Then click “*Next*” to continue.

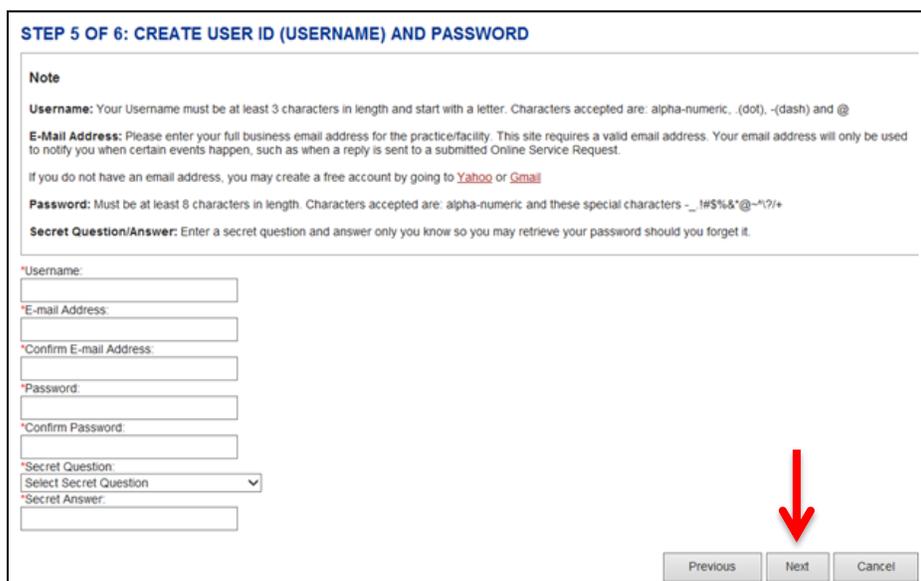


Step 5. Create a Username and Password. When finished, click “*Next*” to continue.

- **Username:** Your username must be at least 3 characters in length and start with a letter. Accepted characters: alpha-numeric, .(dot), -(dash) and @.
- **E-Mail Address:** Please enter your full business email address for the practice/facility. This site requires a valid email address. Your email address will only be used to notify you when certain events happen, such as when a reply is sent to a submitted Online Service Request.

If you do not have an email address, you may create a free account by going to [Yahoo](#) or [Gmail](#)

- **Password:** Must be at least 8 characters in length. Characters accepted are: alpha-numeric and these special characters: -_!#\$%&*~^`?/+
- **Secret Question/Answer:** Enter a secret question and answer that only you know so you may retrieve your password should you forget it.



Step 6. Verify that your information is correct and choose **“Finish”** to complete the sign up process for your account set up. At this point, you have successfully set up your user account. If any information is incorrect, click **“Previous”** and correct your information.

STEP 6 OF 6: VERIFY

Note
Please review the information provided. If correct, click "Finish". If not, click "Previous" to make changes.

Username:
First Name:
Last Name:
E-Mail Address:
Address:

Phone:
Practice Name:

TIN:

If you need to change the email address that you used to create the account, if you forgot your username and/or password, or if you have any questions or concerns about creating an account, please call the **Web Support Help Desk at 1.877.606.5172 between 9:00 a.m. - 4:00 p.m. EST, Monday through Friday.**



Login to CultureVision™

Once you have finished setup, you will be logged into the provider portal automatically. After login, you will be brought to the secure provider portal Provider Main Page.

The CultureVision™ link can be found near the bottom of the page, beneath the HUSKY Health plan description.

