

**BILINGUAL ASSISTANCE PROGRAM
EVALUATION**

**Part I: Strategies for Reducing Cultural and
Linguistic Barriers to Health Care for Hispanic
and Asian/Pacific Islander Populations**

Final Report

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EXECUTIVE SUMMARY

The Disadvantaged Minority Health Improvement Act of 1990 authorized the Bilingual Assistance Program (BAP), a three year initiative to improve the health status of racial and ethnic minorities. Under the program, the Health Resources and Services Administration (HRSA) provided grant funds to three national organizations — Association of State and Territorial Health Officials (ASTHO), National Association of County Health Officials (NACHO) and U.S. Conference of Local Health Officials (USCLHO). These organizations, in turn, awarded 13 grants to state and local health departments, on a competitive basis in 1993, for projects focused on reducing cultural and linguistic barriers to care among Asian/Pacific Islander and Hispanic populations.

I. STUDY OBJECTIVES AND METHODS

The Office of Minority Health/Health Resources and Services Administration (OMH/HRSA) contracted for a study with MDS Associates to examine:

- factors that allowed projects to leverage federal funding and to promote improved inter-agency working relationships.
- realistic approaches to setting performance measures.
- technical assistance needs of grantees, including exploring the use of national minority organizations and mentors.
- replicability of the products or training curricula developed by the grantees.

This executive summary presents the principal research findings with regard to grantee strategies for reducing cultural and linguistic barriers, the achievements through the BAP projects, and the lessons these experiences hold for future endeavors. A second document, "Bilingual Assistance Program Evaluation Part II: Assessment of Three Training Curricula," reviews in more detail three of the BAP developed curricula and training approaches.

Site visit interviews and review of background documentation provided the major information sources for this project. The one to two day site visits occurred between April and June 1996. The two person site visit teams included personnel with expertise in both the language and culture of the major target populations. An information collection protocol with modules dedicated to different project activities (training, interpretation/translation services, cultural competency, outreach, and database development) provided the framework for our study.

OMH/HRSA selected the five grantees that are the subjects of this study. These five grantees constitute a cross-section of the types of programs funded under BAP, with the exception that no direct service delivery programs were included:

- California Department of Health Services, Office of Multicultural Health project developed a resource database/directory of health education materials and service delivery programs related to chronic disease among Southeast Asian populations.
- Colorado Department of Health, Migrant Health Program project developed a Medical Interpreter Training Syllabus and trained bilingual personnel in medical terminology and interpretation techniques for use primarily with “settled out” **Latino** migrant populations.
- City of Waterbury (Connecticut), Department of Public Health project developed health education materials in concert with the Hispanic community (Puerto Rican, Dominican) to support an immunization initiative.
- North Carolina Department of Environment, Health & Natural Resources, Division of Maternal and Child Health project developed and implemented a cultural competency curriculum for local health departments in addressing the needs of the migrant and settled out Latin0 population.
- Rhode Island Department of Health grant offered a Medical Interpreter Training Academy to improve the skills for medical interpretation among diverse populations, including Hispanic (Puerto Rican, Dominican, Colombian) and Asian (Hmong, Cambodian, Laotian, Vietnamese) communities.

II. BAP PROGRAM ACHIEVEMENTS

The five grantees of this study planned and carried out training and resource development projects to address the needs of their communities. Study findings show that grantees:

- Produced both ***immediate achievements and longer term effects.***
- ***Leveraged BAP funds*** to achieve an impact beyond the dollars invested.
- ***Promoted improved working relationships*** among organizations and with target communities.
- Took steps toward ***developing a more linguistically and culturally responsive health care system.***

A. Short and Long-term Impact of BAP

Primary short-term achievements included: (1) development of training curricula, health education materials, and a resource database; and (2) delivery of training related to cultural competency and medical interpretation. The BAP grants served not only as a catalyst for more expansive immediate efforts but also influenced the longer term direction of other initiatives after BAP funding ceased. Exhibits ES. 1 and 2 summarize short term achievements and longer term effects.

Short-term achievements for the five grantees included:

- Development of three curricula and implementation of training sessions for: (1) 157 health department and other health service personnel in cultural competency; and (2) 41 interpreters in methods that would upgrade their medical interpretation skills.
- Development and dissemination of Spanish language health education materials (immunization calendar and posters, and Resource Manual for family **planning/perinatal** health);
- Development of a computerized resource database of chronic disease programs for Southeast Asians and dissemination of a directory of these programs; and
- Sponsoring various other types of training sessions, including ones for: (1) 60 **health** professionals to learn how to use medical interpretation in delivering health services; (2) 80 persons in health related fields in cultural competency; and (3) 17 trainers in how to provide instruction in cultural competency.

Examples of longer term effects that BAP activities contributed to include: (1) further dissemination of information and health education materials (e.g., through the Combined Health Information Database or outreach activities); (2) ongoing training by those who had participated in Training of Trainees (TOT); (3) improvements in childhood immunization rates; and (4) organizational changes in **response** to cultural competency training.

Exhibit ES.1 Immediate Achievements and Longer Term Effects

<i>Grantees</i>	<i>Immediate Achievements</i>	<i>Longer Term Effects</i>
<p>Southeast Asian (SEA) Health Information Database, California Office of Multicultural Health</p>	<ul style="list-style-type: none"> • Distributed 500 copies of "The SEA Health Information and Resource Directory of Chronic Diseases" (1994). • Developed an infrastructure which attracted additional funding. 	<ul style="list-style-type: none"> • Used SEA infrastructure to expand database to other groups (Latinos, Blacks, Native Americans). Expansion funded by CDC and the Preventive Health Services Block Grant. • Selected program information entered into the federal Combined Health Information Database.
<p>Health Access by Language Advocacy (HABLA) Colorado Migrant Health Program</p>	<ul style="list-style-type: none"> • "Basic Interpreting Syllabus: Medical Terminology " • Trained 18 interpreters. *Trained 80 persons in cultural competency. *Trained 17 instructors on cultural competency. 	<ul style="list-style-type: none"> • At least 5 trainees became employed in local health care settings. • Instructors provided "turn around" training in cultural competency in their communities.
<p>Hispanic Immunization Initiative (HII) Waterbury (Connecticut) Department of Public Health</p>	<ul style="list-style-type: none"> • Distributed 1500 Vacunelos calendars. • Distributed 500 posters. 	<ul style="list-style-type: none"> • Hispanic childhood immunization rates increased to 88% by coupling HII materials with outreach. Continuation funded by CDC.

Exhibit ES.2 Immediate Achievements and Longer Term Effects

<i>Grantees</i>	<i>Immediate Achievements</i>	<i>Longer Term Effects</i>
<p>Latino Cultural Competency Training (LCCT) North Carolina Women's Preventive Health Services Branch</p>	<ul style="list-style-type: none"> • Developed LCCT Curriculum. • Trained 157 persons in 4 workshops around the state. • Model Resource Manual distributed to every county health department and workshop participant. 	<ul style="list-style-type: none"> • Local Health Department Action Plans to Improve Cultural Competency • Provided baseline information for North Carolina OMH needs assessment on Latino health
<p>Medical Interpreter Training Academy Rhode Island Office of Minority Health</p>	<ul style="list-style-type: none"> • Trained 23 interpreters (11 SEAs, 9 Latinos, 3 Portugueses, 1 Armenian, 1 Russian). • Provided in-service to 60 health professionals on how to use interpreters. 	<ul style="list-style-type: none"> • Trainees applied new knowledge in their health related jobs.

B. Leveraged BAP Funds

Our previous exploratory study of four BAP grantees suggested that a small investment of federal funds could serve as a catalyst for a more expansive project with potential long-term impact.¹ The current review confirmed that grantees were able to leverage **BAP** funding in multiple ways:

- by *attracting additional state/federal funds* to expand BAP activities;
- by *influencing the longer term direction of other federal and state initiatives* (e.g., disease monitoring, immunization, minority health) that continued after BAP funding ceased;
- by developing resources that enhanced health *system infrastructure*; and
- by giving *greater visibility to minority health issues*.

This confirms the previous finding that BAP projects had a more substantial impact than might be expected given the relatively small amount of grant funding.

- Two projects attracted additional funding for more expansive immediate efforts. The North Carolina **Latino** Cultural Competency Training (LCCT) program and the Colorado medical interpretation training project attracted funds from other state agencies to sponsor additional workshops and provide stipends for individual trainees.
- Three grantees (Waterbury, California, and North Carolina) influenced the longer term direction of other federal/state initiatives even after BAP funding ceased. The Waterbury Hispanic Immunization calendar continues to be funded through CDC dollars and serves as the primary vehicle for immunization education material used during outreach to the Hispanic **community**. The CDC funded expansion of the California information and resource database system differs from most states in its emphasis on compiling data by ethnic group, a legacy of the BAP project. Even though the newly formed North Carolina **Office** of Minority Health was not the **BAP** grantee, the findings and recommendations of the project provided a basis for its assessment of **Hispanic/Latino** health service needs.
- Three grantees contributed to health delivery system infrastructure in various ways. The Colorado medical interpreter project placed five of its trainees in the County Health Department and health clinics in the area, and also instructed 17 trainers on cultural competency who provide training around the state. The California BAP database project produced working relationships, data collection forms, mailing lists, and database software

¹MDS Associates, The Bilingual Assistance Program: An Exploratory Study Final Report, February 10, 1995 (HRSA #102HR940990P000-000)

that provide the infrastructure for the current expansion of the database to include additional minority groups. Local health department representatives developed action plans during the LCCT (North Carolina) to bring about changes in system responsiveness to Latin0 clients.

- In three states, BAP projects supported the activities of small and emerging Offices of Minority Health (OMH). In Rhode Island, the grant allowed its one person OMH to supplement its staff and expand its influence by upgrading the skills of medical interpreters. The BAP resource database development project was the first activity of the California Office of Multicultural Health and increased its visibility across state government and in Asian communities around the state. Although the new North Carolina OMH was not the BAP grantee, its staff's participation in the **Latino** Cultural Competency Advisory Committee and co-sponsorship of the LCCT workshops provided visibility and a chance for community networking that provided the underpinnings for some of the North Carolina OMH's activities.

C. **Promoted Improved Working Relationships**

The exploratory study of four BAP grantees also revealed that improved interagency relationships were forged during these short-term projects. This study confirms that grantees strengthened interagency relationships through collaborative endeavors but also extends this finding to note the importance of improved working relationships with community members who are not necessarily part of an organized group. The BAP projects facilitated activities that enabled government agencies and community members to work together for a common purpose, and for many it was the first time that such an opportunity had presented itself. Examples of these approaches follow:

Strengthened interagency working relationships. Typically this approach included bringing together representatives of different agencies to advise the BAP project, but often members were more active participants. Less formal interpersonal relationships that developed throughout the projects may be as important as the formal relationships. For example:

- The California Office of Multicultural Health with the Asian & Pacific Islander American Health Forum worked as partners in the day-to-day development of the resource database. Additionally, the Advisory Committee had representatives from the Asian Health Services (Oakland), Sacramento Lao Family Community, Southeast Asian Health Project (Long Beach) and Vietnamese Community Health Promotion Project (**Suc Khoe La Vang!** University of California, San Francisco) as well as state representatives from the Refugee Health Program, Center for Health Statistics, and pertinent chronic disease programs (risk reduction, diabetes, tobacco, and breast and cervical cancer control).
- The local Colorado HABLA project Advisory Committee included Rocky Mountain SER (Service, Employment and Rehabilitation), the Migrant Health Program and the County

Health Department who worked together to train employable medical interpreters from the targeted community for the private sector. HABLA developed the curriculum and provided training; SER provided tuition assistance; the County Health Department hired one of the trained interpreters; and the Migrant Health Office was able to reduce its financial burden from providing interpretation services in the private health care sector.

- Through its Advisory Committee the North Carolina LCCT project built a coalition of agencies through its Advisory Committee with a common interest in improving health access for migrants. Membership of the AHECs helped to facilitate replication around the state; other members representing minority, migrant and rural health offices became co-sponsors of the workshops; committee members also served as faculty for the cultural competency workshops.

Creating a dynamic advisory group seems to be one way to **influence** change as is working to empower community members. Grantees also built on existing community networks such as those developed under Ryan White funding to reach out to the target communities. All members of Advisory Committees do not always buy into project goals; for example, in Colorado the project sought to change the attitude of a private family practice group towards hiring bilingual **staff**; despite membership on the Advisory Committee, the practice did not hire its own bilingual staff from the pool of trainees as some of the other Advisory committee members did but continued during its OB clinics to depend on the Migrant Health Program staff for translation.

Developed community ties to target populations. Giving an integral role in project implementation rather than unfulfilled promises to ethnic organizations and community representatives engendered trust and long term goodwill. Examples include:

- The Waterbury Health Department did not have a community reputation of being sensitive to members of the **Latino** communities. During its Hispanic Immunization Initiative, staff worked hand-in-hand with the local Hispanic Coalition, giving them a role in setting project direction, interviewing staff to be hired for the initiative, and helping convene focus groups in the **community**. Furthermore, the outcome of the focus groups is well documented so that the community participants' comments are very visible in the final calendar and poster products.
- The **Latino** Cultural Competency Training also sought innovative strategies to break down barriers between the health department and the community by providing community members a forum to express the difficulties they face in accessing health care. Community reputation surveys provided information on perceived barriers to accessing the health department that could be incorporated into the health department action plans following the workshop. Community-based **Latino** businesses were employed rather than mainstream vendors to provide support for the workshop and its social events.

The Waterbury Hispanic Immunization Initiative illustrates the importance of this involvement. When asked by other health departments around the country if they could use the immunization calendar, the project coordinator advised that each community should develop its own. She stressed that the process of building links with the community and the community's ownership of the calendar brought an immeasurable amount of goodwill. The process was particularly important to the Waterbury health department because their reputation up until that point was one that was not particularly sensitive to Latinos, partially because of its lack of bilingual staff. Other grantees echoed these sentiments, noting that the "time and energy are well-spent" but that sufficient time must be invested to build bridges.

It must also be remembered that the **Latino** and Asian communities are diverse. A single "mainstream" minority organization even at the local level, may not reflect this diversity (e.g., an Asian Assistance Society may have roots in the Chinese community and may not be as knowledgeable about other groups). The type of activities supported by BAP grants can help develop community infrastructure among various subgroups through direct community outreach, training and needs assessments.

D. Fostered Linguistic and Cultural Competence

Each of the five projects reviewed sought to improve some element of the health system related to serving limited English speaking populations. They chose a number of means for improving linguistic and cultural competence:

- hiring staff or consultants who represented and had knowledge of the target community;
- giving members of the target community an integral role in project implementation and/or evaluation;
- demonstrating and documenting changes in response to target population recommendations;
- assessing materials (e.g., health education materials, evaluation tools) for linguistic and cultural relevance; and
- empowering the minority community and its organizations by building infrastructure (e.g., skill development such as computer databases, using ethnic vendors).

As previously noted, grantees indicated developing trust within the target community and employing strategies for ensuring minority input can be time consuming but has positive outcomes.

III. PROJECT IMPLEMENTATION OBSERVATIONS

During project implementation, four out of the five grantees encountered some problems with state/local government personnel and fiscal procedures. Some were able to resolve these issues by pairing with a private organization. Other observations based on our cross-site review show that grantees: (1) take advantage of pre-existing community networks (most notably those developed through Ryan White funding); (2) make targeted use of national minority organizations; and (3) use of a variety of sources for technical assistance (e.g., mentors, AHECS, consultants, national minority organizations) and have a preference for using local talent.

A. State/Local Government Personnel and Fiscal Procedures

The short term nature of the BAP projects was often at odds with lengthy governmental requirements for hiring and reimbursement. This problem surfaced in three of the state agency projects and one local project. Two of the grantees expressly took steps to avoid delays by transferring funds to a non-governmental agency. The North Carolina **Latino** Cultural Competency Training project, where the project coordinator encountered considerable difficulty in reimbursing consultants, **Latino** businesses, and community representatives in a timely manner, is illustrative. State fiscal procedures required six weeks to set up grant accounts and two months to process requests for service reimbursement or honoraria. The project succeeded in meeting deadlines only through the incredible goodwill and commitment of a self-employed training consultant who worked for months without a contract and bore the costs of the workshops on her own credit card. Furthermore, inclusion of ethnic vendors and community representatives was an essential part of the community outreach strategy, but state fiscal procedures did not prove sensitive to the short term financial requirements of these small businesses and community representatives, who incurred child care and transportation costs when participating in workshops.

B. Building on Pre-existing Community Networking

BAP projects benefitted from other federally sponsored efforts to build community connections, specifically federally sponsored HIV programs. For example, the North Carolina BAP project utilized community connections and a needs assessment developed under Project REACH (Rural Education, Advocacy & Care for HIV), a Ryan White Title II Special Project of National Significance (1991-1994). The collaborative community planning process of Project REACH served as a model for planning the **Latino** Cultural Competency Training (LCCT) sessions. The first LCCT Advisory Committee meeting actually took place at a Project REACH sponsored conference on AIDS which included two sessions called, "A Day in the Life of a Migrant Farmworker" and "Settled-Out Latinos ." This experience gave the Advisory Committee additional first hand exposure to local **Latino** community representatives. Fifteen of the 20 people who had participated in the Settled-Out **Latino** Talk Circle continued to meet over the next few months planning the LCCT workshops and curriculum together.

C. Role of National Organizations

Across the five projects, national minority organizations played a limited role except in the California project where the Asian & Pacific Islander Health Forum actually carried out the daily tasks critical to development of the resource database. The three other grantees who consulted with national organizations benefitted from (1) specifically targeted training (e.g., HABLA Interpreter Trainer attending course on interpretation in Denver given by the Asian Pacific Center), (2) resource materials (e.g., COSSMHO *Proyecto Informar* curriculum was adapted for cultural competency training of providers and trainers in Colorado), and (3) advice (North Carolina consulted by telephone with COSSMHO as well as reviewed its materials).

D. Use of Technical Assistance

All of the grantees required assistance from consultants or other outside support in developing their projects. Each sought a different complement of persons or organizations based on the particular expertise needed. However, there did appear a preference to use local resources for day-to-day activities and national organizations for specific tasks (i.e., provision of resource materials). Only one of the sites in this study sample had a mentoring relationship. In the site visit interviews, grantees reported that the technical assistance helped in achieving project objectives.

Preference for local resources. Each of the grantees noted that physical proximity of consultants enhanced working relationships especially when frequent contact was necessary. The preference for local rather than national consultants/staff was primarily based on feelings that a local individual's personal network of resources and knowledge of the targeted area would facilitate tailoring the project approach to the area. Although California used the Asian & Pacific Islander American Health Forum, a national resource, the physical proximity of the Forum and its knowledge of California resources were key elements fostering collaboration. cost considerations (e.g., travel) and availability for day-to-day operations were also reasons cited for limited use of national organizations.

Use of mentor. *Only the* City of Waterbury had a mentoring relationship in this study sample. The mentor provided useful guidance on the use of focus groups, but the Hispanic Immunization Project Coordinator thought the information was not as timely as it could have been. She recommended that clearer guidelines be given to the mentor about the time that they needed to make available.

As a byproduct of BAP, some project staff have become advisors (or mentors) to others. For example, the Hispanic Immunization Initiative received broad dissemination through presentation at conferences; this placed the Project Coordinator, in turn, in the role of mentor to other organizations, a time consuming task.

Role of Area Health Education Centers (AHECs). Each of the four projects that involved training noted that they received materials (particularly videos) and/or assistance in organizing training from the Area Health Education Centers. Several AHECs had a prominent role on the Advisory Committee for the North Carolina **Latino** Cultural Competency Training; they co-sponsored the workshops and provided trainers. Including representation of the AHECs from the beginning of the project was viewed as a way to enhance replication across North Carolina.

IV. RECOMMENDATIONS FOR FUTURE DIRECTIONS

Our review sheds light on project implementation issues that have implications for future grant-making:

- **Length of grant period.** The short timeframe allowed for the BAP grants (3 to 8 months) contributed to: (1) some implementation problems, particularly due to state personnel and fiscal procedures, and (2) limitations in the types of activities and evaluations that were carried out.
- **Reporting and Performance measures.** Grantees, even of a similar type (e.g., training), were inconsistent in data reported.
- **Technical assistance.** All grantees required outside assistance. While showing a preference for local talent, they did consult with National Minority Organizations.

The remainder of this summary explores these findings and issues in further detail. The paper concludes with some suggestions for building upon the BAP experience in setting directions for future programs aimed at reducing linguistic and cultural barriers to health care for limited and non-English speaking populations.

A. Future Grant-making Implications

1. Limitations of Short-term Projects

Each of the BAP projects was for a relatively short term (e.g., **three** to eight months). At times accomplishment of project activities exceeded the official BAP period; for instance, in the California project the grant period was July to September of 1993, but the Southeast Asian program resource directory was not actually published until May 1994. On the plus side, the short timeframe motivated grantees to get projects up and running as soon as possible; however, the short term nature of the projects had the following effects:

- reduced scope of activities because they were originally too ambitious for the timeframe;
- required full time commitment of staff/consultants;

- increased dependence on pre-existing training materials;
- reduced efforts in community networking; and
- limited the scope of follow-up and evaluation activities.

The short timeframe of most projects often required the project coordinators to devote almost full time to the task and/or hire outside staff/consultants to carry out the tasks. Dependence on outside consultants often means that without adequate documentation, in depth knowledge of project implementation disappears once the consultant is gone. In instances where the project was the first activity of a new office (e.g., the new Office of Multicultural Health in California or new Immunization Coordinator in Waterbury), the projects yielded the offices a tangible product and increased visibility, but it did limit staff availability for other tasks.

The project time limits tended to make grantees more dependent on pre-existing materials and curricula. In some instances, this can be a positive outcome such as the use of the *Proyecto Informar* curriculum to train instructors for cultural competency training. Time pressures reduced the grantee's ability to produce curricula that are complete and fully **replicable**.² Grantees found that the opportunity to offer a training course more than once provided experiences that enriched the final training curriculum and gave staff more time to polish the final product so that it was suitable for wider dissemination.