<p>Provider Main Page Patient Reports Provider Directory Contact Your Provider Engagement Services Rep Authorizations Eligibility CMAP Active (billing), Performing-Only, or OPR Status providers</p>	<p>WELCOME CHNCT</p> <p>Welcome to the secure portal of the HUSKY Health Program. For primary care physicians, this portal will allow you to access your patient information, including utilization information. If you have any questions or feedback on the secure provider portal, please contact your Provider Engagement Services representative.</p>	<p>How can we help you?</p> <p>For Provider Engagement Services Call Center:</p> <p>The Provider Engagement Services Call Center is open Monday through Friday from 8 a.m. to 6 p.m. The number is 1.800.440.5071 or you can contact us by secure email.</p> <p>For Provider Engagement Services Representative:</p> <p>Click here to find your Provider Engagement Services Representative and region.</p> <p>For Technical Support:</p> <p>Please contact us via email at Web Support.</p> <p>Or call us at 1.877.606.5172 during the hours of 9 a.m. - 4 p.m. EST, Monday through Friday.</p>
<p>Find it here:</p> <p>Person-Centered Medical Home Benefits & Authorizations Provider Trainings & Events Policies & Procedures Provider Bulletins, Updates & Forms Provider Manual Health Education Materials</p>	<p>Action Center</p> <p>PCP Panel Reports</p> <p>Your patient panel report lists the HUSKY Health members whose claims history has identified you as their usual source of care for preventive, and evaluation and management services. You may also see members on your panel report for whom you have not provided care but who have self-selected you as their PCP. If a patient wishes to select you as their PCP, they may call Member Engagement Services at 1.800.859.9689 and request that you be designated as their PCP.</p> <p>The HUSKY Health Program will provide updated Patient Panel reports on a monthly basis. Please note that we will evaluate members' claim history on a quarterly basis to identify their usual source of care. Therefore, you may see more changes in your patient panel when this occurs. You may access your updated report on the 20th of each month. If the 20th falls on a holiday or weekend, your report will be available on the next business day.</p> <p>To access your patient panel reports, please click on the Reports link.</p> <p>For questions on your PCP panel reports, please contact your Provider Engagement Services Representative.</p> <p>PCP Portal Report Survey</p> <p>The HUSKY Health secure provider portal provides all Primary Care Providers (PCPs) with access to reports which contain information and data about your HUSKY Health members. To help us make sure these reports are as useful for you as they can be, we have a brief survey we would like you to take.</p> <p>Click here to complete the survey.</p> <p>CMAP Active (billing), Performing-Only or OPR Status Provider List</p> <p>To verify any CMAP Active (billing), Performing-Only, or OPR Status provider click here.</p>	<p>Authorizations</p> <p>Changes to Radiology Program</p> <p> The existing radiology program administered by Care to Care has transitioned to eviCore healthcare for dates of service January 1, 2017 and forward. eviCore will review authorization requests and render medical necessity determinations for non-emergent outpatient advanced imaging services. eviCore will accept requests for dates of service January 1, 2017 and forward beginning December 19, 2016. For more information, refer to DSS Provider Bulletin 2016-70.</p> <p>Radiology Authorization Portal</p> <p>Submit prior-authorization requests for high-tech radiology procedures (MRI, MRA, CT, CTA, PET, PET/CT) electronically over the internet.</p> <p>New, retrospective requests and modifications must be submitted to eviCore.</p> <p>Click here to access the eviCore portal and to obtain additional information on submitting request.</p> <p>New Webinar on Updates to the Radiology Benefit Management Program:</p> <p>View the webinar</p> <p>Download the presentation slides</p> <p>For access to additional resources and forms, use these links:</p> <ul style="list-style-type: none"> • HUSKY Health Program Implementation Resources • Online Forms and Resources <p>For Technical Support for the eviCore portal, please contact: 1.800.575.4594.</p> <p>ClearCoverage</p>
<p></p>	<p>The new HUSKY Health program has a focus on preventative care. Through this program, we want to ensure that our members get the right care, in the right place, at the right time.</p> <p></p> <p>Cultural Competence at Your Fingertips</p> <p>Today's healthcare professionals are seeing a growing number of patients with diverse cultural backgrounds, and understanding their particular needs is critical. The more you know about someone's healthcare beliefs or practices, the more your care and treatment plans can be designed for the best health outcomes possible.</p> <p>CultureVision™ is the first comprehensive, user-friendly database that gives healthcare professionals access to culturally competent patient care.</p> <p>To access this database, please click on the CultureVision icon:</p> <p> CultureVision</p>	

Because you are logged into the provider portal, you do not need to enter any login information for CultureVision™ and can begin using the service immediately.

Use the drop-down lists on the right side of the page to select Ethnic Groups, Religious Groups, and Additional Communities.



Watch Demo Video
Learn what CultureVision is and how to navigate around inside of it.

[View Demo](#)

What's New?
Explore all that CultureVision offers with our updated Scavenger Hunts.

[Hunt Now](#)

Getting Started with CultureVision

Three Important Principles to Remember

- Diversity exists among individuals even within a given culture.** CultureVision provides information about general cultural archetypes, and prevalences within cultures. Individual differences occur depending upon a wide variety of influences including level of acculturation, socio-economic status, level of education, religious background, the region one comes from, as well as personal experience and history.
- Each patient operates within a unique cultural blueprint.** Use CultureVision as a source of questions, not answers. Explore how culture may have affected your patient – but do not make assumptions about them, as this can lead to stereotyping. Visit **14 Questions to Ask** for ideas on how to begin.
- Some patients may be receiving care outside the mainstream medical system.** Alternative forms of care may include herbal medications, acupuncture, energy treatments, nutritional supplements, and religious healing, among other treatments. Become familiar with these parallel healthcare treatments so you can learn to anticipate interactions.