Developing collaborative community relationships requires a lot of ground work and team building. Networking to identify community members to participate in projects, holding focus groups, following up with communities so they know that **their** input was heard and valued takes a lot of intensive one-on-one effort. Neither the Waterbury immunization initiative nor the North Carolina cultural competency training would have been as successful without their outreach to the target communities. The fact that community representatives had an opportunity to express their feelings about health services is significant. Rarely are these individuals allowed to articulate issues that arise from language and cultural barriers. Providing such mechanisms proves to be empowering for the community persons involved in the process. Trust is built. The word is spread. Barriers come down. Cooperative efforts emerge.

In the Colorado project, replication of its medical interpretation training curriculum through a "train the trainer" session only attracted two persons, and this part of the project was canceled. Additional time would have allowed a more proactive recruitment period. It is worth noting that the timing of the grants in the migrant-related training projects (Colorado and North Carolina) ended up being in the midst of migrant season which appeared to have affected response

² See companion document, Bilingual Assistance Program Evaluation Part II: Assessment of Three Training Curricula.

to training in Colorado and the Migrant Health Program staff's ability to devote additional time to active recruitment,

Importantly, the short timeframe generally limited the scope of evaluation activities. There was more of a tendency to focus on process measures rather than assessing the impact of changes on infrastructure or accessibility for clients. Documentation should go beyond dry statistics to capture memorable quotes and scenarios in case study profiles to illustrate project implementation issues and outcomes. There were no follow-up evaluation efforts three to six months post training to determine the effects that training had on individuals and organizations. Without some follow-up, it is difficult to determine if there have been any systemic changes. Only some anecdotal evidence of change was provided for the few health departments in North Carolina making changes after cultural competency training.

Recommendation: HRSA could consider a longer project term for future grants. This could be coupled with expectations that grantees: (1) will produce more polished materials and training curricula ready for further dissemination, and (2) will make further strides toward impact evaluation by conducting more extensive follow-up. Continuation of the concept of phasing is also appropriate; additional funds could be held in reserve for funding the most promising materials and evaluation techniques.

2. Grants to State and Local Governments

State and local governments offer considerable benefits. They generally provide more in-kind support than most community-based organizations could. For example, the Connecticut and North Carolina projects would have cost considerably more without this because of almost full time dedication of government staff during project period. Governmental agencies also provide easier access to a network of programs and have the clout often necessary to convene disparate groups, both of which can be instrumental in project implementation and institutionalization.

At the same time, short term grants can create problems for states where hiring and fiscal procedures are lengthy and restrictive. Some such as California avoided the issue by having the grant funds go directly to a private agency with which it developed a work agreement, in this case the Asian & Pacific Islander American Health Forum. Others such as the Rhode Island Health Department found it easier to provide reimbursement to individuals for child care and transportation via the Providence Ambulatory Health Care Foundation.

Recommendation: HRSA may want to encourage creative alliances between government and local community-based agencies. These agreements should ensure the best use of the project time period by avoiding staffing delays, and should be responsive to the needs of persons of lower socioeconomic means and small businesses called upon to participate in project activities.

BAP funds were funneled to grantees through three separate organizations (ASTHO, NACHO, USCLHO). This approach provided expanded staff resources to OMH/HRSA in

implementing BAP for grant reviews, technical assistance to grantees, and dissemination within their memberships. This three-pronged distribution system may have resulted in differences in expectations among the grantees in their responsibilities for reporting performance achievements. Also some grantees gave credit for the funds to ASTHO or another organization rather than HRSA; others gave credit to both HRSA and the other organization.

Recommendation: If HRSA adopts a similar grant making approach, they should ensure that reporting requirements and performance expectations among the organizations are consistent.

B. Implications for Future Evaluation

Setting realistic goals and measuring progress towards them is important to assessing project outcome. Each BAP project set a variety of easily monitored process measures to track progress toward accomplishment of their outcome. These, however, were not consistent in level of documentation even for similar projects such as training programs. Documentation of longer-term impact, such as what impact the project has had on changing system infrastructure or improving effective access for those with limited English proficiency, relied more heavily on qualitative assessments and judgements by project participants. Additionally, all training projects employed some means of individual assessment of trainees, usually a combination of pre and post training evaluations.

1. Strengthening Program Expectations

Developing a uniform, objective set of performance expectations is a challenge to any grant program that funds diverse projects designed to meet local needs and circumstances. During this study, we explored the types of quantitative and qualitative data collected by grantees and the grantees' views on appropriate performance measures for projects of this type.

The expectations outlined in Exhibits ES. 3 and 4 present the types of information gathered by this sample of grantees. Some specified the objectives in quantitative terms at the outset of the project; others used more narrative statements. These data were not collected systematically across all grantees even among those performing similar activities, but they illustrate that it is quite possible to design objectives at the outset, both quantitative and qualitative, that will lend themselves to cross-program analysis at the end of the grant period. The elements in Exhibit 3 are primarily descriptive, but also encourage applicants to think about methods of assessment and project replicability in advance. Some elements such as demonstrating leveraging of federal funds, building health system infrastructure and assessing impact (Exhibit ES.4) might require extra effort and might serve as justification for increased funding and/or an extended project period.

Consistency of data among projects. Grantees did not collect uniform data even for the same type of activity. For example, among the four grantees offering training in this study, some set specific goals at the outset on the numbers and types of persons to be trained, and others only

specified that training sessions would be conducted. It was easy to note that the Colorado project met its objectives in terms of numbers trained, and that certain targeted individuals like **the** Cora Indian group were harder to reach and might require a more individualized approach. When there is lack of clarity in specifying who would receive training in cultural competency or how to use an interpreter, this masks problem areas in implementation. For example, objectives that state training of physicians or policy-makers (e.g., Health Department Director) as a priority are more easily monitored if numbers are reported for these specific categories. It was only upon questioning in the site visits that it became clear how difficult it had been for projects to recruit physicians into training because measures are often constructed solely to include categories like health professionals or persons in health-related jobs.

Recommendation: HRSA could consider requiring grantees to address the elements outlined in the accompanying exhibits in designing future project proposals and use them as a framework for analyzing overall program accomplishments. Previous project activities fell into four main activity areas (product development, training, service delivery, information resource). Projects often combined activities in different configurations (e.g., curriculum products plus training, information database of interpreters plus training). The outlined elements give more structure to future evaluations yet still give future recipients flexibility to address their particular needs.

Improving assessment of project activities and potential for replication. While all grantees reported their achievements, critical assessment of those achievements was often limited. For example, the number of trainees might be reported, but little or no information would be collected on the amount of knowledge gained and/or skills developed that trainees could apply in a health care setting. More detailed assessment would lend credibility to efforts to replicate the program model.

Recommendation: OMH/HRSA could require grantees to develop methods to assess knowledge gained by trainees as well as the appropriateness, usefulness, and cultural competence of project activities. Grantees may need assistance in refining these assessment approaches (e.g., pre/post training evaluations) during implementation. Applicants should also address what their plans will be to insure replicability (e.g., video of training process, curricula free of copyright restrictions, case study).

Exhibit ES.3 Specification of Project Objectives

- Specific process and outcome objectives (expressed in quantitative terms wherever possible) with timelines for each program activity. Projects may have a combination of activities (e.g., development of curriculum product followed by training activity) and would select the appropriate sets of activity measures below:
 - **Product development activities (e.g.,** curriculum, a directory, a health education product) would specify: the development approach (e.g., adaptation of pre-existing curriculum, new development, review by target group); type of product and number of copies to be produced; distribution strategy; methods for assessment of appropriateness, usefulness and cultural competence; and plans for ensuring replicability to other sites.
 - **Training activities** would specify: number and type of personnel trained [e.g., physicians, other professionals (nurses, nurse practitioners, etc.), health related service personnel (e.g., outreach workers), administrators] as well as demographic information (e.g., membership in target population, bilingual); content of curriculum; certification; subjects covered; criteria for acceptance of trainees; methods of assessment of knowledge gain and appropriateness/usefulness/ cultural competence; changes in policy or practices and plans for ensuring replicability to other sites (e.g., include tram the trainer materials).
 - **Service delivery activities (e.g.,** direct service/outreach) would specify: number and type of persons served (e.g., demographic characteristics); intervention model; how will change existing policies/practices; culturally appropriate means of assessing patient/community satisfaction; and replicability of model to other sites.
 - **Information resource activities (e.g.,** information referral center, medical interpreter referral system, database development) will require specification of: the number and types of resources to be **catalogued** or developed (e.g., interpreters or programs or materials); information retrieval categories (e.g., disease, preventive health service, risk factor, language); types of information to be collected; how will change existing policy and practices; methods for assessing appropriateness, usefulness and cultural competence of information; and plans for replicability to other sites.
- Describe the collaborative relationships (e.g., interagency within government, government to private sector, community-based organization to health facility) **that** are integral to project implementation and describe the roles of each in development and implementation and how this collaboration will lead to higher visibility.
- Describe the role of the target population, minority organizations, and/or community representatives in development and implementation of the project.
- Describe the elements that will ensure that this project will be culturally competent.

Exhibit ES.4 Specification of Project Objectives

- Describe how the project will leverage these federal funds to attract other funds for the implementation of the specific project, its expansion, or institutionalization.
- Describe how the project builds infrastructure (e.g., train people who are then hired in health setting; developed health education materials used in outreach; train trainers who extend the developed curriculum to others). This is an area that may be most applicable to longer term projects, and could be a criteria in determining extended funding.
- Describe the measures they would use in assessing the impact of their projects on the target population and the health system infrastructure. (While grantees may need assistance in crafting the means to evaluate impact, they often can suggest creative ideas for the direction of these evaluations; the worthiness of these ideas might be one determinant in whether grantees would get extended funding).

Collaborative relationship building. While not usually set out as a specific goal or objective for a project, grantees found relationship building with other organizations and target communities perhaps the most important and longest lasting outcome for all projects. A challenge for evaluation is how to track and measure or at least document this component. Too often minority groups are contacted at the outset of projects to provide their imprimatur so that an applicant will receive a grant, but then minority groups feel taken advantage of when not given a substantial role in implementation. Projects in this study employed various ways to go beyond cursory involvement of minority groups and organizations, giving them integral roles in the project.

Recommendation: *Future grantees should be on notice of the necessity to provide meaningful involvement to the target population(s) and to document their contributions.*

Strengthening health system infrastructure. The BAP had an implied expectation that grantee activities would strengthen community infrastructure. This study has afforded a longer term view of how these projects contributed to health delivery system infrastructure and how objectives might be crafted at the beginning of a project to ensure that material development or training are not isolated events. Steps to institutionalize programs or build infrastructure were not typically spelled out in BAP program objectives. However, it should be noted that these steps are more likely to be achieved when the grantee received longer terms of BAP funding or continuation funding from another source. Training or product development can be followed up with specific steps to ensure that there are changes in infrastructure. Examples follow:

- The HABLA project (Colorado) set an objective to place a certain number of trainees into health service delivery jobs and documented this capacity-building goal in its final report. At our site visit, three years later, we were able to meet with several of the trainees who are still employed in the County Health Department and health clinics in the area.
- OMH staff for the California database project indicated that the greatest legacy of the BAP project was not the directory produced but the infrastructure for its current expansion (relationships, data collection forms, mailing lists, database software).
- The culminating activity in LCCT (North Carolina) was development of individual action plans for each local health department which listed at least two steps the department could take to increase cultural competence (e.g., hiring a trainer to provide basic Spanish skills to staff).
- The HABLA ‘train the trainer’ program in cultural competency set an objective that each person should do turn-around training in his or her community within one month of the HABLA program. Four of the 17 were able to do it within the tight timeframe.
- At the end of its project, Rhode Island suggested that development of a Medical Interpreter Association in Rhode Island could be an outcome of the Academy. While this did not

happen, if it had been built into the objectives of the project it could have provided a locus for continuing education programs and support among interpreters after termination of the grant.

Recommendation: In the future, project activities -- whether they be curriculum development, service delivery, or training -- should not be evaluated only as isolated events. Rather evaluation frameworks should consider these as events that can foster more permanent changes in the health system and make it more responsive to the target community. While all grantees should be able to develop ideas/plans for such institutionalization, additional time in the grant period and additional funds might be required to accomplish/finish the planned tasks. OHM/HRSA could consider a separate follow-up grant phase for those projects with the most promising approaches.

Documenting improvements in access or health status. Documenting improvements in effective access or improving health status for those with limited English proficiency is perhaps beyond the scope of most short-term projects like those funded under BAP. It is difficult to isolate the effects of a BAP project on health status and little information was gathered by grantees that related to improvements in health status and access. Direct service delivery projects may be more successful in documenting this type of change (e.g., increase in number of **Latino** clients served).

One grantee, the Waterbury Health Department, was able to document changes in immunization compliance over two years during a period of continued CDC funding. Baseline data showed that 39-53 % of children in the three target health centers were up-to-date by age two for the 4:3:1 childhood immunization series.³ Now the centers have 75 to 90% completion rates, with the rate for Hispanics at 88%. Isolating the effects of the health education materials from the accompanying outreach and follow-up has not been possible, but the Immunization Coordinator cites the trust built between the health department and the Dominican and Puerto Rican community during the BAP project as important in people's receptivity to the immunization outreach worker.

Several other grantees had specific ideas about how to approach these issues but were not able to accomplish them within the timeframe of the grant. These approaches give ideas that have the potential for testing in future longer term projects.

- The **HABLA** project (Colorado) wanted to track if there were improvements in the rate of keeping appointments once bilingual staff were available in primary care settings.
- The North Carolina LCCT developed a survey and interviewer's guide for assessing the community reputation of local health departments. The survey was employed to develop baseline information used in the workshops, but sufficient time had not elapsed between

³ 4 DPT: 3 oral polio: 1 MMR.

the workshops and the end of the grant to assess whether there was a change in community reputation.

Recommendation: OMH/HRSA could also consider follow-up grants to develop methods to assess improvement in access and health status.

C. Building on BAP--Potential Future Directions.

Examination of the experience of these five projects yields some lessons that deserve consideration in designing future bilingual assistance grants. Review of the experiences of these grantees has suggested a variety of topics for focusing program directions, and areas where technical assistance would benefit future grantees. This assistance could be offered from a more centralized resource (e.g., OMH Resource Center, national minority organizations, contractors). Alternately, some of these areas lend themselves to being priorities for model development by new grantees. Areas where collaboration within DHHS might benefit issues of common concern are noted.

Strategies for attracting health professionals, especially physicians, to training. Both of the projects (Colorado, Rhode Island) that offered training to health professionals in cultural competency and how to use medical interpreters initially had difficulties attracting health professionals. The lesson from these projects is when the time commitment was reduced (e.g., from 2 days to 1 day; or 2 days to 2 hours), recruitment was more successful. However, there remained difficulty in attracting physicians to these sessions, even when offered in the context of a hospital Grand Rounds. Other types of projects have found that MDs, CEOs, and Board Chairs often require a specialized training environment. The AIDS Education and Training Centers (AETC), whose responsibility it is to train physicians, may be a good technical assistance resource.

Recommendation: OMH/HRSA might work with the Bureau of Health Professions on gathering and developing strategies for exposing physicians to these issues. Suggestions made at the state level were tying training to licensure, residency training, or contract requirements. Another suggestion is to tap the pool of foreign-born or first generation health professionals in recruiting and training their peers. OMH/HRSA might work with national medical associations in securing continuing education credits for specific cultural competency and medical interpretation programs.

Strategies for reaching immigrant groups where bilingual personnel are rare. The approaches employed in the Medical Interpreter Training projects appeared to work better for those who had very good English and second language skills. Those whose English was limited (e.g., Huichol and Cora Indians of Colorado; some Southeast Asians in Rhode Island) were not able to keep up with the quick pace of either the Colorado or Rhode Island models. These people often represent groups who have not only the greatest health care needs but also the most limited ability to communicate. In some parts of the country the immigrant populations are changing and interpreters for additional languages and materials for these emerging groups are needed.

Recommendation: HRSA could put a priority on development of different models to provide medical interpretation for emerging immigrant groups.

Strategies for promoting the hiring of medical interpreters. Each of the BAP sponsored medical interpretation training programs had many more applicants than could be accommodated. The former grantees still report continued dependence by providers on family members, and housekeeping staff in hospitals. The need appears particularly acute in rural areas where migrants have settled out and for new immigrant groups whose language is not as well known in this country.

Recommendation: HRSA could help grantees by helping to clarify expectations and educate grantees and providers about responsibilities under civil rights and Hill-Burton regulations. This is particularly important in the current anti-immigrant climate. The Office of Civil Rights and the Health Care Financing Administration co-sponsored a conference and research study on these issues in 1995. The Rhode Island project noted the positive impact on providers of the AARP's Health Watch study which pointed out violations of these provisions in that area.

Defining the role of a medical interpreter. Another area needing attention is what is the role of an interpreter and what level of training should HRSA grantees expect that interpreters have. Organizations such as the Massachusetts Medical Interpreters Association have been trying to work toward defining “standards of practice and/or credentialing criteria” for medical interpreters. Professionalization is one avenue, but many organizations cannot dedicate a person solely to interpretation and prefer to hire someone who also acts as an outreach worker/health advocate.

Recommendation: HRSA could convene a panel to examine: (1) the state of knowledge with respect to the effectiveness of different modes of medical interpretation; (2) the practical realities that HRSA grantees face in recruiting, training, and paying medical interpreters; and (3) what agencies can realistically expect to achieve in one-time v. ongoing training for medical interpreters. (This recommendation overlaps with one in the separate review of the BAP sponsored training curricula).

Strategies to avoid reinventing the wheel. Grantees have limited ability to distribute materials developed under their projects to a wider audience; they need assistance. For example, the Connecticut project gained visibility and promoted its accomplishments at national conferences but was not equipped to respond to requests for hundreds of copies of its calendar. The federal OMH Resource Center was not intended to act as a clearinghouse, but as a reference center giving grantees ideas about where to go for additional ideas and giving citations from the published literature. Under this approach future grantees who wanted to benefit from past BAP funded projects would have to contact the former grantee directly; besides the burden on individual grantees, given our difficulty in tracking down copies of materials once there is staff turnover, this suggests that material availability is very time limited. Perhaps as part of initial technical assistance, future grant recipients could be provided with a package of similar products and

resources by the granting agency. Surprisingly, the Waterbury Immunization Coordinator was not even aware of the existence of National Council of La Raza and COSSMHO, nor was the local Hispanic Coalition.

Background materials that are culturally related maybe more plentiful than just those targeted to culture and health. Caution should be exercised in the development of materials; immigrant needs change the longer they are here. Specific scenarios rather than generalizations about groups of people tend to be less offensive.

Recommendation: HRSA could work with the federal OMH Resource Center, national minority organizations, the Area Health Education Centers and other groups such as the AIDS Education and Training Centers in developing pertinent packages of background materials.

Development and evaluation of health education materials. Grantees noted health providers' concern about not having the ability to assess the appropriateness of health education materials in different languages. Neither the federal OMH Resource Center nor the California Resource Directory project provide this level of review. The OMH Resource Center has some in-house Spanish language capability, but none for other languages. In this sample the North Carolina and Waterbury grantees performed reviews, but it was limited to Spanish language materials. North Carolina compiled existing materials, and Waterbury reviewed existing materials and developed their own. The need for appropriate language materials is most acute for newly immigrating groups. Also grantees noted that many health areas are neglected in bilingual health education materials; while information on perinatal issues is often available, other areas (such as chronic disease, breast cancer, preventive screening for adults, death and dying issues) are neglected. The model Resource Manual for Spanish/English perinatal and family planning education produced in the North Carolina project is a model that could be extended to other health areas in multiple languages with attention to proper literacy levels. The North Carolina project used two levels of review, bilingual, bicultural health professionals and monolingual users.

Recommendation: OMH/HRSA could work with the federal OMH Resource Center, the Area Health Education Centers, and HRSA grant recipients to develop priorities for health education materials and provide the means for review and evaluation of these materials, particularly for less common languages.

Development of replicable products. Successful replication of training curricula or health education materials requires a substantial investment of dollars specifically in the production of the product itself. Producing replicable products that are professional looking and complete is costly in time and materials; grantees particularly need guidance on what would make a complete and replicable curriculum product. Some of the curricula produced under BAP and reviewed for this study often incorporated xeroxed material from copyrighted sources; this was an expeditious way to produce portions of the curriculum, but it does not leave it ready to replicate as is. The full texture of the courses offered is not always documented in writing (for example, the curriculum suggests role playing without giving scenarios for role playing; outlines but not text

of presentations are available). Videotaping portions may have captured the classroom dynamics and content better, but it is costly and may be intimidating to some students. All of the training programs did make use of existing videos obtained from the AHECs. These were of varying quality.

Recommendation: If OMH/HRSA wishes to continue to support local development of curricula and health education materials, grantees appear to need guidance with respect to the use of pre-existing documents in training, and how to produce a polished product for further dissemination. National minority organizations, AHECs, training institutions or contractors might provide assistance in the production of replicable materials. (This recommendation overlaps partially with the separate review of BAP sponsored training curricula).

Evaluation assistance. Projects would benefit from technical assistance in setting and measuring performance. This is needed not only to enhance their own ability to measure project success, but also would enable OMH/HRSA to ensure that the measures would be constructed to yield an overall BAP program evaluation. One approach to providing evaluation assistance used by The Robert Wood Johnson Foundation 'Opening Doors' projects is pairing grantees with qualified evaluators in their area under the guidance of a national program evaluator; these project budgets are quite a bit bigger and span multiple years.

Recommendation: Further specification in program guidance of the expectations for evaluation will help as would providing samples of instrumentation such as those for pre/post tests for training, and patient satisfaction and/or community reputation survey tools. HRSA could also consider adapting the approach used by the RWJ project to suit the scope of future bilingual grants.

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Appendix A Information Collection Guide

Appendix B Site Visit Reports

I. INTRODUCTION

The Disadvantaged Minority Health Improvement Act of 1990 authorized the Bilingual Assistance Program (BAP), a three year initiative to improve the health status of racial and ethnic minorities. Under the program, the Health Resources and Services Administration (HRSA) provided grant funds to three national organizations — Association of State and Territorial Health Officials (ASTHO), National Association of County Health Officials (NACHO) and U.S. Conference of Local Health Officials (USCLHO). These organizations, in turn, awarded grants to state and local health departments, on a competitive basis, for projects focused on reducing cultural and linguistic barriers to care among Asian/Pacific Islander and Hispanic populations.

In 1994, the Office of Minority Health/HRSA contracted with MDS Associates for an exploratory study of four projects funded under the BAP.¹ The study had two primary objectives: (1) to gain an improved understanding of the funded projects and (2) to explore approaches for conducting a more comprehensive evaluation built upon their experience. The study raised a series of issues that became the underpinnings for the research questions of the current study.

The research objectives of this study are to examine:

- factors that allowed projects to leverage federal funding and to promote improved inter-agency working relationships.
- realistic approaches to setting performance measures.
- technical assistance needs of grantees, including exploring their use of national minority organizations and mentors.
- replicability of the products or training curricula developed by the grantees.

This paper examines the strategies employed by grantees to reduce cultural and linguistic barriers based on our assessment of the experience of individual grantees, with data collected from site visits interviews and review of background materials. A second document, “Bilingual Assistance Program Evaluation Part II: Assessment of Three Training Curricula,” draws upon information obtained during the site visits and an in-depth review of the BAP developed curricula and training approaches.

¹ MDS Associates, The Bilingual Assistance Program: An Exploratory Study: Final Report, February 10, 1995 (HRSA #102HR940990P000-000).

A. Overview of Bilingual Assistance Program (BAP)

During 1992, ASTHO, NACHO and USCLHO conducted surveys of their membership to (1) examine policies targeting linguistic minorities, (2) assess the capacity of health departments to provide services to cultural and linguistic minorities, and (3) identify exemplary models of service delivery. During year two, 13 grants were awarded to health departments (see Exhibit I. 1).

Grantees under BAP conducted a variety of activities directed toward the overall goal of increasing organizational capacities to serve cultural and linguistic minorities. These approaches included:

- ***Development of products for the grantee 's own use in project implementation***, including cultural competency and health education training curricula; medical interpreter training curricula; culturally and linguistically-appropriate health education and outreach materials; and resource directories.
- ***Conducting training in cultural competence and medical interpretation*** for interpreters/translators, project and health department staff, health professionals in the community, and staff of community-based organizations.
- ***Provision of interpretation and other direct services*** such as outreach/case finding activities directed toward community providers and members of target populations;
- ***Development of statewide resources***, including expansion of a state health database on minorities, a medical interpreter resource and referral center, and resource directory of health programs and health education materials for Southeast Asians.

B. Study Approach and Site Selection

This descriptive evaluation relies on case study methods to examine research questions of interest and to assess the lessons learned from the experience of five of the 13 BAP grantees. Site visit interviews and review of background documentation provide the major information sources for this project. Our guide for information collection has modules dedicated to different activities (training, interpretation/translation services, cultural competency, outreach, and database development) (See Appendix A). The site visit teams included personnel with expertise in both the language and culture of the major target populations.

Exhibit I.1 1993 BAP Grantees

<i>Grantees</i>	<i>Target Group</i>	<i>Project Focus</i>
ASTHO		
California Office of Multicultural Health*	Southeast Asians	Development of program resource database
Colorado Migrant Health Program*	Migrant and settled out Latinos	Medical interpreter and cultural competency training
Massachusetts Department of Public Health**	Asians and Hispanics	Cultural competency training and development of needs assessment database
Michigan Ingram County Health Department	Hmong	Outreach
Minnesota Department of Health	Hmong, Vietnamese, Laotians	Centralized medical interpreter resource and referral center
North Carolina Women's Preventive Health Services Branch*	Migrant and settled out Latinos	Cultural competency training
Rhode Island Office of Minority Health*	Diverse populations, including Asians and Latinos	Medical interpreter training
NACHO		
Hawaii Department of Health Adult Mental Health Division. **	Asians/Pacific Islanders	Training in Western concepts of mental health and integration of mental health services at local level
Howard County Health Department (Maryland)**	Hispanic, Korean and Vietnamese women	Outreach and health education services plus training in cultural competence and medical interpretation
San Luis Obispo County Health Agency (California)	Hispanics	Outreach
* Grantees visited in the current study. ** Grantees interviewed in the exploratory study.		

Exhibit I.1 1993 BAP Grantees (continued)

<i>Grantees</i>	<i>Target Group</i>	<i>Project Focus</i>
USCLHO		
Toledo Health Department (Ohio)**	Chinese, Laotians, Vietnamese	Advocacy and support services for men and the elderly; cultural sensitivity training; and health education materials and classes for clients
Waterbury Department of Public Health (Connecticut)*	Dominicans and Puerto Ricans	Health education materials on immunization
Springfield, Massachusetts Department of Health	Amerasian/Vietnamese women	Outreach and health education
<p>* Grantees visited in the current study. ** Grantees interviewed in the exploratory study.</p>		

OMH/HRSA selected the five grantees for the study. These five grantees constituted a cross-section of the types of programs funded under BAP, with the exception that no direct service delivery programs were included:

- Three involved training in medical interpretation techniques and cultural competency; one developed health education materials and another a resource database.
- The projects addressed **Latino** and Asian populations
- One had an alliance with a national minority organization and one used the services of a mentor.

C. Organization of Report

The focus of this study was to learn more about the strategies employed by grantees to reduce cultural and linguistic barriers. This report examines not only the achievements of the BAP projects but also the lessons their experiences hold for **future** endeavors. Chapter II profiles each of the study grantees individually. These profiles summarize steps in project implementation, evaluation of project objectives, and whether the activities set in motion by BAP continue into the present. Chapter III moves into the cross-site analysis, looking at the immediate achievements of **the** grantees and **their** longer term effects as well as typical implementation issues, technical assistance sources, and evaluation approaches. Chapter IV develops recommendations for setting **the** direction of future initiatives in this area and a framework for program expectations.

II. DESCRIPTIONS OF STUDY GRANTEEES

A. Overview

Different circumstances triggered various approaches for BAP grantees, but they all had in common efforts to improve the delivery of health care to those with limited English proficiency. This chapter examines the objectives set for these projects, how they were implemented and evaluated, and how minority groups were involved in implementation. Looking back at these projects after several years gives a unique opportunity to determine if the projects were able to continue after BAP funding.

The five sites selected for this study, their activities, and target populations included:

- California Department of Health Services, Office of Multicultural Health project developed a resource database/directory of health education materials and service delivery programs related to chronic disease among Southeast Asian populations.
- Colorado Department of Health, Migrant Health Program project developed a Medical Interpreter Training Syllabus and trained bilingual personnel in medical terminology and interpretation techniques for use primarily with “settled out” Latino migrant populations.
- City of Waterbury (Connecticut), Department of Public Health project developed health education materials in concert with the Hispanic community (Puerto Rican, Dominican) to support an immunization initiative.
- North Carolina Department of Environment, Health & Natural Resources, Division of Maternal and Child Health project developed and implemented a cultural competency curriculum for local health departments for addressing the needs of the migrant and settled out Latino population.
- Rhode Island Department of Health grant offered a Medical Interpreter Training Academy to improve skills for medical interpretation among diverse populations, including Hispanic (Puerto Rican, Dominican, Colombian) and Asian (Hmong, Cambodian, Laotian, Vietnamese) communities.

Exhibit II.1 summarizes the objectives, target populations and funding levels of the five projects. The grants were a relatively small investment of federal dollars.

Exhibit II.1 Overview of Case Study Sites		
<i>Objectives</i>	<i>Grant Amount</i>	<i>Target Group</i>
<i>Southeast Asian (SEA) Health Information Database California Office of Multicultural Health</i>		
<ul style="list-style-type: none"> • Develop resource database and directory of health programs and educational materials for Southeast Asians. • Apply for expansion funding. 	\$20,000	Southeast Asians, including Cambodians, Chinese-Vietnamese, Vietnamese, Hmong, Laotians, and Mien.
<i>Health Access by Language Advocacy (HABLA) Colorado Migrant Health Program</i>		
<ul style="list-style-type: none"> • Develop medical interpretation curriculum and training program. • Train health professionals in cultural competency. • Train instructors in cultural competency and medical interpretation. 	Phase I \$11,957 Phase II \$28,692	Mexican migrant and settled out workers
<i>Hispanic Immunization Initiative Waterbury (Connecticut) Department of Public Health</i>		
<ul style="list-style-type: none"> • Develop culturally and linguistically appropriate childhood immunization materials. 	\$21,000	Puerto Rican and Dominican immigrants

Exhibit II.1 Overview of Case Study Sites (continued)

<i>Objectives</i>	<i>Grant Amount</i>	<i>Target Group</i>
<p><i>Latino Cultural Competency Training (LCCT)</i> <i>North Carolina Women's Preventive Health Services Branch</i></p>		
<ul style="list-style-type: none"> • Develop cultural competency curriculum and deliver training to county health department staff. • Compile Spanish language health education materials 	<p>Phase I \$15,000</p> <p>Phase II \$24,800</p>	<p>Migrant and settled out Latinos</p>
<p><i>Medical Interpreter Training Academy</i> <i>Rhode Island Office of Minority Health</i></p>		
<ul style="list-style-type: none"> • Develop medical interpretation curriculum and provide training to upgrade the skills of individuals employed as interpreters. • Provide in-service training for health professionals on effective use of interpreters 	<p><i>\$14,326</i></p>	<p>Diverse multi-ethnic community (Southeast Asians, Latinos, Portuguese, Armenians, & Russians)</p>

B. Profiles of Grantees

Each grantee developed an approach designed to address a specific local need. This section presents brief profiles of the five study sites; more extensive site profiles appear in Appendix B.

1. Southeast Asian Health Information Database Office of Multicultural Health, California Department of Health Services

Objectives: The California initiative was to develop a prototype resource database and directory of health service delivery programs and health education materials related to chronic disease among Southeast Asians as a basis for securing additional funding.

Justification for Grant: California has the largest Asian and Pacific Islander population in the United States, and 20% of the state's limited English speaking population speak an Asian or Pacific Islander language. Several chronic conditions (cancer, diabetes, heart disease/stroke) and risk factors (tobacco and nutrition) were five priority areas identified in the Asian and Pacific Islander Task Force Report on the Year 2000 Health Promotion Objectives and Recommendations for California (1992) and needing attention.¹ The Office of Health Services (CDHS) chronic disease/injury control staff attended a conference sponsored by CDC on the federal Combined Health Information Database (CHID)¹ and found that it had very limited information on program resources for Southeast Asians.

Role of Minority Groups in Project Implementation: The project gathered community input by involving the Asian & Pacific Islander American Health Forum (hereafter referred to as the Health Forum) and community leaders on an Advisory Committee with state health officials. State officials brought knowledge of chronic disease programs while the representatives of community-based organizations helped ensure a culturally sensitive survey questionnaire as well as helped identify organizations and agencies serving Southeast Asians. The Advisory Committee community representatives came from Asian Health Services (Oakland), Sacramento Lao Family Community, Southeast Asian Health Project (Long Beach) and Vietnamese Community Health Promotion Project (Suc Khoe La Vang! University of California, San Francisco). State representatives came from the Office of Multicultural Health, Refugee Health Program, Center for Health Statistics, and pertinent chronic disease programs (risk reduction, diabetes, tobacco, and breast and cervical cancer control). Furthermore, the Health Forum played a key role in carrying out survey and research activities with OMH and Advisory Committee oversight and guidance.

¹The Combined Information Database (CHIC) is a federally produced computerized bibliographic database of health information and health education/health promotion resources produced by CDC, NIH, HRSA, and the Veterans Administration.

Implementation of Project Objectives: Development of the database required devising a data collection strategy, designing an information collection form, choosing software, and deciding on a format for a final product. The data collection strategy was a joint endeavor with **OMH** focusing on state and local government while the Health Forum targeted private groups serving Southeast Asian populations.

The initial proposal stipulated that they would collect program descriptions for projects addressing chronic diseases among only two groups--Laotian and Vietnamese. It became apparent many programs served a broader Southeast Asian community and a wider net could be cast to collect pertinent information for all Southeast Asian groups at one time. Thus, the data collection form queried which target populations were served (giving 18 Asian/Pacific Islander ethnic group choices that match census groupings), and inquired about the availability of written and oral language translation capability for six Asian languages. Similarly, the initial five chronic disease choices were expanded to 18 possible health programming choices.

The product developed from the database is the Southeast Asian Health Information and Resource Directory of Chronic Diseases. Over 350 copies of the original survey instrument were distributed, but the final directory lists only 69 programs. Program descriptions in the directory follow the format of the data collection form and include name, contact, address, phone, program areas and activities, Asian and Pacific Islander group served, language capabilities, settings, target population, goals and objectives, funding, and available information materials. The directory index sorts programs by ethnic group (Cambodian, Chinese-Vietnamese, Hmong, Laotian, Mien and Vietnamese) and by chronic disease and associated risk factors (cancer, cardiovascular diseases, diabetes, exercise/fitness, hypertension/stroke, nutrition, and smoking and tobacco).

Technical Assistance: The BAP funded project required technical assistance in two major areas--training in software for database development and identification of and liaison with Asian and Pacific Islander groups. Since the intention of the project was to develop a database that was compatible with the CDC Combined Health Information Database (CHID), staff chose the same software used by CDC, **ProCite**, for easier export and import into the CHID. Use of this bibliographic retrieval software has proven challenging because it is not user friendly beyond standard bibliographic entries and output, but it provides greater indexing and searching capabilities than a standard word processing program. CDC provided continuous support in the use of **ProCite** software, providing on-site consultation as well as by telephone. The Asian & Pacific Islander American Health Forum contributed its specific knowledge of the target communities and lists of constituents involved in health programming for Asian and Pacific Islanders. The Health Forum also ran the day-to-day operations of surveying and compiling of data.

Measuring Success: The project met and exceeded its goals of developing an operational database with information related to at least two Southeast Asian groups and five chronic diseases. They developed and distributed approximately 500 copies of the directory. The project took

considerably longer than the three months originally envisioned; the directory was not published until May 1994. Selected programs from the directory were listed in the federal Combined Health Information Database (CHID). Staff indicated that the greatest legacy of the BAP project was not the directory produced but the infrastructure for the current expansion (relationships developed, data collection forms, mailing lists, and database software).

The BAP project promoted collaborative effort between the new Office of Multicultural Health and community based organizations. The relationships have led to increased communication between state government and each of the target groups. This has served as a springboard to collaborative work on issues of common concern like the implementation of Medicaid managed care.

Continuation of Effort: The development and expansion of a multicultural health information network continues to be a primary focus of the Office of Multicultural Health. The basic infrastructure built under the BAP project supports this expansion to Latinos, Native Americans, Blacks and additional Asian & Pacific Islander Americans. The elements of the database system (database elements, survey forms, software) and the original pairing of OMH and the Asian & Pacific Islander American Health Forum remain. Expansion funding comes from CDC and the Preventive Health Services block grant. The original survey questionnaire has been adapted to each group's needs; for example under the category of diseases/conditions, the Native American questionnaire asks about fetal alcohol syndrome, and the Black Health Network form asks about sickle cell disease.

The expanded database will also include a "Resource Rolodex" of individuals to expand the network of resource consultants, trainers and other experts on health care for ethnic/racial communities that the state and others can engage for providing cultural competency training and technical assistance to others.

2. **Health Access by Language Advocacy (HABLA)** **Colorado Department of Health, Migrant Health Program**

Objectives: The Migrant Health Program received two BAP grants to (1) develop and deliver medical interpreter training for Hispanics and (2) train health providers in cultural competency. Phase I (February to June 1993) concentrated on the development of the medical interpretation curriculum and the first training session. The locus of curriculum development and training was Delta (Colorado) on the Western slope of the Rockies. Phase II (July-September) continued the training but also sought to provide "train the trainer" workshops in both medical interpretation and cultural competency statewide.

Justification for Grant: Since the Immigration Reform and Control Act of 1986, many of the 6,000 to 9,000 migrant and seasonal farmworkers working in Delta and Montrose County settled out of the migrant stream to remain in the community. This immigrant population needed access

to year-round health services in a community with a limited history of providing health services to monolingual clients. Neither the Health Department, Montrose County Nursing Service, nor the only OB/GYN practice in the area employed bilingual staff. The monolingual population of the area had increasingly put demand on the Delta Migrant Health Program (MHP) office to provide interpretation services (2,063 hours in 1992) whenever they accessed health care services in the community. A survey of community physicians found that they depended on the MHP or migrant family members for interpretation rather than employing bilingual staff. The project sought to shift this burden by training medical interpreters who could be hired by these providers or by individuals seeking care.

Role of Minority Groups in Project Implementation: A Local Advisory Committee, composed of providers of services but not members of the migrant community itself, was established to address local implementation issues. It was composed of representatives from the Delta Migrant Health Program, the County Health Department, Rocky Mountain SER (Service, Employment and Rehabilitation), West Central BOCES, and Delta Family Physicians. A State Advisory Committee addressed "big picture" issues such as replicability and critical review of implementation. While the MHP held occasional focus groups on issues of health in which farmworkers had expressed a need for better communication with providers, the Local Advisory Committee did not ask migrants about some critical implementation issues in this project such as their willingness to pay for interpretation services or their ability to access transportation to and from medical appointments. The Denver-based LARASA provided a trainer for the first cultural competency training session.

Implementation of Project Objectives: The first step in implementation was development of the curriculum guide, "BASIC INTERPRETING SYLLABUS Medical Terminology." Two training sessions were held; with 18 participants completing the program. An attempt to replicate the sessions by offering a train the trainer workshop was cancelled when only two persons signed up for the workshop.

The HABLA curriculum stressed medical terminology and a professional interpretation style that fostered face-to-face contact between client and provider. The course was a combination of 27 hours of classroom work and a four hour supervised interpretation internship during actual provider/client encounters. The curriculum employs a variety of techniques including: (1) learning Spanish and English vocabulary of anatomy, body functions, simple signs and symptoms; (2) memorization exercises; (3) role playing as providers, patients, and interpreter; and (4) videotaping interpretation skills of students. Students were encouraged to expand upon the standard written vocabulary list and enrich it with any idiomatic expressions with which they were familiar. The same pre and post tests measured student progress in learning the course content.

From the beginning, the Local Advisory Committee stressed that they wanted to train people who would be highly employable so that the HABLA program would have lasting value. They wanted to find trainees who were bilingual and already had experience interpreting. All candidates had at least finished high school. The HABLA course was developed in affiliation with the

Delta/Montrose Vocational Technical Training Center; placement at the school, however, made it necessary to charge tuition. To make tuition bearable for the target population of trainees (i.e., under \$100), the number of class hours had to be limited to 27. This limitation in hours translated into a limited scope in curriculum.

In Phase I cultural competency training was offered in a one day workshop for health workers in the Delta area, cosponsored by the Colorado Migrant Health Program, LARASA, and the Western Colorado Area Health Education Center. COSSMHO's *Proyecto Informar* training, which normally takes 2 1/2 days, provided the basis for the training. Eighty people came for the training. No physician signed up for the class although staff working in their offices came, including three mid-level providers. In Phase II, a 2 day cultural competency workshop provided training to 17 trainers from rural areas throughout the state. Materials used included COSSMHO's manual "Delivering Preventive Health Care to Hispanics," COSSMHO's Trainer Manual for *Proyecto Informar*, and a video "Racial and Cultural Bias in Medicine" from the Committee on Minority Health Affairs (American Academy of Family Physicians). In the month following training, all of the trainers were expected to do turn-around training in their localities. Four of the 17 were able to do so in that short timeframe.

Technical Assistance: The Migrant Health Program office hired two local residents of the Delta area to develop the curriculum and provide the course for interpreter training. The Project Coordinator was a retired dentist with knowledge of training programs but limited knowledge of Spanish; the Interpreter Trainer was bilingual and an LPN. The Migrant Health Program office in Denver and the Area Health Education Office provided ideas for resource materials, including the videos used. The Delta/Montrose Vocational Technical Training Center Nursing Director gave advice on how to structure the interpretation course to meet certification requirements and also provided access to medical illustrations, books and anatomical models. The Interpreter Trainer, who would develop the syllabus, was able to attend a training course for interpreters in Denver given by the Asian Pacific Center. The COSSMHO *Proyecto Informar* curriculum was adapted for use in both Phases I and II cultural competency training of providers and trainers. Consultants (e.g., health center providers and a LARAZA trainer) within the state were selected to provide these sessions.

Measuring Success: The project met its interpreter training objective by developing the curriculum and training 18 candidates; staff were disappointed that they were not able to sustain in the course a Cora Indian, but he did not have sufficient English or Spanish skills to keep up with the pace. The initial project objectives went beyond just training to setting a goal of developing bilingual capacity in at least two agencies, programs or health provider offices, and having at least one interpreter hired. Bilingual capacity was established in the Olathe Medical Clinic (Montrose), Montrose County Nursing Service, and Delta Memorial Hospital--four of the 7 HABLA Phase I trained interpreters were hired. At the initiation of the HABLA project, even the County Health Department did not have bilingual staff, but subsequently hired one of the Phase II HABLA trainees after the Delta County Commissioners approved funding for a part-time interpreter. At least 4 of the trainees were still known to be employed in some capacity in the

local health care system in 1996; others have used the knowledge of interpretation in other settings such as business and human service/education programs such as Head Start. The Phase II train the trainers workshop in medical interpretation did not attract sufficient enrollment (perhaps from lack of promotion and recruitment rather than lack of need).

The goal of training at least 15 health care providers in cultural competency during Phase I was met and exceeded by the one-day *Proyecto Informar* training session for 80 persons in health related fields although the lack of physician participation was a disappointment. Due to compression of the training into a one-day session, organizers decided not to spend time on pre and post testing of knowledge; anecdotal feedback indicated that the sessions were provocative. The Phase II "train the trainers" was considered "a significant infusion of expertise in rural parts of the state where Hispanic advocates have previously not had the tools to educate others regarding cultural issues. "

Continuation of Effort: The Local Advisory Group wanted an approach to training that would result in lasting improvement in capacity and would not foster dependence on outside funding by offering it in conjunction with a local educational institution. The **Delta/Montrose** Vocational Technical Training Center continued to offer the interpreter training course in its catalogue, but it did not attract enough students to hold the class again. Proactive recruitment by the original HABLA trainer and the availability of tuition assistance may have been critical to successful recruitment during the BAP grant period.