Select Groups

Ethnic Groups ▼

Religious Groups ▼

Additional Communities ▼



Special Contact Areas

Culture News You Can Use

Select Groups

- Ethnic Groups
- Afghan
- African American
- American Indian
- Arab
- Argentinean
- Asian Indian
- Bhutanese
- Bosnian
- Brazilian
- Burmese
- Cambodian
- Caribbean/West Indian
- Central American
- Chinese
- Congolese
- Cuban
- Ethiopian/Eritrean
- Filipino
- Ghanaian
- Greek
- Haitian
- Hmong/Laotian
- Iranian
- Iraqi
- Italian
- Japanese
- Korean
- Latino
- Liberian
- Mexican
- Moldovan
- Native HI/Pacific Islander
- Nepali
- Nigerian
- Pakistani
- Polish
- Portuguese
- Puerto Rican
- Roma/Gypsy
- Russian
- Somali
- Sudanese
- Thai
- Ukrainian
- Vietnamese
- White, Non-Hispanic

Select Groups

Ethnic Groups ▼

- Religious Groups**
- Amish
- Atheism or Non-Religious
- Baha'i
- Buddhism
- Catholicism
- Christian Science
- Christianity
- Confucianism
- Hinduism
- Islam
- Jehovah's Witnesses
- Judaism
- Mormon/Latter-day Saints
- Pagan
- Sikhism
- Taoism

Select Groups

Ethnic Groups ▼

Religious Groups ▼

- Additional Communities**
- Blind/Has Low Vision
- Deaf/Hard of Hearing
- Elderly
- Homeless
- Intersex
- Intimate Partner Violence
- LGBTQ2
- Military Families
- Obesity/Overweight
- Physical Disability
- Refugees & Torture Survivors
- Rural
- Veterans/Military

Once you select a group, use the links on the left to view information about that group:

Latino

- > [Concept of Health](#)
- > [Beliefs, Religion & Spirituality](#)
- > [Language & Communication](#)
- > [Family & Social Issues](#)
- > [Gender Roles](#)
- > [Diet & Nutrition](#)
- > [Health Promotion/Disease Prevention](#)
- > [Illness-Related Issues](#)
- > [Treatment Issues](#)
- > [Mental Health Issues](#)
- > [Labor, Birth & After Care](#)
- > [Death & Dying](#)
- > [Take the quiz on this culture!](#)

[Home](#) » [Latino](#)

Latino

The term Hispanic was created by the federal government to designate people of Mexican, Central/South American, Caribbean or Southwestern US origin who are of Spanish cultural heritage. Hispanics may be White, Black, Native American or Asian; many are racially mixed but may prefer to identify with one race or another. The word Latino, referring to the Latin American roots of many Hispanics, is also commonly used to describe this large and diverse segment of the US population. Members of the Hispanic/Latino community may variously self-identify as Latino/Ladino, Hispanic, Chicano, Mexican-American, Gente de La Raza, or in the case of more recent immigrants, by their country of origin (Salvadoran, Honduran, Colombian, etc.). While Mayan, runa (Quechua-speaking) and other Amerindian groups are often subsumed under the Hispanic/Latino rubric, many of these indigenous peoples do not speak Spanish and maintain strong ties to their pre-Colombian past.

Latinos are increasingly dispersed throughout the country ([USCB ACS 2013](#)):

- 40.3% of the Latino population lives in the West (29.3% of the total population in the West)
- 36.5% in South (16.7% of total population)
- 14% in the Northeast (13.5% of the total population)
- 9.2% in the Midwest (7.3% of total population)



HUSKY Health Library

HUSKY Health library of topics is located on the HUSKY Health website under the Health and Wellness section. The health library offers videos and articles on general health topics, specific health conditions, and contains:

- Health articles and content
- Test and procedure guides
- Supplemental health resources
- Health calculators such as body mass index and target heart rate
- Health risk assessments
- Interactive health quizzes
- Educational animations
- Monthly health news updates

Visit the HUSKY Health Library at: www.ct.gov/husky, click "**For Members,**" then "**Your Health Library**" under the "**Health and Wellness**" menu item.



Cultural Linguistic Access Services for HUSKY Health Members

Cultural Linguistic Access Services are free for all HUSKY Health members

Members can call Member Engagement Services at 1.800.859.9889

- Members should have their Member ID ready so that a Member Engagement Services representative can validate their eligibility.
- The Member Engagement Services representative will access the Language Line for the member.



Additional Resources to Assist Practices with Attaining Health Equity

- <http://www.minorityhealth.hhs.gov/>
- www.thinkculturalhealth.hhs.gov
- www.ctmhp.org
- <http://www.hhs.gov/ocr/civilrights/resources/specialtopics/hospitalcommunication/eclep.html>
- <http://www.hrsa.gov/publichealth/healthliteracy/>
- <http://healthcare411.ahrq.gov/aprendeavivir.aspx>
- www.ethnomed.org
- <http://www.depts.washington.edu/pfes/CultureClues.htm>
- www.chcs.org

Education Materials in Other Languages

- www.nlm.nih.gov/medlineplus/languages/languages.html
- www.ct.gov/husky
- www.healthinfotranslations.org