Requests to the Migrant Health Program interpreter referral center dropped as bilingual capacity in the community increased both from hiring of the interpreter trainees within the local primary care health care system, and from the opening of a federally funded Community Health Center with a philosophy of hiring bilingual health personnel. It is also possible that the newly implemented requirement that clients pay half of the interpreter fee may have deterred some requests.

3. **Hispanic Immunization Initiative** **City of Waterbury (Connecticut) Health Department**

Objectives: The Hispanic Immunization Initiative focused on developing culturally and linguistically appropriate childhood immunization materials for the Hispanic community of Waterbury.

Justification for Grant: Childhood immunization levels were far below desired levels, and the growth in the Hispanic community made it necessary to develop materials targeted to this group.

- **Immunization levels.** A retrospective study of 269 consecutive Waterbury children seen at two city clinics found that 31% were delayed one month or more according to American Academy of Pediatrics guidelines for childhood immunizations. For children, who were

regular users of the clinics or the emergency room for primary care, the results were worse; 57% were delayed or **un(der)** immunized. Similarly, state statistics indicated that urban immunization levels stood at 65 % , far below the 90% goal of the National Health Promotion and Disease Prevention Objective for childhood immunization by age 2.

- **Growth in Hispanic nonulation.** Over 13 percent of the population is Hispanic, with 50% indicating that they do not speak English well. Additionally, approximately 20% of births in Waterbury were to Hispanic women. The Health Department lacked bilingual and bicultural personnel; of the 60 people employed in the public health nursing division, only one person was bilingual.

Role of Minority Groups in Project Implementation: In the BAP proposal development stage, the Hispanic Coalition of Greater Waterbury provided input from the target community. This organization came into existence in 1988 to provide a means for advocacy and empowerment in the Hispanic community, particularly for economic development, health (AIDS and mental health), culture, and youth. They also assisted the project by identifying candidates for bilingual, bicultural staff positions and helped organize community focus groups to review immunization education materials. The Health Department Director demonstrated flexibility by hiring a Dominican medical doctor whose English was poor, but who had a following in the community from giving health education talks. Community focus groups contributed to the form and content of the health education materials that emerged from the project.

Implementation of Project Objectives: The BAP funded project focused on producing health education materials related to immunization for use in the Hispanic community. To ensure that the materials were responsive to the community, focus groups reviewed existing materials, made suggestions for new materials and reviewed newly drafted materials. Previously, materials that the Health Department had purchased were simply Spanish translations of pre-existing English language materials. The focus group participants indicated that existing materials were not in the dialect of the Puerto Rican and Dominican population, and were also overly complex in their presentation of ideas and in their reading level.

Originally, the production of a brochure, calendar, posters, and videos were considered, but there was neither time nor money to produce all of these elements; instead the objectives were narrowed to a calendar and three posters (1500 calendars and 500 posters). The slogan for the project is, "VA CUNELOS!" meaning "Vaccinate them!" Each poster has a different message: "*EL VACUNAR A TIEMPO ES SALUDABLE!*" (It's healthy to vaccinate now); "*LA ZMPORTANCZA DE LAS VACUNAS ES LA SALUD DE NUESTROS NZNOS!*" (Vaccines are important for the health of all children!); and "*ESTA FELICIDA PUEDE CONTZNUAR, DE TZ DEPENDE.*" (If happiness is to continue, it depends on you.). These and other slogans on the calendar came directly from focus group comments. Words and phrases that the focus groups thought inappropriate, such as injection, were avoided. Each month of the calendar year focuses on one childhood disease describing its symptoms, cause, prevention and harm if a child is not properly immunized. January features the vaccine schedule. A calendar was chosen as the educational

vehicle rather than a brochure because it could serve the dual purpose of educating the community about vaccine preventable disease and the importance of immunization, and of serving as a functional calendar ensuring that it would be used throughout the year.

Initially, staff distributed the posters and calendars to local churches, health care providers, civic and social organizations, and local businesses that target the Hispanic Community. Since then the distribution strategy for the calendar has been more focused on one-to-one distribution by the Immunization Outreach Worker, public health nurses during prenatal and postnatal visits, and WIC staff who provide an educational message on immunization along with handing clients a calendar.

Technical Assistance: This initiative had a mentor assigned by USCLHO; it was the Project Coordinator's view that neither the mentor nor the Health Department were given any guidance on the role of the mentor. The mentor helped the project make more effective use of focus groups; unfortunately, this assistance was not as timely as it could have been. The Project Coordinator sought technical assistance from USCLHO through weekly, often daily, telephone and mail contact. USCHLO staff made a site visit and helped focus the project on development of the calendar and posters. After the BAP project was completed, the coordinator found out about the existence of the National Council of La Raza and COSSMHO.

Measuring Success: The Health Department set evaluation objectives in its initial BAP **workplan** which contained basic process measurement elements such as holding focus groups and producing the calendar and posters. Since the use of the calendar continued after the BAP time period, staff did a more extensive evaluation that contained client feedback on the calendar and examined methods to assess the childhood immunization levels in families receiving the calendar. The Health Department employed both informal and formal feedback mechanisms to gather client input on the calendars. First, client responses to the calendar were gathered by persons who distributed the calendars. Client responses included: liking the bright colors and use of photographs of community children; ease of flipping to immunization schedule; information was easy to understand; and use as a functional calendar. Second, a call-back written survey tool was employed. The survey was reviewed by the Hispanic Coalition and Immunization Outreach Worker for readability. Overall, respondents liked the information, used the calendar regularly, and would like to see the calendar reprinted in the future. The overwhelming majority (97%) found the calendar useful and easy to understand, and had read the immunization information.

The project coordinator found that it was logistically impossible to ascertain whether the immunization histories of children whose families received the calendars were better than those who had not. Furthermore, it would be difficult to separate the effects of the calendar from other confounding variables such as the health care provider, the influence of family and friends, and the knowledge base of the individual. However, they did ask parents to recall whether their child had received immunizations (94.9 % said yes); had received DTP (85.3 % yes); and received polio (51.5% yes).

The project had additional benefits. Although not initially stated as a goal for the BAP project, the Hispanic Immunization Initiative helped to bring together a coalition of persons working together for a common purpose--healthier children in Waterbury. Further, the BAP project succeeded in bringing additional bilingual, bicultural staff into the Health Department. The Health Department received special commendations from Former First Lady Rosalyn Carter and Governor Lowell Wicker for its immunization outreach efforts (which includes use of the calendar) and was awarded the 1994 Healthy Mothers, Healthy Babies Achievement Award.

Continuation of Effort: The BAP grant provided the basis for the ongoing immunization education campaign. Calendars were distributed for 1994, 1995, and 1996, with the initial year supported by the BAP grant. In subsequent years, the 1500 calendars printed yearly have been supported by federal CDC immunization dollars (\$8,000) as educational materials to support the city Immunization Action Plan. The Immunization Coordinator indicated that the successful reception of the BAP produced materials made it possible to justify use of the entire educational materials line item in the CDC budget for calendar production.

When the immunization initiative began in 1993, there were no baseline statistics on immunization levels. In a 1994 retrospective survey by the health department, approximately 39-53% of children in the St. Mary's Pediatric Ambulatory Clinic, Stay Well Health Center and the Health Department Public Health Nursing Division were up-to-date by age two for the 4:3:1 immunization series, far from the goal of 90%. **Now the** clinics monitored have from 75 to 90 % completion rates, with the St. Mary's clinic, where there is intensive tracking and outreach for no-shows, having the highest rating. In 1995, the on-time completion rate for Hispanics overall in each of the clinics was 88%. The improvement is credited to intensive community outreach, tracking, and education efforts which started with the BAP funded initiative.

4. **Latino Cultural Competency Training (LCCT) Project** **North Carolina Department of Environment, Health and Natural Resources**

Objectives: The Women's Preventive Health Services Branch received two BAP grants to: (1) deliver cultural competency training for county health department staff and (2) compile Spanish language health education materials at an appropriate literacy level.

- Phase I (February to June 1993) concentrated on development of the cultural competency curriculum and a resource manual of health education materials for health care providers. One cultural competency training session was held.
- Phase II (July to September 1993) focused on replication by implementing three more cultural competency workshops statewide.

Justification for Grant: North Carolina has the fifth largest migrant farmworker population in the United States. Providing health services on a year-round basis to an increasing number of

migrant farmworkers who chose to “settle out” posed a challenge to local Health Department staff. Since almost 92% of the migrant population is Spanish speaking, increasing sensitivity to this community became the focus of the BAP sponsored initiative. The Women’s Preventive Health Branch surveyed the 28 county health departments across the state for the types of assistance needed to improve effective access to the migrant population. Cultural competency training and Spanish language health education materials were top priorities.

Role of Minority Groups in Project Implementation: The BAP proposal built on community connections and a needs assessment developed under Project REACH (Rural Education, Advocacy & Care for HIV), a Ryan White Title II Special Project of National Significance (1991-1994). The collaborative community planning process of Project REACH served as a model for planning the Latino cultural competency training sessions.

The LCCT project had a two-tiered advisory structure: a state level committee composed of organizational and government representatives and local area advisors in each of the communities where workshops were held. The state-level project Advisory Committee consisted primarily of Health Department staff, members from the Primary Care Association and University of North Carolina School of Public Health Continuing Education office, and representatives of the Coastal, Wake and Mountain AHECs; this was a purposeful selection to build a statewide network that would aid in replication. Members of the target population identified through Project REACH and other means assisted in planning individual workshops, identifying community representatives for attendance, and evaluating both the workshops and the Health Department’s reputation in the communities. Members of the migrant and settled out communities took an active role in presentations at the workshops.

Implementation of Project Objectives: Four two-day workshops were held around the state, targeting areas where the migrant impact was greatest. The format incorporated a variety of more didactic presentations supplemented with more experiential sessions (e.g., *Convivio* and Talking Circles). The workshops culminated in drafting local action plans for Health Departments to improve the cultural competency of their organizations. Presentation topics included Latino cultural values; stereotypes and prejudices; demographics and health status of Hispanics in North Carolina; and the barriers faced by Latinos in accessing health care. Throughout the workshop, Spanish phrases were taught, and attendees sampled ethnic food.

A key feature of LCCT was involvement of the target community. On the evening of the first training day, a *convivio* was held; *convivio* is a term used in rural Mexico to connote a gathering and sharing/conversation of people in a community. Its purpose was to allow health department staff and the Latino community to see each other in a different light and build bridges that would lead to better communication. On the second day of training, selected community members came as “invited guests” to share in the Talking Circles typical working and living experiences and the problems encountered in accessing health care.

The model resource manual developed for distribution at the workshops contains copies of health education materials (usually in both English and Spanish) covering the following topics:

- Pre/post Natal Care and Breastfeeding
- Family Planning/Contraception
- STD and HIV/AIDS
- Other Health Topics (e.g., immunization, pap smears, breast/colon cancer).

In addition, the book *Que Paso? An English/Spanish Guide for Medical Personnel* was included.

Technical Assistance: The project benefitted from formal and informal technical assistance from a variety of sources. Local self-employed training and evaluation consultants developed the cultural competency curriculum and evaluation instruments as well organized the workshops. The Project Director also received advice and materials from ASTHO, COSSMHO, Project BEACH, and University of North Carolina School of Public Health. UNC helped draft an agenda for training that would meet the content requirements for continuing education credits.

Measuring Success: The project met its objectives by producing a replicable training curriculum and a model resource manual compiling Spanish/English materials on pregnancy and family planning. The project evaluated the impact of training on: (1) individual participants, (2) organizational changes at local health departments, and (3) community perceptions of the health departments. Analysis of pre and post tests administered to participating Health Department staff showed statistically significant changes in knowledge of Latino culture and health beliefs and decision-making for specific health care scenarios. When responses were categorized by type of position, the medical group had the lowest pre-test-scores, and the greatest improvement after training. Similarly, responses among those who were not bilingual or had never had any cultural competency training also showed greater improvement over their comparison groups (bilingual persons, those previously trained).

In the month after the workshops, local health departments provided anecdotal reports of changes in their environment, policies, or resources that would make the health department more culturally responsive. One strategy for evaluating the impact of training was to determine if there was any change in the reputation of the Health Department within the community; this proved too ambitious given the short timeframe of the project. Community reputation was chosen as opposed to a typical patient satisfaction survey used by Health Departments, because patient satisfaction surveys were seen as not effective in gathering the true feeling of Latinos because of discomfort in being critical at the time and place of service delivery. Furthermore, community reputation was considered important because of reliance in this community on word-of-mouth referrals.

Continuation of Effort: Phase II served as a means to replicate the cultural competency curriculum to a wider statewide audience. Strands of the curriculum are featured in ongoing training in the state, although the branch has not specifically mounted the same format with a *convivio* and talking circles. The University of North Carolina School of Public Health, the

AHECs, and local health departments as well as other state agencies were intimately involved in development and implementation during this project. The value of the Resource Manual and workshops was recognized across state offices; the Office of Rural Health and Resource Development, the Office of Migrant Health, and the Office of Minority Health all supplemented BAP funds to ensure that the manual would be available to all participants.

Findings and recommendations gathered throughout the project during the community networking, curriculum development, and training phases fed into the North Carolina Office of Minority Health's assessment of **Hispanic/Latino** health service needs. This office was newly formed about the time of the BAP grant, and staff from that office participated on the LCCT Advisory Committee.

5. Medical Interpreter Training Academy Rhode Island Department of Health, Office of Minority Health

Objectives: The Rhode Island Office of Minority Health (OMH) received the BAP grant to: (1) implement a Medical Interpreter Training Academy which would provide bicultural, bilingual interpreters with more formalized medical knowledge and clarification of their role as an interpreter and (2) provide in-service training for health professionals on effective use of interpreters.

Justification for Grant: Although there had been movement toward hiring **bilingual/bicultural** individuals within the public and private health care system, there had never been a medical interpreter training program in the state prior to the BAP initiative. Several specific events triggered more attention toward the issue of medical interpretation:

- Growth in ethnic and linguistic communities, particularly the influx of Southeast Asians.
- The American Association of Retired Persons (AARP) release of a Health Watch study concluding that many health providers were in violation of civil rights laws and regulations as a result of failing to provide interpreters in health care settings.
- The Rhode Island Department of Health (**RIDH**) and Providence Ambulatory Health Care Foundation (**PAHCF** -- a network of community health centers) had just completed a three year demonstration grant to train bilingual, bicultural patient representatives in maternal and child health for the Southeast Asian community (**INSEARCH** project). Health providers acknowledged that their patient outcomes were improved because the trained staff was able to convey how cultural beliefs and practices had an impact on patient willingness to accept Western approaches to medicine.

The Rhode Island OMH and the Health Department Minority Health Advisory Committee recognized that expanded training in medical interpretation would enhance the delivery of care to persons with limited English proficiency.

Role of Minority Groups in Project Implementation: The Minority Health Advisory Committee was created to advise the RIDH on issues related to the health status of people of color in Rhode Island. Its function was not specific to the BAP project, but the members reviewed the curriculum proposal. The Committee included twelve representatives of community-based organizations, four health care providers, representatives from Rhode Island Health and Human Services, and a representative of the Rhode Island Foundation. Course content for the Medical Interpreter Training Academy derived in part from focus groups with the bilingual, bicultural workers from the **INSEARCH** (Increasing Numbers of Southeast Asians Receiving Comprehensive Health Care Services) project.

Implementation of Project Objectives: The primary activity of the project was to develop a Medical Interpreter Training Academy. Providence and the surrounding areas have diverse ethnic and linguistic groups; thus, trainees were selected to reflect the multi-cultural complexion of the population. Persons interviewed indicated that the composition of the population is ever changing with newly arrived immigrants necessitating expansion of the range of interpreter languages.

Ninety-three people applied for the training, and twenty five were selected for training by a Review Committee; 23 completed the training. All of the trainees were employed as medical interpreters, **bilingual/bicultural** health aides, or program directors; each person was also intended to be literate in English and their native language. The ethnic make-up of those accepted was 11 Southeast Asians (Hmong, Laotians, Cambodians and Vietnamese), nine Latinos, three Portuguese, one Armenian, and one Russian.

The structure of the medical interpreter training academy was two intensive weekend sessions (totalling 32 hours) primarily in a lecture/discussion format with some role playing and viewing of videos. Course content was very ambitious in view of the time limit. Instructors covered: medical terminology; basic anatomy and physiology; medical interpreter theory and practice; cross-cultural communication; medical interpretation and the law; domestic violence/child abuse; emergency room; infection control; mental health; and death and dying and grieving. The major emphasis of the training was on medical terminology (12 hours) and the role of the interpreter (9 hours).

A second objective for the project was provision of in-service training for health providers on how to use the services of a medical interpreter. A two-hour Grand Rounds at St. Joseph's Hospital (Providence) presented by a physician from Boston City Hospital attracted 60 health professionals. They were mainly nurses; few physicians attended. The presentation addressed the importance of the interpreter to health care delivery, their appropriate role, cultural beliefs, and some of the stereotypes associated with persons having limited English proficiency.

Technical Assistance: The Rhode Island OMH Project Coordinator, after attending a three day training session on cultural competency and medical interpretation conducted in Boston by a consulting firm, hired these same consultants for their BAP project. The consultants had the expertise to pull together the desired program and team of trainers within the time constraints.

Measuring Success: This project met its major objectives of providing training to both interpreters and health professionals. Evaluation of the success of the actual training sessions focused on the use of pre and post-training questionnaires. Some of the themes that ran through the pretraining questionnaire for those providing interpretation services were the desire to learn additional medical terminology and to be recognized as an important professional asset in the health care field. Overall trainees indicated that the sessions had definitely provided them with skills that they could immediately use in performing their jobs; however, the compressed nature of the workshop made it difficult to assimilate so much information in such a short time. The ability to apply the information to one's job is likely to be based on the trainee's motivation and their ability to comprehend the presented materials.

With regard to the Grand Rounds, health professionals indicated in pretests their concern about the lack of trained medical interpreters (e.g., provider wrote, "We do not have them available in the facility where I work. Housekeeping is often used. ") Reasons cited for wanting interpreters ranged from improvement of communication between provider and patient to their ability to save the provider time and reduce the risk of a malpractice incident. Professionals found the presented statistics on the potential cost savings associated with use of interpreters and information on different styles of interpreting most useful.

Continuation of Effort: The BAP Project Coordinator in the Rhode Island OMH (a one person office) left shortly after the completion of the BAP project, and no one replaced her for a year. In the meantime, ideas for continuation fell by the wayside (e.g., forming a Medical Interpreter Association for Rhode Island to end feelings of isolation among interpreters). The training was never repeated; however, at the time of our interviews Rhode Island OMH, Providence Ambulatory Health Care Foundation (PAHCF) and others were considering reviving training for medical interpretation. Their approach to training, however, would differ in that it would place the training within an educational setting (e.g., **community** college) to ensure accreditation rather than as a freestanding training session. The PAHCF trains new staff on working with interpreters by using the videos previously used by the interpreter training academy.

III. LEARNING FROM GRANTEE EXPERIENCES

While each of the five BAP grantees developed unique approaches and projects, their experiences provide important lessons for designing similar programs in the future. This chapter summarizes grantee achievements and discusses project implementation and evaluation issues.

- The projects achieved short term objectives and longer term effects on local delivery systems. They provided greater visibility to minority health issues, strengthened interagency working relationships, involved target populations in substantive tasks, and began the process of building culturally responsive health care infrastructure.
- Examination of project implementation reveals some patterns with respect to: problems with state/local government **personnel** and fiscal procedures; targeted but limited use of national minority organizations, preference for a variety of local resources for technical assistance; and use of pre-existing community networks.
- All projects set some easily documented process measures. These, however, were not consistent in level of documentation even for similar projects such as training programs. Documentation of longer-term impact relied more heavily on qualitative assessments and judgements by project participants.

A. ACHIEVEMENTS OF BAP PROJECTS

Each of the grantees met major short-term expectations and made a meaningful contribution to their community. Actions taken during implementation set the stage for longer term change within the communities by giving greater visibility to minority health issues, and building interagency and community ties. The grantees also were able to document elements of longer-term impact. Exhibit III. 1 summarizes short term achievements and longer term effects.

Exhibit III.1 Immediate Achievements and Longer Term Effects

<i>Grantees</i>	<i>Immediate Achievements</i>	<i>Longer Term Effects</i>
<p>Southeast Asian (SEA) Health Information Database, California Office of Multicultural Health</p>	<ul style="list-style-type: none"> • Distributed 500 copies of “The SEA Health Information and Resource Directory of Chronic Diseases” (1994). • Developed an infrastructure which attracted additional funding. 	<ul style="list-style-type: none"> • Used SEA infrastructure to expand database to other groups (Latinos, Blacks, Native Americans). Expansion funded by CDC and the Preventive Health Services Block Grant. • Selected program information entered into the federal Combined Health Information Database.
<p>Health Access by Language Advocacy (HABLA) Colorado Migrant Health Program</p>	<ul style="list-style-type: none"> • “Basic Interpreting Syllabus: Medical Terminology” • Trained 18 interpreters. • Trained 80 persons in cultural competency. *Trained 17 instructors on cultural competency. 	<ul style="list-style-type: none"> • At least 5 trainees became employed in local health care settings. • Instructors provided “turn around” training in cultural competency in their communities.
<p>Hispanic Immunization Initiative (HII) Waterbury (Connecticut) Department of Public Health</p>	<ul style="list-style-type: none"> • Distributed 1500 Vacunelos calendars. • Distributed 500 posters. 	<ul style="list-style-type: none"> • Hispanic childhood immunization rates increased to 88% by coupling HII materials with outreach. Continuation funded by CDC.

Exhibit III.1 Immediate Achievements and Longer Term Effects (continued)

<i>Grantees</i>	<i>Immediate Achievements</i>	<i>Longer Term Effects</i>
<p>Latino Cultural Competency Training (LCCT) North Carolina Women’s Preventive Health Services Branch</p>	<ul style="list-style-type: none"> • Developed LCCT Curriculum. • Trained 157 persons in 4 workshops around the state. • Model Resource Manual distributed to every county health department and workshop participant. 	<ul style="list-style-type: none"> • Local Health Department Action Plans to Improve Cultural Competency • Provided baseline information for North Carolina OMH needs assessment on Latin0 health.
<p>Medical Interpreter Training Academy Rhode Island Office of Minority Health</p>	<ul style="list-style-type: none"> • Trained 23 interpreters (11 SEAs, 9 Latinos, 3 Portugueses, 1 Armenian, 1 Russian). • Provided in-service to 60 health professionals on how to use interpreters. 	<ul style="list-style-type: none"> • Trainees applied new knowledge in their health related jobs.

1. Immediate Achievements

The primary short-term achievements of grantees included: (1) development of training curricula, health education materials, and a resource database; and (2) delivery of training related to cultural competency and medical interpretation. Over all of the five projects studied, their achievements encompassed:

- 41 interpreters participated in training to upgrade their medical interpretation skills;
- **60** health professionals learned how to use medical interpretation in delivering health services;
- 237 individuals participated in cultural competency training;
- 17 received instruction in how to provide cultural competency training;
- 1500 persons with young children received immunization calendars in the first year of the Waterbury Hispanic Immunization Initiative; and
- 500 copies of *The Southeast Asian Health Information and Resource Directory of Chronic Diseases* (identifying 69 health programs in California directed to serving Southeast Asians, including Cambodians, Chinese-Vietnamese, Vietnamese, Hmong, Laotians, and Mien people) were distributed.

Recognition of the value of **BAP** projects to the local communities can be seen in the monetary contributions from other organizations for expansion during **BAP** implementation. Examples include:

- In North Carolina, the value of the Resource Manual and workshops was recognized across state offices; the Office of Rural Health and Resource Development, the Office of Migrant Health, and the Office of Minority Health all supplemented **BAP** funds to ensure that the manual would be available to all workshop participants.
- In the Colorado HABLA program, the Rocky Mountain SER (Service, Employment and Rehabilitation) program provided tuition assistance to support trainees taking the HABLA classes since the eventual goal was to place some of the trainees in jobs.

2. Setting the Stage for Longer Term Change

While some of the immediate achievements of the projects are easy to measure (e.g., number to be trained), others critical to bringing about longer term change are not amenable to quantification. These include expanding the capacity and visibility of Offices of Minority Health, developing and strengthening interagency working relationships, and developing meaningful linkages with the target population.

Giving Visibility to Minority Health Issues. BAP funds often sponsored projects that gave credibility to an emerging part of state or local government involved in improving the health of ethnic populations. The grants also allowed very small state Offices of Minority or Multicultural Health to supplement their staff and expand their influence. For example, Rhode Island's one person OMH would not have been able to establish the Medical Interpreter Academy without hiring additional resources to implement the project. The BAP project was the first activity of the California Office of Multicultural Health and increased its visibility across state government. Although the new OMH in North Carolina was not the BAP grantee, it participated in the Advisory Committee, co-sponsored the workshops, and provided supplementary funding to the BAP project. More importantly the BAP project findings collected through community networking and training provided the underpinnings for North Carolina OMH's first needs assessment for improving Latino health.

Strengthening Interagency Working Relationships. BAP projects brought together agencies and people, some for the first time, for a common purpose. For example:

- The local Colorado HABLA project Advisory Committee included Rocky Mountain SER (Service, Employment and Rehabilitation), the Migrant Health Program and the County Health Department who worked together to train employable medical interpreters for the private sector. HABLA developed the curriculum and provided training; SER provided tuition assistance; the County Health Department hired one of the trained interpreters; and the Migrant Health Office was able to reduce its financial burden from providing interpretation services in the private sector.
- Similarly, the North Carolina LCCT project built a coalition of state and local level agencies with a common interest in improving health access for migrants. Membership of the AHECs helped to facilitate replication around the state; other members representing migrant and rural health offices became co-sponsors of the workshops; findings from the project provided a basis for the emerging state OMH's work in the Latino community.
- In California, the Advisory Committee brought representatives of a number of state agencies and community-based organizations together to work across programmatic lines for the first time. Advisory Committee community representatives came from Asian Health Services (Oakland), Sacramento Lao Family Community, Southeast Asian Health Project (Long Beach) and Vietnamese Community Health Promotion Project (Suc Khoe

La Vang! University of California, San Francisco). State representatives came from the Office of Multicultural Health, Refugee Health Program, Center for Health Statistics, and pertinent chronic disease programs (risk reduction, diabetes, tobacco, and breast and cervical cancer control).

Developing Community Ties with Target Populations. An integral role in project implementation, rather than cursory and unmeaningful contact, played by ethnic organizations and community representatives engendered trust and long term goodwill. The Waterbury Hispanic Immunization Initiative illustrates the importance of this involvement. When asked by other health departments around the country if they could use the immunization calendar, the project coordinator advised that each community develop its own. She stressed that the process of building links with the community and the community's ownership of the calendar brought an immeasurable amount of goodwill. The process was particularly important to the Waterbury Health Department because their reputation up until that point was one of not being particularly sensitive to members of the **Latino** community, partially because of its lack of bilingual staff.

Similarly, the North Carolina **Latino** Cultural Competency Training (LCCT) project organized its program to break down barriers between the health department and the community. Organizers first sponsored a social event where community members and local health department staff could interact in a more informal atmosphere. Then the next day, they included community representatives in training sessions where they could discuss the barriers faced in getting health care (e.g., difficulty in getting a TB x-ray for work). The LCCT Advisory Committee had debated whether it would be worth the time investment to identify and recruit community members and whether their contributions would be meaningful. Participants noted that the sessions "help ease the fear of the unknown of dealing with people who are different" and "help us be more effective advocates for serving Spanish-speaking clients." The Project Coordinator concluded that the "time and energy are well-spent" on these activities and implementation is feasible when sufficient time is invested in field work prior to training.

3. **Longer Term Effect**

The BAP grants served not only as a catalyst for more expansive immediate efforts but also influenced the longer term direction of other initiatives (e.g., disease monitoring, immunization, minority health) after BAP funding ceased. Projects also contributed to longer term infrastructure development. There was little documentation that projects contributed to changes in health status of the target population; none of the grantees in this sample sponsored projects that delivered direct services. Only the Waterbury project has demonstrated some longer term health status change associated with intensive CDC sponsored outreach coupled with the BAP sponsored health education message.

Influencing Direction of Other Initiatives. The California, Connecticut and North Carolina projects provide examples of how the BAP investment influenced the longer term direction of initiatives funded from other federal and state sources even after **BAP** funding ceased.

- The Waterbury Health Department received BAP funding and CDC funding almost simultaneously. The BAP project focused on developing health education materials that could be used for the overall CDC funded Immunization Action Plan (IAP). The immunization calendars continue to be the focus of immunization education with Hispanic members of the **community**. The Immunization Coordinator indicated that the successful reception of the BAP produced materials made it possible to justify the yearly use of the entire CDC educational materials line item (\$8,000) for calendar production.
- a CDC funds a certain number of states each year to improve their information system capacity in the chronic disease area. California received its CDC funds after the BAP grant; staff at CDC could not specifically say whether the BAP grant was cause for the award, but did indicate that California differs from most states in its emphasis on compiling the data by ethnic group, a legacy of the BAP project.
- When the North Carolina Women’s Preventive Health Services Branch, MCH received the BAP award, the Health Department had just established an Office of Minority Health. As noted earlier, OMH staff participated on the LCCT Advisory Committee, provided financial support for the workshops, and used the workshops as an information gathering network.

Institutionalization of the BAP projects is most apparent in Connecticut and California where dollars and staff commitment still remained available at the time of our site visits, three years after BAP funding. In North Carolina institutionalization of LCCT cannot be measured today as a discrete activity, but its influence seems to have permeated the fabric of the department’s broader commitment to cultural competency training and improvement of health for minorities.

Developing Infrastructure. This study afforded the opportunity to assess how projects enhanced health delivery system infrastructure.

- The HABLA project (Colorado) set an objective to place a certain number of trainees into health service delivery jobs and documented this capacity-building goal in its final report. At our site visit, three years later, we were able to meet with several of the trainees who are still employed in the County Health Department and health clinics in the area. HABLA also further developed training capacity in cultural competency by conducting a ‘train the trainer’ program.
- OMH staff for the California database project indicated that the greatest legacy of the BAP project was not the directory produced but the infrastructure for its current expansion (relationships developed, data collection forms, mailing lists, database software).
- The culminating activity in **Latino** Cultural Competency Training (North Carolina) was development of individual action plans for each local health department that listed at least

two steps the department could take to increase cultural competence (e.g., **hiring a trainer** to provide basic Spanish skills to staff).

Grantee plans for building infrastructure did not always come to fruition or once initiated did not always accomplish what was intended. Besides placing trainees in jobs, the Colorado HABLA project also sought to institutionalize the medical interpretation course at the local Vocational Training Center. While offered in the catalog for a while, the course was not taught again. Reasons given were: the original trainer was no longer willing to teach the course because of a dispute over who owned the copyright to the curriculum; interpreters receive only minimum wage in this community, and employment is sporadic. The community still believes there is a need for trained interpreters, but until potential trainees see that interpreters can command a more reasonable salary, they also believe the course will not attract enough people on its own. The training did provide expanded opportunities for some trainees; for example, one went from working in a fruit packing shed to being a receptionist in a health clinic. The other medical interpretation training project in this sample of grantees also did not continue. Lack of funding and turnover of project leadership were the main reasons cited at the site visit rather **than** salary issues since all of the trainees were already employed as interpreters/health advocates.

Improving Health Status. It is difficult to isolate the effects of a BAR project on health status and little information was gathered by grantees that related to improvements in health status and access. One grantee, the Waterbury Health Department, documented changes in immunization compliance over two years. The baseline showed that 39-53 % of children in the three target health centers were up-to-date by age two for the 4:3:1 childhood immunization series.¹ Now the centers have 75 to 90% completion rates, with the rate for Hispanics at 88%. Isolating the effects of the health education materials from the accompanying outreach and **follow-up** has not been possible, but the Immunization Coordinator cites the trust built between the health department and the Dominican and Puerto Rican community during the **BAP** project as important in people's receptivity to the immunization outreach worker.

B. PROJECT IMPLEMENTATION

During project implementation, four out of the five grantees encountered some problems with state/local government personnel and fiscal procedures. Some were able to resolve these issues by pairing with a private organization. Other observations based on our cross-site review show that grantees: (1) take advantage of pre-existing community networks (most notably those developed through Ryan White funding); (2) make targeted use of national minority organizations; and (3) use a variety of sources for technical assistance (e.g., mentors, AHECS, consultants, national minority organizations) and have a preference for using local talent.

¹ 4 DPT: 3 oral polio: 1 MMR.

1. **Problems with State/Local Government Personnel and Fiscal Procedures**

The short term nature of the BAP projects was often at odds with lengthy governmental requirements for hiring and reimbursement. This problem surfaced in three of the state agency projects and one local project. Two of the grantees took steps to avoid delays by transferring funds to a non-governmental agency. For example, to avoid the delays inherent in hiring state staff or even in contracting with a private agency, the California project developed an interagency agreement between state government and the Asian & Pacific Islander American Health Forum. The ASTHO funds went directly to the Forum. In Rhode Island, it simplified matters considerably by making one transfer of funds from the state to the Providence Ambulatory Health Care Foundation who, in turn, provided timely reimbursement to trainees for transportation and child care expenses while attending the Medical Interpreter Training Academy.

The North Carolina project encountered considerable difficulty in reimbursing consultants, Latino businesses, and community representatives in a timely manner. State fiscal procedures required six weeks to set up grant accounts and two months to process requests for service reimbursement or honoraria, with the two month process not starting until the point of service delivery. The project succeeded in meeting deadlines only through the incredible goodwill and commitment of a self-employed training consultant who worked for months without a contract and bore the costs of the workshops on her own credit card. However, she is no longer inclined to work for the state. Furthermore, inclusion of ethnic vendors and community representatives was an essential part of the community outreach strategy, but state fiscal procedures did not prove sensitive to the short term financial requirements of these small businesses and community representatives, who incurred child care and transportation costs when participating in the workshops. They both needed immediate reimbursement at the time services were rendered. One of the specific obstacles encountered was the difficulty in cashing checks because the participants often did not have picture IDs, Social Security numbers or bank accounts.

In the Waterbury Hispanic Immunization Initiative, local government sensitivity to target group needs was mixed. On one hand, the Health Department Director was flexible in hiring a part-time staff person with limited English. On the other, procurement procedures did not allow the Immunization Coordinator to take into account experience with the ethnic community when engaging photographers or the company that printed the posters and calendar which resulted in some errors in the initial run of calendars. Once the calendar was produced, the city health department did not have a mechanism for responding to bulk order requests for the calendars from other communities around the country.

2. **Building on Pre-existing Community Networking**

BAP projects benefitted from other federally sponsored efforts to build community connections, specifically federally sponsored HIV programs. For example, the North Carolina BAP project utilized community connections and a needs assessment developed under Project REACH (Rural Education, Advocacy & Care for HIV), a Ryan White Title II Special Project of

National Significance (1991 - 1994). The collaborative community planning process of Project BEACH served as a model for planning the Latino Cultural Competency Training (LCCT) sessions. The first LCCT Advisory Committee meeting actually took place at a Project BEACH sponsored conference on AIDS which included two sessions called, "A Day in the Life of a Migrant Farmworker" and "Settled-Out Latinos." This experience gave the Advisory Committee additional first hand exposure to local Latino community representatives. Fifteen of the 20 people who had participated in the Settled-Out Latino Talk Circle continued to meet over the next few months planning the LCCT workshops and curriculum together. Similarly, the only viable relationship between the Waterbury Health Department and the Hispanic Coalition had been through the AIDS program coordinator;² his recommendation was instrumental in the Hispanic Coalition's willingness to join forces for the Hispanic Immunization Initiative.

3. Role of National Organizations

Across the five projects, national minority organizations played a limited role except in the California project where the Asian & Pacific Islander Health Forum actually carried out the daily tasks critical to development of the resource database. The three other grantees who consulted with national organizations benefitted from (1) specifically targeted training (e.g., HABLA Interpreter Trainer attending course on interpretation given in Denver by the Asian Pacific Center), (2) resource materials (e.g., COSSMHO *Proyecto Informar* curriculum was adapted for cultural competency training of providers and trainers in Colorado), and (3) advice (North Carolina consulted by telephone with COSSMHO as well as reviewed its materials).

4. Need for Technical Assistance during Project Implementation

As was found in the exploratory study, all of the grantees required assistance from consultants or other outside support in developing their projects. Each sought a different complement of persons or organizations based on the particular expertise needed. However, there did appear a preference to use local talent for day-to-day activities and national organizations for specific tasks (i.e., provision of resource materials). One of the sites in this study sample had a mentoring relationship. The types of assistance grantees received is explored in more detail in the project profiles (Chapter II). In the site visit interviews, grantees reported that the technical assistance helped in achieving project objectives.

Preference for local talent. Each of the grantees noted that physical proximity of consultants enhanced working relationships especially when frequent contact was necessary. In some respects, staff hired for these short term projects are consultants as they bring specific expertise applicable to carrying out the project. The preference for local rather than national consultants/staff was primarily based on feelings that a local individual's personal network of resources and knowledge of the targeted area would facilitate tailoring the project approach to the

² The Waterbury HIV/AIDS program receives Ryan White I and II case management funding.

area. Although California used the Asian & Pacific Islander American Health Forum, a national resource, the physical proximity of the Forum and its knowledge of California resources were key elements fostering collaboration. Cost considerations (e.g., travel) and availability for day-to-day operations were also reasons cited for limited use of national organizations. For example in the HABLA project based in a somewhat remote rural town, the Interpreter Trainer needed to be available three nights a week over several weeks to teach the course. Furthermore, the consultants' personal networks and knowledge of the area's medical providers assisted in recruiting trainees and placing candidates in jobs as well as negotiating donations of space and supplies for training. Additional Colorado-based consultants (e.g., from Denver LARASA or health centers) were brought in for discrete, time-limited (1-2 day) cultural competency training sessions.

Use of Mentor. Only the City of Waterbury had a mentoring relationship in this study sample. The mentor provided useful guidance on the use of focus groups, but the Hispanic Immunization Project Coordinator thought the information was not as timely as it could have been. She recommended that clearer guidelines be given to the mentor about the time that they need to make available.

As a byproduct of BAP, some project staff have become advisors (or mentors) to others. The Hispanic Immunization Initiative received broad dissemination through presentations at conferences, placing the Project Coordinator in the role of mentor to other organizations, a time consuming task. Similarly, the Office of Multicultural Health, California has found additional demands on its limited staff to respond to information about its Resource Directory and database.

Role of Area Health Education Centers (AHECs). Each of the four projects that involved training noted that they received materials (particularly videos) and/or assistance in organizing training from the Area Health Education Centers. Several AHECs had a prominent role on the Advisory Committee for the North Carolina Latino Cultural Competency Training; they co-sponsored the workshops and provided trainers. Including representation of the AHECs from the beginning of the project was viewed as a way to enhance replication across North Carolina.

Grantee Assessment of Technical Assistance. Project staff viewed these different types of assistance as favorably contributing to the accomplishment of project objectives. In several sites, project consultants or temporary staff with specific expertise were critical to the accomplishment of the projects. In North Carolina, the training consultant, not only developed the curriculum, but also developed the community networks and organized the workshops. Similarly, in Colorado the bilingual Interpreter Trainer developed the curriculum and delivered the interpreter training. In Waterbury, the local Hispanic Coalition provided knowledge of the community and language skills which the Project Coordinator did not have. The downside to using consultants is that when the project is over much of the expertise leaves with them unless the project implementation and accomplishments are well documented so that others can replicate the project.

In some cases, organizers indicated that they might use other personnel in the future. For example in Colorado, compression of the *Proyecto Informar* curriculum into one-day resulted in a session that was provocative, but perhaps too confrontational for non-Hispanics; this may, however, have been the presenter rather than the curriculum. In Rhode Island, future medical interpreter training, if resurrected, would incorporate local instructors rather than bring trainers from a neighboring state; however, the approach used to reach physicians--bringing in a physician presenter with sufficient stature (e.g., proven expertise through publishing, noted hospital affiliation)--would not change.

c. **EVALUATION OF BAP PROJECT ACHIEVEMENTS AND PRODUCTS**

Setting realistic goals and measuring progress towards them is important to assessing project outcome. Each BAP project set a variety of easily monitored process measures to monitor progress toward accomplishment of goals. For example, it is easy to document that a focus group was held or that a product was produced or that a training session was held. Additionally, training projects employed some means of individual assessment of trainees, usually a combination of pre and post training evaluations. Measurement difficulty increased when trying to assess what impact the project had on changing system infrastructure or improving effective access for those with limited English proficiency.

1. **Consistency of Data among Training Projects**

Grantees did not collect uniform data. Among the four grantees offering training in this study, some set specific goals at the outset on the numbers and types of persons to be trained, and others only specified that training sessions would be conducted. For instance, having specific objectives like the Colorado project made it easy to note that the project met its goals in terms of numbers trained, and that certain targeted groups (e.g., Cora Indians) were harder to reach and might require a more individualized approach.

Training projects generally had dual objectives for **pre/post** training evaluations: first, to obtain the trainees' view of the curriculum/workshop and its trainers and second, to determine the level of knowledge obtained through the workshop. These assessments are generally, but not always, reported in the final evaluation of these projects; their results were quite useful to the project staff in refining curriculum and preparing it for replication. For example, the North Carolina **Latino** Cultural Competency Training (LCCT) Curriculum went through reevaluations after each workshop so the developer could ensure the notes to facilitators were more complete, enhancing curriculum replicability. The LCCT also had a sufficient critical mass of trainees (157) that allowed analysis of knowledge gains by the type of position (e.g., medical), and other variables such as a trainee being bilingual or previously receiving some sort of cultural competency training. None of the projects had longer term follow-up to ensure retention of knowledge from the sessions and to provide an opportunity for trainees to ask questions that arose in applying their knowledge to the workplace.

The LCCT staff enriched their analyses by providing quotes from attendees which are perhaps even more telling than the statistical analysis:

- “Program convinced me of things I need to change. ”
- “My desk faces the front door of the clinic and in the past, whenever I have seen someone who looks like they speak Spanish come through the door, I confess that I would look down and try to avoid them...sometimes I’d even get up and leave. I didn’t know any Spanish and just didn’t know how to help them. But in the last two days, I see that they are people too.. **they** have feelings and needs too, just like us. And they can read body language and can tell if someone cares, even if that person doesn’t speak Spanish. So after today, when I go back, when I see someone who looks like they speak Spanish come through the door, I will look right at them and give a big smile.. **even say "Hola!"** .. I will try to let them know through my body language that I care about them and will try to help them the best I can! ”
- “The morning sessions with locally settled or migrant Latinos were especially valuable to help ease the “fear of the unknown” of dealing with people who are different. ”

Community representatives were affected as well, with the interchange being characterized as “healing and helpful. ” For example, one man got to verbalize for the first time how difficult it was to get a TB x-ray for work and his appreciation for the opportunity to share his frustrations. At the workshop another woman, who up until then was characterized as very shy, withdrawn and unwilling to open up to Health Department staff about the problems she faced, shared openly with great emotion her frustrations with the system. Now when she come to the clinic, “She is very outgoing and demonstrative. ”

Advisory Committee members were also asked to evaluate their participation in the project; clearly the collaboration model worked to broaden interest in the health problems facing Latinos. Sample feedback include:

- “I personally gained through the networking of various agencies.. . These contacts give me more resources for making (my agency) more "**Latino** friendly” regarding the development of new programming. I also personally benefitted... as a facilitator in getting to know more public health staff and developing appropriate training skills. ”
- “The working relationships established and the knowledge gained about the various agencies and resources has helped strengthen our state’s infrastructure and will continue after this Project’s completion. Also, our understanding of the needs and gaps in services has become clearer. This will help us be more effective advocates for serving **Spanish**-speaking clients. ”

2. Documenting Distribution and Usefulness of Resource Materials

Projects that developed materials generally, but not always, reported the number of materials printed. For example, we know how many calendars were produced in Connecticut and the number of directories published in California, but the total number of Resource Manuals produced for North Carolina is not reported. While each project had a target group for distribution (e.g., local health departments, parents of young children), the number sent to other groups (e.g., other states requesting sample directories or calendars) is not documented.

Assessment of how useful a product is to its recipient was based on anecdotal reports and in one instance a survey. The California database project tended to depend on anecdotal reports. From the state staff's perspective, documenting the programs in the directory gave the state a wider pool of resources to call upon. They expressed concern that a printed directory quickly becomes dated and that perhaps sits on someone's shelf and is not used. No systematic way was used to assess whether the listed programs received requests for information or not. Staff have begun to rethink their distribution strategy (e.g., change to distributing through information brokers like reference librarians). No assessment was done of the adequacy or usefulness of programs or materials listed in the directory.

The Waterbury project went further in assessing the usefulness of their materials to the target community. The Waterbury development process, as noted earlier, incorporated the comments of the focus groups in its calendar design and content and its design. Staff also followed that up in two ways. First, at the initial distribution of calendars clients were asked what they liked about the calendar (e.g., inclusion of pictures of Waterbury children, easy to understand). In the following year as part of the **Immunization** Coordinator's graduate degree program, she conducted a written survey which showed that clients regularly used the calendar and had read the immunization information.

In the North Carolina LCCT project, staff packaged preexisting Spanish language health education materials in a way that made them more accessible for county health department staff. The LCCT consultant collected a wide spectrum of perinatal and family planning materials and incorporated in the model Resource Manual only those that were deemed acceptable after review by both local health professionals and primarily monolingual community representatives. Additionally, there are anecdotal reports of positive health department response to the Resource Manual materials such as a county Health Director ordering "*Que Paso? An English-Spanish Guide for Medical Personnel*" for each clinic.

3. Documenting Improvements in Access or Health Status

Several grantees had specific ideas about how to approach evaluation of effective access or health status but were not able to accomplish them within the timeframe of the grant. Grantees also raised concerns about their ability to isolate the effects of their efforts from other factors that

might generate change among the target population. Direct service delivery projects may be more successful in documenting this type of change (e.g., increase in number of **Latino** clients served).

- The HABLA project (Colorado) wanted to track if there were improvements in the rate of appointment no-shows once bilingual staff were available in primary care settings.
- The North Carolina LCCT developed a survey and interviewer's guide for assessing the community reputation of local health departments. The survey was employed to develop baseline information used in the workshops, but sufficient time had not elapsed between the workshops and the end of the grant to assess whether there was a change in community reputation.

IV. CONCLUSIONS AND RECOMMENDATIONS FOR FUTURE DIRECTIONS

The purpose of this study was to assess and evaluate Bilingual Assistance Program (BAP) projects to increase OMH/HRSA's knowledge and understanding of the best practices employed by the five grantees in planning, developing and implementing bilingual assistance programs. In the previous chapters, individual projects have been profiled, and the achievements of the program as a whole examined. In summary, our findings show that grantees:

- Produced ***both immediate achievements and longer term effects.***
- ***Leveraged BAP funds*** to achieve an impact beyond the dollars invested.
- ***Promoted improved working relationships*** among organizations and with target communities.
- Took steps toward ***developing a more linguistically and culturally responsive health care system.***

Our review sheds light on project implementation issues that have implications for future grant-making:

- ***Length of grant period.*** The short timeframe allowed for the **BAP** grants (3 to 8 months) contributed to: (1) some implementation problems, particularly due to state personnel and fiscal procedures and (2) limitations in the types of activities and evaluations that were carried out.
- ***Reporting and performance measures.*** Grantees, even of a similar type (e.g., training), were inconsistent in data reported.
- ***Technical assistance.*** All grantees required outside assistance. While showing a preference for local talent, they did consult with National Minority Organizations.

The remainder of this chapter explores these findings and issues in further detail. The paper concludes with some suggestions for building upon the BAP experience in setting directions for future programs aimed at reducing linguistic and cultural barriers to health care for limited and non-English speaking populations.

A. Short and Long-term Impact of BAP

The five grantees of this study planned and carried out training and resource development projects to address the needs of their communities; there were no direct health service delivery

projects in this sample of grantees. Grantees met their immediate objectives and set the stage for longer term change by taking steps to leverage BAP funds and improve working relationships.

1. BAP Achievements

The specific immediate achievements and longer term effects for each of the grantees are outlined in Exhibit III. 1 in the previous chapter. In sum, primary short-term achievements for the five grantees included:

- Development of three curricula and implementation of training sessions for: (1) 157 health department and other health service personnel in cultural competency; and (2) 41 interpreters in methods that would upgrade their medical interpretation skills.
- Development and dissemination of Spanish language health education materials (immunization calendar and posters, and Resource Manual for family planning/perinatal health);
- Development of a computerized resource database of chronic disease programs for Southeast Asians and dissemination of a directory of these programs; and
- Sponsoring various other types of training sessions, including ones for: (1) 60 health professionals to learn how to use medical interpretation in delivering health services; (2) 80 persons in health related fields in cultural competency; and (3) 17 trainers in how to provide instruction in cultural competency.

Examples of longer term effects from BAP include: (1) further dissemination of information and health education materials (e.g., through the Combined Health Information Database or outreach activities); (2) ongoing training by those who had participated in Training of Trainers (TOT); (3) improvements in childhood immunization rates; and (4) organizational changes in response to cultural competency training.

2. Leveraged BAP funds

Our previous exploratory study of four BAP grantees suggested that a small investment of federal funds could serve as a catalyst for a more expansive project with potential long-term impact'. The current review confirmed that grantees were able to leverage BAP funding in multiple ways:

- by *attracting additional state/federal finds* to expand BAP activities;

¹ MDS Associates, The Bilingual Assistance Program: An Exploratory Study Final Report, February 10, 1995 (HRSA #102HR940990P000-000).

- *by influencing the longer term direction of other federal and state initiatives (e.g., disease monitoring, immunization, minority health) that continued after BAP funding ceased;*
- *by developing resources that enhanced health system infrastructure; and*
- *by giving greater visibility to minority health issues.*

This **confirms** the previous finding that BAP projects had a more substantial impact than might be expected given the relatively small amount of grant funding.

- Two projects attracted additional funding for more expansive immediate efforts. The North Carolina **Latino** Cultural Competency Training (LCCT) program and the Colorado medical interpretation training project attracted funds from other state agencies to sponsor additional workshops and provide stipends for individual trainees.
- Three grantees (Waterbury, California, and North Carolina) influenced the longer term direction of other federal/state initiatives even after BAP funding ceased. The Waterbury Hispanic Immunization calendar continues to be funded through CDC dollars and serves as the primary vehicle for immunization education material used during outreach to the Hispanic **community**. The CDC funded expansion of the California information and resource database system differs from most states in its emphasis on compiling data by ethnic group, a legacy of the BAP project. Even though the newly formed North Carolina Office of Minority Health was not the BAP grantee, the findings and recommendations of the project provided a basis for its assessment of **Hispanic/Latino** health service needs.
- Three grantees contributed to health delivery system infrastructure in various ways. The Colorado medical interpreter project placed five of its trainees in the County Health Department and health clinics in the area, and also instructed 17 trainers on cultural competency who provide training around the state. The California BAP database project produced working relationships, data collection forms, mailing lists, and database software that provide the infrastructure for the current expansion of the database to include additional minority groups. Local health department representatives developed action plans during the LCCT (North Carolina) to bring about changes in system responsiveness to Latin0 clients.
- In three states, BAP projects supported the activities of small and emerging Offices of Minority Health (OMH). In Rhode Island, the grant allowed its one person OMH to supplement its staff and expand its influence by upgrading the skills of medical interpreters. The BAP resource database development project was the first activity of the California Office of Multicultural Health and increased its visibility across state government and in Asian communities around the state. Although the new North Carolina OMH was not the BAP grantee, its staff's participation in the **Latino** Cultural Competency Advisory Committee and co-sponsorship of the LCCT workshops provided visibility and

a chance for community networking that provided the underpinnings for some of the North Carolina OMH's activities.

3. **Promoted Improved Working Relationships**

The exploratory study of four BAP grantees also revealed that improved interagency relationships were forged during these short-term projects. This study confirms that grantees strengthened interagency relationships through collaborative endeavors but also extends this finding to note the importance of improved working relationships with community members who are not necessarily part of an organized group. The BAP projects facilitated activities that enabled government agencies and community members to work together for a common purpose, and for many it was the first time such an opportunity had presented itself. Examples of these approaches follow :

Strengthened interagency working relationships. Typically these included bringing together representatives of different agencies to advise the BAP project, but often members were more active participants. Less formal interpersonal relationships that developed throughout the projects may be as important as the formal relationships.

- The California Office of Multicultural Health with the Asian & Pacific Islander American Health Forum worked as partners in the day-to-day development of the resource database. Additionally, the Advisory Committee had representatives from the Asian Health Services (Oakland), Sacramento Lao Family Community, Southeast Asian Health Project (Long Beach) and Vietnamese Community Health Promotion Project (Suc Khoe La Vang! University of California, San Francisco) as well as state representatives from the Refugee Health Program, Center for Health Statistics, and pertinent chronic disease programs (risk reduction, diabetes, tobacco, and breast and cervical cancer control).
- The Colorado HABLA project Local Advisory Committee included Rocky Mountain SER (Service, Employment and Rehabilitation), the Migrant Health Program and the County Health Department who worked together to train employable medical interpreters from the target community for the private sector. HABLA developed the curriculum and provided training; SER provided tuition assistance; the County Health Department hired one of the trained interpreters; and the Migrant Health Office was able to reduce its financial burden from providing interpretation services in the private health care sector.
- Through its Advisory Committee the North Carolina LCCT project built a coalition of agencies through its Advisory Committee with a common interest in improving health access for migrants. Membership of the AHECs helped to facilitate replication around the state; other members representing minority, migrant and rural health offices became co-sponsors of the workshops; committee members also served as faculty for the cultural competency workshops.

Developed community ties to target populations. Giving an integral role in project implementation rather than unfulfilled promises to ethnic organizations and community representatives engendered trust and long term goodwill. Examples include:

- The Waterbury Health Department did not have a community reputation of being sensitive to members of the **Latino** communities. During its Hispanic Immunization Initiative, staff worked hand-in-hand with the local Hispanic Coalition, giving them a role in setting project direction, interviewing staff to be hired for the initiative, and helping convene focus groups in the community. Furthermore, the outcome of the focus groups is well documented so that the community participants' comments are very visible in the final calendar and poster products.
- The **Latino** Cultural Competency Training also sought innovative strategies to break down barriers between **the health** department and the community by providing community members a forum to express the difficulties they face in accessing health care. Community reputation surveys provided information on perceived barriers to accessing the health department that could be incorporated into the health department action plans following the workshop. Community-based **Latino** businesses were employed rather than mainstream vendors to provide support for the workshop and its social events.

Creating a dynamic advisory group seems to be one way to influence change as is working to empower community members. Grantees also built on existing community networks such as those developed under Ryan White funding to reach out to the target communities. All members of Advisory Committees do not always buy into project goals; for example, in Colorado the project sought to change the attitude of a private family practice group towards hiring bilingual staff; despite membership on the Advisory Committee, the practice did not hire its own bilingual staff from the pool of trainees as some of the other Advisory Committee members did but continued during its OB clinics to depend on the Migrant Health Program staff for translation.

Reaching out to ethnic and linguistic minorities may require flexibility on the part of state and local governments. For example, the Hispanic Immunization Initiative in Waterbury helped bring bilingual, bicultural staff into the Health Department. The Health Director was willing to take a risk on hiring a medical doctor of Dominican heritage who spoke very little English; the health department wanted to reach out to the predominantly monolingual Dominican community. Staff of the community-based Hispanic Coalition commented during our interview that the BAP project had developed a wonderful resource person for the community and state; the doctor is now employed by the state health department.

4. Fostered Linguistic and Cultural Competence

Each of the five projects reviewed sought to improve some element of the health system related to serving limited English speaking populations. They chose a number of means for improving linguistic and cultural competence:

- hiring staff or consultants who represented and had knowledge of the target community;
- giving members of the target community an integral role in project implementation and/or evaluation;
- demonstrating and documenting changes in response to target population recommendations;
- assessing materials (e.g., health education materials, evaluation tools) for linguistic and cultural relevance; and
- empowering the minority community and its organizations by building infrastructure (e.g., skill development such as computer databases, using ethnic vendors).

Grantees indicated developing trust within the target community and employing strategies for ensuring minority input can be time consuming but has positive outcomes.

B. Future Grant-making Implications

1. Limitations of Short-term Projects

Each of the BAP projects was for a relatively short term of three to 8 months long (see Exhibit IV. 1). At times accomplishment of project activities exceeded the official BAP period; for instance, in the California project the grant period was July to September of 1993, but the Southeast Asian program resource directory was not actually published until May 1994. On the plus side, the short timeframe motivated grantees to get projects up and running as soon as possible; however, grantees indicated that the short term nature of the projects had the following effects:

- reduced scope of activities because they were originally too ambitious for the timeframe;
- full time commitment of staff/consultant;
- increased dependence on pre-existing training materials;

- reduced efforts in community networking; and
- limited the scope of follow-up and evaluation activities.

The short timeframe of most projects often required the project coordinators to devote almost full time to the task and/or hire outside staff/consultants to carry out the tasks. In instances where the project was the first activity of a new office (e.g. the Office of Multicultural Health in California or new Immunization Coordinator in Waterbury), the projects yielded a tangible product and increased the office's visibility, but it did limit staff availability for other tasks. In North Carolina, the grant was awarded to an existing office with training responsibilities and was by all accounts a successful project. Still the Project Coordinator for the LCCT was criticized during our site visit for having spent almost all of her time on its implementation, the clear implication was that she had neglected other duties (she herself was not available for interview).

The project time limits tended to make grantees more dependent on pre-existing materials and curricula. In some instances, this can be a positive outcome such as the use of the *Proyecto Informar* curriculum to train instructors for cultural competency training. In the Rhode Island project, the consultants provided a quick response to produce the one time training class, but the resulting training manual is incomplete and limits **replicability**.² Grantees found that the opportunity to offer a training course more than once provided experiences that enriched the final training curriculum and afforded staff more time to polish the final product so that it was suitable for wider dissemination.

Developing collaborative community relationships requires a lot of ground work and team building. Networking to identify community members to participate in projects, holding focus groups, following up with communities so they know that their input was heard and valued takes a lot of intensive one-on-one effort. Neither the Waterbury immunization initiative nor the North Carolina cultural competency training would have been as successful without their outreach to the target communities. The fact that community representatives had an opportunity to express their feelings about health services is significant. Rarely are these individuals allowed to articulate issues that arise from language and cultural barriers. Providing such mechanisms proves to be empowering for the community persons involved in the process. Trust is built. The word is spread. Barriers come down. Cooperative efforts emerge.

² See companion document, Bilingual Assistance Program Evaluation Part II: Assessment of Three Training Curricula.

Exhibit IV.1 BAP Grant Period	
<i>Grantee</i>	<i>Grant Period</i>
Southeast Asian (SEA) Health Information Database, California Office of Multicultural Health	July-September 1993 Directory published May 1994
Health Access by Language Advocacy (HABLA) Colorado Migrant Health Program	Phase I: February-June 1993 Phase II: July-September 1993
Hispanic Immunization Initiative (HII) Waterbury (Connecticut) Department of Public Health	April-August 1993 Calendar published October 1993
Latino Cultural Competency Training (LCCT) North Carolina Women's Preventive Health Services Branch	Phase I: February-June 1993 Phase II: July-September 1993
Medical Interpreter Training Academy Rhode Island Office of Minority Health	February-June 1993

In the Colorado project, replication of its medical interpreter training curriculum through a “train the trainer” session only attracted two persons, and this part of the project was canceled. Additional time would have allowed them a more proactive recruitment period. It is worth noting that **the** timing of the grants in the migrant-related training projects (Colorado and North Carolina) ended up being in the midst of migrant season which appeared to have affected response to training in Colorado and the Migrant Health Program staff’s ability to devote additional time to active recruitment.

Importantly, the short timeframe generally limited the scope of evaluation activities. There was more of a tendency to focus on process measures rather than assessing the impact of changes on infrastructure or accessibility for clients. Documentation should go beyond dry statistics to capture memorable quotes or scenarios in case study profiles to illustrate project implementation issues and outcomes. There were no follow-up evaluation efforts three to six months post training to determine the effects that training had on individuals and organizations. Without some **follow-up**, it is difficult to determine if there have been any systemic changes (e.g., trainees go back and train others in work environment). Only some anecdotal evidence of change was provided for the few health departments in North Carolina making changes after cultural competency training.

Recommendation: HRSA could consider a longer project term for future grants. This could be coupled with expectations that grantees: (1) will produce more polished materials and training curricula ready for further dissemination, and (2) will make further strides toward impact evaluation by conducting more extensive follow-up. Continuation of the concept of phasing is also appropriate; additional funds could be held in reserve for funding the most promising materials and evaluation techniques.

2. Grants to State and Local Governments

State and local governments offer considerable benefits as grantees. They generally provide more in-kind support than most community-based organizations could. For example, the Connecticut and North Carolina projects would have cost considerably more without this because of **almost** full time dedication of government staff during project period. Governmental agencies also provide easier access to a network of programs and have the clout often necessary to convene disparate groups, both of which can be instrumental in project implementation and institutionalization.

As noted in the last chapter, the short term grants can create problems for states where hiring and fiscal procedures are lengthy. Some such as California avoided the issue by having **the** grant funds go directly to a private agency with which it developed a work agreement, in this case the Asian & Pacific Islander American Health Forum. Others such as the Rhode Island Health Department found it easier to provide reimbursement to individuals for child care and transportation via the Providence Ambulatory Health Care Foundation.

Recommendation: HRSA may want to encourage creative alliances between government and local community-based agencies. These agreements should ensure the best use of the project time period by avoiding staffing delays, and should be responsive to the needs of persons of lower socioeconomic means and small businesses called upon to participate in project activities.

BAP funds were funneled to grantees through three separate organizations (ASTHO, NACHO, USCLHO). This approach provided expanded staff resources to OMH/HRSA in implementing BAP for grant reviews, technical assistance to grantees, and dissemination within their memberships. This three-pronged distribution system may have resulted in differences in expectations among the grantees for their responsibilities for reporting performance achievements. Also some grantees gave credit for the funds to ASTHO or another organization rather than HRSA; others gave credit to both HRSA and the other organization.

Recommendation: If HRSA adopts a similar grant making approach, they should ensure that reporting requirements and performance expectations among the organizations are consistent.

3. Program Expectations

Developing a uniform, objective set of performance expectations is a challenge to any grant program that funds diverse projects designed to meet local needs and circumstances. During this study, we explored the types of quantitative and qualitative data collected by grantees and the grantees' views on appropriate performance measures for projects of this type. The expectations outlined in Exhibits IV.2 and 3 present the types of information gathered by this sample of grantees. Some specified the objectives in quantitative terms at the outset of the project; others used more generally stated objectives. These data were not collected systematically across all grantees even those performing like activities, but they illustrate that it is quite possible to design objectives at the outset, both quantitative and qualitative, that will lend themselves to cross-program analysis at the end of the grant period. Some elements such as demonstrating leveraging of federal funds, building health system infrastructure and assessing impact (Exhibit IV.3) might require extra effort and might serve as justification for increased funding and/or an extended project period.

Exhibit IV.2 Specification of Project Objectives

- Specific process and outcome objectives (expressed in quantitative terms wherever possible) with timelines for each program activity. Projects may have a combination of activities (e.g., development of curriculum product followed by training activity) and would select the appropriate sets of activity measures below:
 - **Product development activities** (e.g., curriculum, a directory, a health education product) would specify: the development approach (e.g., adaptation of **pre-existing** curriculum, new development, review by target group); type of product and number of copies to be produced; distribution strategy; methods for assessment of appropriateness, usefulness and cultural competence; and plans for ensuring replicability to other sites.
 - **Training activities** would specify: number and type of personnel trained [e.g., physicians, other professionals (nurses, nurse practitioners, etc.), health related service personnel (e.g., outreach workers), administrators] as well as demographic information (e.g., membership in target population, bilingual); content of curriculum; certification; subjects covered; criteria for acceptance of trainees; methods of assessment of knowledge gain and appropriateness/usefulness/ cultural competence; changes in policy or practices and plans for ensuring replicability to other sites (e.g., include train the trainer materials).
 - **Service delivery activities** (e.g., direct service/outreach) would specify: number and type of persons served (e.g., demographic characteristics); intervention model; how will change existing policies/practices; culturally appropriate means of assessing patient/community satisfaction; and replicability of model to other sites.
 - **Information resource activities** (e.g., information referral center, medical interpreter referral system, database development) will require specification of: the number and types of resources to be **catalogued** or developed (e.g., interpreters or programs or materials); information retrieval categories (e.g., disease, preventive health service, risk factor, language); types of information to be collected; how will change existing policy and practices; methods for assessing appropriateness, usefulness and cultural competence of information; and plans for replicability to other sites.
- Describe the collaborative relationships (e.g., interagency within government, government to private sector, community-based organization to health facility) that are integral to project implementation and describe the roles of each in development and implementation and how this collaboration will lead to higher visibility.
- Describe the role of the target population, minority organizations, and/or community representatives in development and implementation of the project.
- Describe the elements that will ensure that this project will be culturally competent.

Exhibit Iv.3. Specification of Project Objectives

- Describe how the project will leverage these federal funds to attract other funds for the implementation of the specific project, its expansion, or institutionalization.
- Describe how the project builds infrastructure (e.g., train people who are then hired in health setting; developed health education materials used in outreach; train trainers who extend the developed curriculum to others). This is an area that may be most applicable to longer term projects, and could be a criteria in determining extended funding.
- Describe the measures they would use in assessing the impact of their projects on the target population and the health system infrastructure. (While grantees may need assistance in crafting the means to evaluate impact, they often can suggest creative ideas for the direction of **these** evaluations; the worthiness of these ideas might be one determinant in whether grantees would get extended funding).

Consistency of data among projects. Grantees did not collect uniform data even for the same **type** of activity. For example, among the four grantees offering training in this study, some set specific goals at the outset on the numbers and types of persons to be trained, and others only specified that training sessions would be conducted. It was easy to note that the Colorado project met its objectives in terms of numbers trained, and that certain targeted individuals like the Cora Indian group were harder to reach and might require a more individualized approach. When there is lack of clarity in specifying who would receive training in cultural competency or how to use an interpreter, this masks problem areas in implementation. For example, objectives that state training of physicians or policy-makers (e.g., Health Department Director) as a priority are more easily monitored if numbers are reported for these specific categories. It was only upon questioning in the site visits that it became clear how difficult it had been for projects to recruit physicians into training because measures are often constructed solely to include categories like health professionals or persons in health-related jobs.

Recommendation: *HRSA could consider requiring grantees to address the elements outlined in the accompanying exhibits in designing future project proposals and use them as a framework for analyzing overall program accomplishments. Previous project activities fell into four main activity areas (product development, training, service delivery, information resource). Projects often combined activities in different configurations (e.g., curriculum products plus training, information database of interpreters plus training). This approach gives more structure yet still gives grantees flexibility to address their particular needs.*

Improving assessment of project activities and potential for replication. While all grantees reported their achievements, critical assessment of those achievements was often limited. For example, the number of trainees might be reported, but little or no information would be collected on the amount of knowledge gained and/or skills developed that trainees could apply in a health care setting. More detailed assessment would lend credibility to efforts to replicate the program model.

Recommendation: *OMH/HRSA could require grantees to develop methods to assess knowledge gained by trainees as well as the appropriateness, usefulness, and cultural competence of project activities. Grantees may need assistance in refining these assessment approaches (e.g., pre/post training evaluations) during implementation. Applicants should also address what their plans will be to insure replicability (e.g., video of training process, curricula free of copyright restrictions, cast study).*

Collaborative relationship building. While not usually set out as a specific goal or objective for a project, grantees found relationship building with other organizations and target communities perhaps the most important and longest lasting outcome for all projects. A challenge for evaluation is how to track and measure or at least document this component. Too often minority groups are contacted at the outset of projects to provide their imprimatur so that an applicant will receive a grant, but often minority groups feel taken advantage of when not given a substantial role in implementation. Projects in this study employed various ways to go beyond

cursory involvement of minority groups and organizations, giving them integral roles in the project. For example,

- The California database project had the Asian & Pacific Islander American Health Forum as a full partner in the development of this statewide resource on chronic disease information for Southeast Asians. The CDC funded expansion builds on this prototype, giving the Rural Indian Health Board, Latinos for a Healthy California, and the Black Health Network specific roles in building the expanded database. This approach not only provides information to the community at large, but has built expertise in these minority organizations in surveying, data analysis, and computer systems.

Recommendation: Future grantees should be on notice of the necessity to provide meaningful involvement to the target population(s) and to document their contributions.

Strengthening health system infrastructure. The BAP had an implied expectation that grantee activities would strengthen community infrastructure. This study has afforded a longer term view of how these projects contributed to health delivery system infrastructure and how objectives might be crafted at the beginning of a project to ensure that material development or training are not isolated events. Steps to institutionalize programs or build infrastructure were not typically spelled out in program objectives. It should be noted that these steps are more likely to be achieved when the grantee received two phases of BAP funding or continuation funding from another source. Training or product development can be followed up with specific steps to ensure that there are changes in infrastructure. Examples follow:

- The HABLA project (Colorado) set an objective to place a certain number of trainees into health service delivery jobs and documented this capacity-building goal in its final report. At our site visit, three years later, we were able to meet with several of the trainees who are still employed in the County Health Department and health clinics in the area.
- OMH staff for the California database project indicated that the greatest legacy of the BAP project was not the directory produced but the infrastructure for its current expansion (relationships developed, data collection forms, mailing lists, database software).
- The culminating activity in LCCT (North Carolina) was development of individual action plans for each local health department which listed at least two steps the department could take to increase cultural competence (e.g., **hiring** a trainer to provide basic Spanish skills to staff).
- The HABLA ‘train the trainer’ program in cultural competency set an objective that each person should do turn-around training in his or her community within one month of the HABLA program. Four of the 17 were able to do it within the tight timeframe.

- At the end of its project, Rhode Island suggested that development of a Medical Interpreter Association in Rhode Island could be an outcome of the Academy. While this did not happen, if it had been built into the objectives of the project it could have provided a locus for continuing education programs and support among interpreters after termination of the grant.

Recommendation: In the future, project activities -- whether they be curriculum development, service delivery, or training -- should not be evaluated only as isolated events. Rather evaluation frameworks should consider these as events that can foster more permanent changes in the health system to make it more responsive to the target community. While all grantees should be able to develop ideas/plans for such institutionalization, additional time in the grant period and additional funds might be required to accomplish/finish the planned tasks. OMH/HRSA could consider a separate follow-up grant phase for those projects with the most promising approaches.

Documenting improvements in access or health status. Documenting improvements in effective access or improving health status for those with limited English proficiency is perhaps beyond the scope of short-term projects like those funded under BAR. One grantee, the Waterbury Health Department, was able to document changes in immunization compliance over two years during a period of continued CDC funding. Baseline data showed that 39-53% of children in the three target health centers were up-to-date by age two for the 4:3:1: childhood immunization series.³ Now the centers have 75 to 90% completion rates, with the rate for Hispanics at 88 % . Isolating the effects of the health education materials from the accompanying outreach and follow-up has not been possible, but the Immunization Coordinator cites the trust built between the health department and the Dominican and Puerto Rican community during the BAP project as important in people's receptivity to the immunization outreach worker. Several grantees had specific ideas about how to approach these issues but were not able to accomplish them within the timeframe of the grant. There were also concerns raised about the ability to isolate the effects, in some cases, of a specific project. Direct service delivery projects may be more successful in documenting this type of change (e.g., increase in number of Latino clients served). Additional ideas that have potential for testing in future longer term projects include:

- The HABLA project (Colorado) wanted to track if there were improvements in the rate of keeping appointments once bilingual staff were available in primary care settings.
- The North Carolina LCCT developed a survey and interviewer's guide for assessing the community reputation of local health departments. The survey was employed to develop baseline information used in the workshops, but sufficient time had not elapsed between the workshops and the end of the grant to assess whether there was a change in community reputation.

³ By age 2, children should receive 4 DTP, 3 OPV and 1 MMR.

Recommendation: *OMH/HRSA could also consider follow-up grants to develop methods to assess improvement in access and health status.*

c. Building on BAP--Potential Future Directions.

Examination of the experience of these five projects yields some lessons that deserve consideration in designing future bilingual assistance grants. Review of the experiences of these grantees has suggested a variety of topics for focusing program directions, and areas where technical assistance would benefit future grantees. This assistance could be offered from a more centralized resource (e.g., OMH Resource Center, national minority organizations, contractors). Alternately, some of these areas lend themselves to being priorities for model development by new grantees. Areas where collaboration within DHHS might benefit issues of common concern are noted.

Strategies **for attracting health professionals, especially physicians, to training.** Both of the projects (Colorado, Rhode Island) that offered training to health professionals in cultural competency and how to use medical interpreters initially had difficulties attracting health professionals. The lesson from these projects is when the time commitment was reduced (e.g., from 2 days to 1 day; or 2 days to 2 hours), recruitment was more successful. However, there remained difficulty in attracting physicians to these sessions, even when offered in the context of a hospital Grand Rounds. Other types of projects have found that MDs, CEOs, and Board Chairs often require a specialized training environment. The AIDS Education and Training Centers (AETC), whose responsibility it is to train physicians, may be a good technical assistance resource.

Recommendation: *OMH/HRSA might work with the Bureau of Health Professions on gathering and developing strategies for exposing physicians to these issues. Suggestions made at the state level were tying training to licensure, residency training, or contract requirements. Another suggestion is to tap the pool of foreign-born or first generation health professionals in recruiting and training their peers. OMH/HRSA might work with national medical associations in securing continuing education credits for specific cultural competency and medical interpretation programs.*

Strategies for reaching immigrant groups where bilingual personnel are rare. The approaches employed in the Medical Interpreter Training projects appeared to work better for those who had very good English and second language skills. Those whose English was limited (e.g., Huichol and Cora Indians of Colorado; some Southeast Asians in Rhode Island) were not able to keep up with the quick pace of either the Colorado or Rhode Island models. These people often represent groups who have not only the greatest health care needs but also the most limited ability to communicate. In some parts of the country the immigrant populations are changing and interpreters for additional languages and materials for these emerging groups are needed.

Recommendation: *HRSA could put a priority on development of different models to provide medical interpretation for emerging immigrant groups.*

Strategies for promoting the hiring of medical interpreters. Each of the BAP sponsored medical interpretation training programs had many more applicants than could be accommodated. The former grantees still report continued dependence by providers on family members, and housekeeping staff in hospitals. The need appears particularly acute in rural areas where migrants have settled out and for new immigrant groups whose language is not as well known in this country.

Recommendation: HRSA could help grantees by helping to clarify expectations and educate grantees and providers about responsibilities under civil rights and Hill-Burton regulations. This is particularly important in the current anti-immigrant climate. The Office of Civil Rights and the Health Care Financing Administration co-sponsored a conference and research study on these issues in 1995. The Rhode Island project noted the positive impact on providers of the AARP's Health Watch study which pointed out violations of these provisions in that area.

Defining the role of a medical interpreter. Another area needing attention is what is the role of an interpreter and what level of training should HRSA grantees expect that interpreters have. Organizations such as the Massachusetts Medical Interpreters Association have been trying to work toward defining “standards of practice and/or credentialing criteria” for medical interpreters. Professionalization is one avenue, but many organizations cannot dedicate a person solely to interpretation and prefer to hire someone who also acts as an outreach worker/health advocate.

Recommendation: HRSA could convene a panel to examine: (1) the state of knowledge with respect to the effectiveness of different modes of medical interpretation; (2) the practical realities that HRSA grantees face in recruiting, training, and paying medical interpreters; and (3) what agencies can realistically expect to achieve in one-time v. ongoing training for medical interpreters. (This recommendation overlaps with one in the separate review of the BAP sponsored training curricula).

Strategies to avoid reinventing the wheel. Grantees have limited ability to distribute materials developed under their projects to a wider audience; they need assistance. For example, the Connecticut project gained visibility and promoted its accomplishments at national conferences but was not equipped to respond to requests for hundreds of copies of its calendar. The federal OMH Resource Center was not intended to act as a clearinghouse, but as a reference center giving grantees ideas about where to go for additional ideas and giving citations from the published literature. Under this approach future grantees who wanted to benefit from past BAP funded projects would have to contact the former grantee directly; besides the burden on individual grantees, given our difficulty in tracking down copies of materials once there is staff turnover, this suggests that material availability is very time limited. Perhaps as part of initial technical assistance, future grant recipients could be provided with a package of similar products and resources by the granting agency. Surprisingly, the Waterbury Immunization Coordinator was not even aware of the existence of National Council of La Raza and COSSMHO, nor was the local Hispanic Coalition.

Background materials that are culturally related maybe more plentiful than just those targeted to culture and health. Caution should be exercised in the development of materials; immigrant needs change the longer they are here. Specific scenarios rather than generalizations about groups of people tend to be less offensive.

Recommendation: *HRSA could work with the OMH Resource Center, national minority organizations, the Area Health Education Centers and other groups such as the AIDS Education and Training Centers in developing pertinent packages of background materials.*

Development and evaluation of health education materials. Grantees noted health providers' concern about not having the ability to assess the appropriateness of health education materials in different languages. Neither the federal OMH Resource Center nor the California Resource Directory project provide this level of review. The OMH Resource Center has some in-house Spanish language capability, but none for other languages. In this sample the North Carolina and Waterbury grantees performed reviews, but it was limited to Spanish language materials. North Carolina compiled existing materials, and Waterbury reviewed existing materials and developed their own. The need for appropriate language materials is most acute for newly immigrating groups. Also grantees noted that many health areas are neglected in bilingual health education materials; while information on **perinatal** issues is often available, other areas (such as chronic disease, breast cancer, preventive screening for adults, death and dying issues) are neglected. The model Resource Manual for Spanish/English perinatal and family planning education produced in the North Carolina project is a model that could be extended to other health areas in multiple languages with attention to proper literacy levels. The North Carolina project used two levels of review, bilingual, bicultural health professionals and monolingual users.

Recommendation: *OMH/HRSA could work with the OMH Resource Center, the Area Health Education Centers, and HRSA grant recipients to develop priorities for health education materials for specific groups with limited English proficiency and provide the means for review and evaluation of these materials, particularly for less common languages.*

Development of replicable products. Successful replication of training curricula or health education materials requires a substantial investment of dollars specifically in the production of the product itself. Producing replicable products that are professional looking and complete is costly in time and materials; grantees particularly need guidance on what would make a complete and replicable curriculum product. Some of the curricula produced under BAP and reviewed for this study often incorporated **xeroxed** material from copyrighted sources; this was an expeditious way to produce portions of the curriculum, but it does not leave it ready to replicate as is. The full texture of the courses offered is not always documented in writing (for example, the curriculum suggests role playing without giving scenarios for role playing; outlines but not text of presentations are available). Videotaping portions may have captured the classroom dynamics and content better, but it is costly and may be intimidating to some students. All of the training programs did make use of existing videos obtained from the **AHECs**. These were of varying quality.

Recommendation: If OMH/HRSA wishes to continue to support local development of curricula and health education materials, grantees appear to need guidance with respect to the use of pre-existing documents in training, and how to produce a polished product for further dissemination. National minority organizations, AHECs, training institutions or contractors might provide assistance in the production of replicable materials. (This recommendation overlaps partially with the separate review of RAP sponsored training curricula).

Evaluation assistance: Projects would benefit from technical assistance in setting and measuring performance. This is needed not only to enhance their own ability to measure project success, but also would enable OMH/HRSA to ensure that the measures would be constructed to yield an overall BAP program evaluation. One approach to providing evaluation assistance used by The Robert Wood Johnson Foundation 'Opening Doors' projects is pairing grantees with qualified evaluators in their area under the guidance of a national program evaluator; these project budgets are quite a bit bigger and span multiple years.

Recommendation: Further specification in program guidance of the expectations for evaluation will help as would providing samples of instrumentation such as those for pre/post tests for training, and patient satisfaction and/or community reputation survey tools. HRSA could consider adapting the approach used by the RWJ project to suit the scope of future bilingual grants.

Appendix A Information Collection Guide

Bilingual Assistance Program:
Evaluation of Strategies for Reducing **Cultural** and **Linguistic** Barriers to Health Care **for**
Hispanic and Asian/Pacific **Islander** Populations

(HRSA # 240-94-0036; DO 240-95-0303)

INFORMATION COLLECTION **GUIDE**

March 6, 1996

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INFORMATION COLLECTION GUIDE

I. PROJECT DEVELOPMENT

A. Overview

1. Please describe the characteristics of your target community, particularly those that were influential in your decision to develop and seek funding from the Bilingual Assistance Program?
 - Was there a formal needs assessment documenting service delivery issues due to a lack of cultural or linguistic competence? If so, what did it show? Are there specific reports addressing these issues which we could obtain?
 - » Alternately, was there informal information gathering through community meetings, staff meetings, training reports, or other avenues?
 - » What insights were derived?
 - What specific problem(s) was the project intended to address?
 - What cultural and linguistic barriers existed at the time of the grant in your community? How did your project attempt to address these barriers? Do these barriers continue to persist?
 - If not addressed above, please describe the ethnic and cultural mix of the target population.
2. How did you arrive at the particular focus (e.g., data base development, interpreter training) of your approach for addressing the problem?
3. Who/what initiated the idea or provided the impetus for the project (e.g., leadership of individual or organization, evaluation of client needs, community population change patterns)? Who (organizations and/or individuals) participated in the decision to seek funding and to develop the ideas in the application?
 - How did you get community input?
 - » Were representatives of cultural and linguistic minority groups represented in the decision-making process leading to this project?

How did they contribute in terms of identifying culturally based obstacles (survey, focus groups, advisor to project, provision of **bilingual/bicultural** staff)?

- Did any state or local legislation or policies serve as an impetus for developing the program or affect its development?

4. Complete Table A.1 (Appendix A) self-assessment of organizational cultural competency.

- How would you define a culturally competent/sensitive organization?
- Had your organization performed a self-assessment of its own cultural competency prior to or during this project? If yes, was it the cultural competence of the organization and/or individuals that was assessed?

» If yes, what elements did you address? What problem areas did you identify with respect to cultural competence? What changes were made as a result of this self-assessment?

» If no, would this have been helpful?

B. Funding

1. Was this project a wholly new endeavor, an expansion or a modification of previous efforts?
2. Did BAP funds help you gather additional dollars for your initiative?
3. Please complete Table A.2 (Appendix A) indicating the source and amount of Project Support.
4. How did you use your funds? Indicate the distribution of expenditures by budget categories (e. g . ,**staff** salaries, consultants, training materials, training sessions, stipends) by completing Table A.3 (Appendix A).
5. Have other sources of funding continued or been obtained to continue or expand the BAP project? Indicate sources and amounts.
 - How did your accomplishments under BAP influence your ability to qualify for additional funding?

- What other organizational attributes do you think were critical in leveraging the BAP funds into a broader and more visible initiative?

C. Staffing

1. Describe staffing for the project (e.g., type of staff; **number/FTEs**; background, including education, race/ethnicity/subgroup) .

- How were the staff organized for this project?
- What specific expertise, if any, did your staff need to develop the materials for this project? Did development of this expertise require them to have specialized training, certification, or specific work experience prior to the project?
- Did you hire anyone directly from the target population to work on the project?

2. Was there special expertise beyond your staff capabilities that required you to use consultants/contract personnel in the development of the project?

- Which type of expertise was needed;
- What tasks did they perform;
- How would you evaluate their efforts;
- Would you need to hire outside expertise again to continue or expand the project, or to identify additional needs?

II. PROJECT IMPLEMENTATION

A. Implementation Issues

1. What type of problems arose during the development of the project (e.g., time/resource constraints, intra-agency politics/conflicts, legal problems, lack of qualified personnel to hire, inability to recruit, other)?
 - Were there any problems encountered that arose specifically from within the target population itself?
2. How were these problems addressed/resolved?
3. What role did the involved community-based organizations or local/state health department play in resolving them?
 - How did you identify the appropriate community based organizations? Was the target group asked to suggest any organizations to work with?
4. Were there formal or informal interagency agreements made during the development of this project? Who were they with and what elements were covered in the agreement? How did the relationships based on these agreements work out; were the agreements practical or not?

B. Project Module(s) [Insert module(s) appropriate to project]

Module 1. Training Projects

1. What problem in your target community was the training specifically intended to address?
2. What was the content of the curriculum?
3. Once developed was the training curriculum intended solely for one-time training in this project, for distribution to other organizations, or to be an ongoing resource)?
 - If an ongoing resource, what was the anticipated duration (i.e., ongoing for 12 months, 18 months, open-ended)?
4. Describe the development of the curriculum.
 - How was the curriculum pilot tested?
 - Were focus groups held? If so, how many, where, and how many participated?
 - Who developed the curriculum? What were their credentials?
 - Did you use community leaders in the development of the curriculum?
 - If you used outside consultants, how did you learn of their expertise?
 - For what areas did you need outside assistance?
5. Describe the experience with the training curricula.
 - How many programs were conducted? How many were trained?
 - Was the training a stand alone program, part of a regular in-house staff meeting, or was it part of a larger conference? Was there any particular benefit to the timing and site chosen for the training?
6. Was the target population involved in the training? If so,
 - Was the training site accessible by public transportation?
 - Were stipends or vouchers given for transportation?
7. What was your assessment of the materials and approach?
 - How useful was it to achieving your own goals as a grantee?
 - How useful was the materials and approach to the trainees? How did you determine this--both process (evaluation by trainees) and

outcome (e.g., did it increase trainees's knowledge and capabilities)?

- Ultimately, how did training improve service to clients? How did you determine this--both process (e.g., evaluation by clients) and outcome (e.g., increased client access and comfort level/satisfaction)?
8. How were those who trained the trainers selected and evaluated? Were they the individuals who developed the curriculum? What were the characteristics of success for the original trainers?
 9. What efforts were made to ensure the training materials were accurate (both for content and linguistic aspects)? How were they verified?
 10. What efforts were made to ensure that both the training materials and approach were culturally appropriate?
 11. Did **you find** that the training materials and approach were more appropriate for one particular type of trainee (e.g., nurse practitioner v. community liaison)? Was that the audience that they were designed for?
 12. Do you think your training materials would be useful in other settings? Why? In what type of sites, situations, or people would they be appropriate?
 - What changes or recommendations would you make before it is adapted/offered to other sites?
 - Would the materials need to be accompanied by hands-on training before it would be useful to others? Who would be appropriate to offer such training?
 - What recommendations would you make to other sites who are considering implementing this specific training? Are there particular recommendations with respect to acceptance of this approach by various administrative and policy makers in the organization?

**Bilingual Assistance Program:
Evaluation of Strategies for Reducing Cultural and Linguistic Barriers to Health Care for
Hispanic and Asian/Pacific Islander Populations**

(HRSA # 240-94-0036; DO 240-95-0303)

INFORMATION COLLECTION GUIDE

March 6, 1996

Module 2. Interpretation/Translation Services

1. Did your services under the BAP program ascribe to a specific philosophy for medical interpretation (for example, should the interpreter translate word for word or also play a role as a cultural mediator)? Has your philosophy remained the same or changed? Please explain your rationale for this approach(es).
 - How do you ensure that your approach is followed in practice? Or does it vary from interpreter to interpreter?
 - How do you get providers to accept this philosophy?
 - Where are the interpreters working now?

2. Under the BAP project, how did patients/providers get access to the interpretation/translation services (e.g., dedicated phone lines for non-English speaking individuals, shared language bank for providers in community)?
 - Were the interpreters located at a specific site or on-call (e.g. face-to-face or by phone)? Was there a specific number to call? Was there advertisement or outreach with respect to services directed to providers or ethnic communities?
 - What was the availability of interpreters/translators (e.g., **24** hours a day; different hours for face-to-face v. over phone)?
 - Were the number of calls/contacts tracked? Were the purposes of the call tracked? What data do you have available? What data would you have found useful for program planning and evaluation (e.g., how caller found out about project, where client referred)?
 - How was interpreter caseload determined (e.g., language, culture, randomly, geography, level of care)?
 - If there was outreach and/or advertising, where was it done (e.g., churches, radio stations)?

3. Were there any attempts to determine patient satisfaction with the services?
 - If yes, was there a specific protocol and what were the results?
 - If not, how would you suggest determining patient satisfaction with similar services? What are the most important issues to address?

4. What screening, if any, of medical interpreters/translators was done?
 - What qualifications did they need to enter the program? Were lay people or health professionals the target of your program training?
 - How was language ability assessed? By whom?
 - What qualifications did they have to meet to be certified?
 - What qualifications did they need to be placed in specific organizations?
 - Were there specific state/local laws or policies regarding medical interpretation that you needed to address in developing your program?
5. What were your policies with regard to confidentiality when serving as a medical interpreter/translators?
6. What subject areas are critical to address in training medical interpreters?
 - medical terminology
 - anatomy
 - treatment protocols
 - cultural competency
 - confidentiality
 - role of medical interpreter
 - other. Please specify.
7. How did you ensure that your medical interpreter/translation program was culturally competent, particularly in understanding of cultural norms related to medical issues?
 - How were these cultural norms taken into account?
8. If your medical interpretation/translation services are continuing, how are they funded?
 - Does Medicaid cover medical interpretation services in your state?
Do many of your clients qualify under Medicaid?
 - Can your clients pay for these services?

9. Did you provide training to providers on how to work with interpreters?
- Is this useful? How did you assess what is the best approach?
 - What mechanism was there for providers to request services?
10. What recommendations would you have for others starting to develop or improve a system of medical interpreters/translators?
- Is a remote translation program as effective as proximate translation? Is it more efficient?
 - Are there specific characteristics of your locality (urban/rural; single v. multiple languages; literacy level of population) that must be addressed in order to provide these services? How did you address these?
 - What would you consider the most practical methodology for requesting and providing these services?
11. In some areas of the country either Title VI of the Civil Rights Act or Hill-Burton requirements have been interpreted as requiring institutions with federal dollars to provide translation services. Has this been an issue in your community?

Module 3. Cultural Competency

1. How did you **define** cultural competence?
2. Was knowledge about the specific target cultures very accessible to health care workers in your organization? How was it accessible (e.g., literature, consultants, **community** resources)?
3. How did you decide who would receive the cultural competency training?
 - Had there been an assessment of specific needs by individual?
4. Based on your experience, which of the following elements do you think are essential for inclusion in a cultural competence curriculum?
 - Which are included in your cultural competence curriculum?
 - » culturally prescribed patterns of communication (verbal and nonverbal), etiquette, and problem solving;
 - » examples of miscommunication across cultures;
 - » family structures, values and history;
 - » origins of stereotypes and prejudices;
 - » unique culturally defined needs;
 - » differences in thought patterns;
 - » distinctions between ethnic group and cultures/subcultures;
 - » prevailing beliefs, customs, norms, and values;
 - » social service needs/problems;
 - » use of culturally specific assessment instruments/treatment approaches;
 - » involvement of traditional healers;
 - » role culture plays in help-seeking behavior;
 - » differential service utilization;
 - » beliefs, practices, and customs of U.S. v. other cultures
 - Could you expand upon how you addressed these elements in your curriculum? For example, (1) how do specific cultural norms influence medical interventions; and (2) can children/adolescents receive care/information without an adult present?

5. Did you evaluate the effectiveness of the cultural competency curriculum? How?

- Did you **find** that trainees who participated in the cultural competency sessions could work more effectively in cross-cultural situations? How did you determine this? Did you assess any of the following:
 - » institutionalized cultural knowledge;
 - » people more in tune with culture;
 - » people acknowledge cultural differences have impact on service delivery;
 - » changed values with respect to diversity;
 - » increased respect for a cultural set of beliefs and behaviors;
 - » changed or adapted methods of service delivery
 - » other. Please specify.
- Were clients/patients asked whether they perceived any changes in service delivery after the cultural competency training?

6. Are you continuing cultural competency training?

- Do service providers initiate requests for their own in-service training?

Module 4. Outreach Projects

1. How was the outreach strategy developed (e.g., needs assessment, consultation with local agencies, consultation with community leaders, interagency communication)?
2. What were the elements of the outreach strategy (radio/television ads, billboards, printed materials, outreach workers)?
 - How were materials distributed?
 - Was there a provider education component?
3. Who developed your materials? What were their qualifications?
 - Were the materials bilingual?
 - How did you determine if the materials were linguistically accurate and culturally appropriate?
4. Describe your use of outreach workers.
 - Was there a match between the ethnicity and dialect of workers and the community served? Were they hired from the target population?
 - What qualifications did you require of outreach workers? Were they knowledgeable about the communities?
 - What training, if any, did outreach workers receive?
 - What were the specific duties of the outreach workers?
 - How did you assess the effectiveness of the outreach workers individually as opposed to the overall outreach strategy?
 - What changes, if any, would you make in your use of outreach workers?
5. What were your results? Do you have data on the number reached, the number brought into service, improved immunization compliance rates, or **other** data?

Module 5. Data Base Development

1. How did you **define** the expanded ethnic identifiers for your data base? What is your rationale for these definitions? Have these identifiers been used for other systems?
2. How did you arrive at the five health topics for inclusion in the database? What was their significance for the particular Southeast Asian subgroups that were your target?
3. Your survey appears to capture information broader than the two ethnic groups and five priority health topics; were additional information areas incorporated into the database?
 - What are the retrieval topics? Were there limitations in structuring the topic areas (e.g., software limits, data entry limitations)?
4. What did you learn from the Combined Health Information Database (CHID) in terms of designing your database? in terms of maintaining a database?
 - What did you have to do to ensure compatibility with CHID?
 - What role does your database play in CHID?
 - How did your initial efforts lay the foundation for a larger database?
 - Were existing CHID databases examined for materials relevant to Southeast Asians? Were there areas that you found to be particularly useful?
5. Why did you choose to develop CDs versus an ongoing online capability?
 - Did your potential users have the capacity for CDs and not for online transmittal?
 - What hardware and software did users have to have to access your database?
 - Have the CDs been updated?

6. What training, if any, did users have to have to access the database? What documentation accompanied the CD (e.g., read me file, directory)?
 - How was this training provided (e.g., conference call, on-site)?
 - Are there materials available?
 - Is it ongoing?
7. What is the function of the centralized depository?
 - Is collection of descriptive program information ongoing?
 - Are materials listed in the program (e.g., Lao and Vietnamese written materials mentioned in Long Beach summary) collected and disseminated? How? Or do users contact individual programs directly?
 - Are materials and/or programs evaluated in any way before entry into the system?
8. How did the database support state and local public health personnel in planning, developing, and evaluating culturally and linguistically appropriate programs?
 - What evidence of the database's usefulness has been gathered?
 - What other groups have had access to the database (e.g., community-based organizations, HMOs, schools)? How have they used the information? Did they provide any feedback about the usefulness of the database?
9. What was the Advisory Committee's role in designing the database, survey tool, and dissemination plan?
10. What is the nature of the relationship between the Office of Minority Health and the Asian American Health Forum?
 - How did each organization contribute to the development of the effort?

III. CONTINUATION OF BAP INITIATED EFFORT

A. Continuation of Effort

1. Was the BAP project intended to continue after the ASTHO/NACHO/USCHLO funds ceased?
 - What environmental factors have posed barriers to continuation? Have these factors changed since you started the project (e.g., changing state/federal/community attitudes toward immigration; legislation on immigration issues)?
 - What environmental factors have allowed these projects to continue or expand?
 - Have any state/local legislation or policies affected your ability to continue these efforts or changed the need for these services?
2. What elements of the original BAP initiative continue today? What changes have been necessary?
 - Did the BAP project lead to a broader effort? What? Supported by whom?
 - How critical were the initial BAP funds to development of current efforts?
 - How were you able to institutionalize either the infrastructure development or direct service delivery components after BAP funding ceased?
 - What are your current plans for future continuation?
3. Has the need for this service(s) changed since you prepared the application for the BAP grant?
4. If additional funds became available, what would you like to do to enhance your efforts in this area?

B. Dissemination

1. Did you use any of the elements or products of this initiative for other purposes than your original area or target group?

- If yes, for whom and how was it disseminated?
2. What elements or products from this initiative would you recommend for broader dissemination? For what purposes (e.g., background information, use by others)?
- Are the materials/approach subject specific (e.g., prenatal only)?
 - Are the materials/approach locale specific (e.g., rural v. urban; state specific)?
 - Are the materials/approach culture specific (e.g., Mexican v. Caribbean migrants)?
 - To what extent do socioeconomic level, degree of assimilation and acculturation of the client population affect usefulness?
 - What adaptation, if any, would these elements or products need prior to broader dissemination?
3. What lessons did you learn from this experience that would be useful to share with others contemplating a similar project? With respect to:
- clients and their needs
 - outreach
 - approach to training
 - trainees
 - trainers
 - consultants
 - data base development
 - developing/maintaining a bilingual initiative
 - evaluating a bilingual initiative

IV. TECHNICAL ASSISTANCE

1. What type of technical assistance, if any, did you require in the development and implementation of your BAP project?
 - In retrospect, what type(s) of technical assistance might have been useful in developing and implementing your project?
2. To what extent did you draw upon national minority organizations (e.g., COSSMHO, National Council of La Raza, Asian/Pacific Islander American Health Forum) for assistance?
 - Why did you choose to use or not to use these groups?
 - If used, what type of assistance did you receive?
 - If used, what was your assessment of the assistance?
 - How do you think these organizations might be helpful in the development and implementation of projects like BAP? Are there specific technical assistance needs that they might meet?
 - Was the target population involved in any capacity with any of these national organizations? Did the target group suggest any other organizations as appropriate for assistance?
3. Which, if any, community based organizations and agencies, including those representing minority groups were involved in developing and establishing your project?
 - How were these organizations/individuals involved (e. g . , funding, advisory committee, review of materials, etc.)?
4. Would it have been useful to you to be matched with a mentor site that has implemented a similar project?
 - If you did use a mentor, describe your experience.
 - » What were your expectations for the mentor?
 - » What specific aid/guidance did the mentor provide?
 - » How were you matched to the mentor?
 - » Could you have done the project without the mentor?

6. If a local or state health department subcontracted with you to conduct this project what role did these organizations play in the development and implementation of the project?
 - How did the organization help with Program implementation and outcomes?

V. DOCUMENTING SUCCESS

A. Setting Goals

1. What goals did you **define** for the project? How did they relate to community need for reducing cultural and linguistic barriers to care?
 - What objectives did you set to move towards these goals?
 - In retrospect, would you have had a different set of goals and/or objectives? Why?
 - Did the target population express any specific goals that they wanted to see met? Were they queried about their own goals and objectives?
2. How did you evaluate your efforts?
 - What performance indicators/measures were selected and monitored?
 - Were these indicators/measures quantifiable?
 - Can you give specific anecdotal evidence of the success of your project?
 - Were there unexpected outcomes/benefits from the project that were different than what you expected you would have achieved?
 - If this project was part of a larger program to improve access to minority health, how did you distinguish the accomplishments of this project?

B. Measuring Success

1. Are there specific measures that you think could be used in the following areas? Did you use any? Which ones?

- increasing consumer knowledge about health care (e.g., numbers trained/served, assessments of increased knowledge);
- increasing use by consumers of appropriate levels of care (e.g., ER use down, preventive service/early intervention use up);
- increasing the cultural sensitivity of providers (e.g., patient satisfaction; assessment of increased knowledge; use of culturally specific education materials in patient interactions; hiring of bilingual, bicultural staff);
- increasing provider knowledge of health care needs of different cultural groups (e.g., dissemination of health status information to providers);
- Other. Please specify.

Appendix A

A.1. Self-Assessment of Organizational Cultural Competence: Check the elements of organizational cultural competency and their frequency as used by your organization.¹

Table A.1. Self-Assessment of. Organizational Cultural Competence			
	Often	Sometimes	Never
Identify cultural groups and their location in the community .			
Identify demographics (age, gender, income, cultural diversity).			
Identify gaps in services for cultural groups.			
Identify access problems for cultural groups.			
Target funds to address specific cultural and linguistic barriers to care.			
Provide outreach to cultural groups.			
Include target groups in ongoing planning and implementation			
Incorporate cultural values and priorities in service planning/implementation/evaluation.			
Include culturally diverse participation at policy and program levels.			
Recruit/hire bilingual/bicultural staff.			
Translate assessment/educational materials into other languages			
Provide ongoing in-service training in cultural competence for staff and volunteers.			
Job descriptions require relevant cultural experience.			
Assess instruments/educational materials for cultural competency			
Envision community empowerment as a treatment goal .			

¹ Based on "To Improve Access to Care and Quality of Life for All Children with special Health Needs and Their Families," a survey of **SPRANS/MCHIP** grantees by Pathfinder Resources, Inc., 1994 and on "Towards a Culturally Competent System of Care," by Mareasa Isaacs and Marva Benjamin, Georgetown University Child Development Center.

A.2. Project Support: Please indicate the source and amount of project support.

Table A.2. Project Support		
	For Original Project	For Continuing Projects (most recent year 19)
BAP		
State Government		
Local Government		
Other Federal		
Private		
In-Kind Contributions		
TOTAL		

A.3. Project Expenditures: Please indicate distribution of expenditures among categories or provide copies of your expenditure format.

Table A.3. Project Expenditures		
	For Original Project	For Continuing Projects (most recent year 19)
Staff Salaries/Benefits		
Consultant Salaries		
Contracts		
Equipment		
Supplies		
Training Materials		
Training Sessions		
Stipends		
Transportation		
Other		
TOTAL		

Appendix B

B.I. Sample Topics for Interviewing Trainees Served under BAP Grant Program

Enhancement of Knowledge

Please explain how the training you received added to your knowledge and to your skills. Can you give examples of how you have applied what you learned and how it has helped you and/or your clients? Do you think you or your co-workers would benefit from ongoing training or a refresher course in this area? If you have questions about a particular culture, is there a specific organization or individual you could go to for information? Give examples of recent questions or concerns about health care of those who face linguistic and cultural barriers.

Assessment

Can you determine from your exposure to the training materials and your subsequent experiences whether the content was accurate, culturally appropriate, and applicable to the language/cultural groups you serve? Give examples. Were there particular elements in the training approach that were particularly effective (lecture, small group discussion, case studies, testing, etc.)? Which elements were not effective? How would you rate the trainer's expertise and delivery? If you were asked to develop similar materials or training program, how would you design them?

Dissemination

After receiving the training, did you share the information you gained with other co-workers? Was this done formally or informally? Would you recommend any changes before the training materials are offered to other sites? Would you consider yourself ready to be a trainer or resource person?

B.2. Interview Guide for Participating Community-Based Organizations

1. What was your role in the development and implementation of the BAP grant proposal (e.g., knowledge of community to be served, specific linguistic/cultural knowledge, needs assessment, **community** contacts)?
 - Were there additional areas where your knowledge and skills could have enhanced the project? Were you made to feel a part of the development and implementation of the project (e.g., were your ideas respected and incorporated?)
 - Were there particular areas of expertise that national minority organizations might have provided in the development, implementation, or dissemination of the project?
 - Were there formal or informal interagency agreements made during the development of this project?
 - How would you evaluate the impact of working together on this project?
 - » on the grantee;
 - » on the availability of care;
 - » on you;
 - » on the community?
2. What specific problem(s) was the project intended to address?
 - What is your assessment of the outcome of the project for the particular target community? How would you measure/monitor achievement of outcome(s)?
 - To what extent did this project contribute to developing a culturally informed service delivery system? What changes did you notice?
 - What more could be done in this arena?

3. Has the BAP initiative continued? What is your role, if any?
 - What would have been necessary for the BAP initiative to become institutionalized?
 - Can the ethnic **community** support this program?
 - If additional funds became available, what would you like to do to enhance the BAP initiative?
 - Could your community or agency adopt this program?
4. What elements or products from this initiative would you recommend for broader dissemination? Why?
5. What lessons did you learn from this experience that would be useful to share with others contemplating a similar project?

Appendix B Site Visit Reports

- Southeast Asian Health Information Database -- Office of Multicultural Health, California Department of Health Services
- Health Access by Language Advocacy (**HABLA**) -- Colorado Department of Health, Migrant Health Program
- Hispanic Immunization Initiative -- City of Waterbury (Connecticut) Health Department
- **Latino** Cultural Competency Training (LCCT) Project -- North Carolina Department of Environment, Health and Natural Resources
- Medical Interpreter Training Academy -- Rhode Island Department of Health, Office of Minority Health

SOUTHEAST ASIAN HEALTH INFORMATION DATABASE PROJECT

Office of Multicultural Health, California Department of Health Services and Asian & Pacific Islander American Health Forum

The team of Cheryl Ulmer and Kim Oanh Cook visited the Office of Multicultural Health (OMH) and the Asian and Pacific Islander American Health Forum on April 23-24, 1996 and interviewed current and former directors and staff of the database project. A subsequent telephone interview was held with the CDC technical adviser to the project (Technical Information and Editorial Services Branch, National Center for Chronic Disease and Health Promotion).

Key points that emerged from the site review are:

- The proposed Southeast Asian Health Information and Resource Directory of Chronic Diseases was produced, incorporating a broader base of information on health conditions and ethnic groups than originally proposed.
- The project was an ambitious undertaking for a three month period (July to September) and took substantially longer (directory published May 1994).
- The BAP seed money allowed development activities which set the direction (chronic disease by ethnic groups) of further CDC funded database activities.
- While the directory is a visible product, the infrastructure built to produce this product is just as important if not more so. The relationship between OMH and the Asian & Pacific Islander American Health Forum developed during the grant period persists. The technical expertise for data collection and entry was also developed during the BAP project.
- The development of the database gave OMH greater visibility both within and outside state government.
- The BAP funded model has extended to bring in new partners (Latinos, Blacks and Native Americans). The basic format of the original data collection form is shared by all groups.
- OMH and the Asian & Pacific Islander American Health Forum needed considerable technical assistance from CDC with software use and database development.

A. *Project Background*

The California initiative to develop a program resource database grew out of the convergence in 1993 of a number of events:

- California Department of Health Services (CDHS) chronic disease/injury control staff attended a conference sponsored by CDC on the federal Combined Health Information Database (CHID)¹ which at that time had very limited information on program resources for Southeast Asians,
- CDHS planned to reorganize, with individuals from the chronic disease/injury control branch providing the core staff for a newly established Office of Multicultural Health (OMH), and
- ASTHO announced the availability of funds for a three month project period.

California has the largest Asian and Pacific Islander population in the United States, and 20% of the state's limited English speaking population speak an Asian or Pacific Islander language. Building on staff expertise in the chronic disease area, OMH proposed database development to fill in gaps in knowledge about programs directed toward chronic disease problems among Southeast Asian groups. The project funded under BAP, known as the Southeast Asian Health Information Database, would survey organizations throughout the state for information on their program content, culturally relevant resources, and language capability.

Cancer, diabetes, heart disease/stroke, tobacco and nutrition programs, particularly for Laotians and Vietnamese, were the primary focus for information collection. These conditions and risk factors were five priority areas identified in the Asian and Pacific Islander Task Force Report on the Year 2000 Health Promotion Objectives and Recommendations for California (1992). Clearly, there had previously been no systematic collection of **information** about programs targeted to these needs, and the BAP funded project would produce a new body of knowledge.

B. *Role of Minority Groups*

The Asian & Pacific Islander American Health Forum (hereafter referred to as the Health Forum) and community leaders on the Advisory Committee provided the perspective of the target populations. The community representatives helped ensure a culturally sensitive survey questionnaire as well as identify organizations and agencies serving Southeast Asians. The Advisory Committee community representatives came from Asian Health Services (Oakland),

¹ The Combined Health Information Database (CHIC) is a federally produced computerized bibliographic database of health information and health education/health promotion resources produced by CDC, NIH, HRSA, and the Veterans Administration.

Sacramento Lao Family Community, Southeast Asian Health Project (Long Beach) and Vietnamese *Community* Health Promotion Project (Suc Khoe La Vang! University of California, San Francisco).

State representatives also served on the Advisory Committee. They came from the Office of Multicultural Health, Refugee Health Program, Center for Health Statistics, and pertinent chronic disease programs (risk reduction, diabetes, tobacco, and breast and cervical cancer control). The Advisory Committee provided an opportunity for state staff to work together across programmatic lines.

The Health Forum played a key role in carrying out survey and research activities with OMH and Advisory Committee oversight and guidance. The Health Forum acted as the fiscal agent during the BAP project because it was able to accept and make the ASTHO funds available more quickly than the state bureaucracy. The Health Forum was also able to supply staff in a timely manner for a project that was originally intended to span only three months. This arrangement is documented in contract agreements with ASTHO.

C. *Project Implementation*

Development of the database required devising a data collection strategy, designing an information collection form, choosing software, and deciding on a format for a final product. The Advisory Group guided OMH and the Health Forum in these endeavors. Building the infrastructure for the database system required significantly more time than anticipated both because of technical programming demands and because of the amount of time needed to reach agreement on content and design of the data collection form.

OMH and the Health Forum made a conscious decision to divide the work effort by individually contacting and providing liaison to their own constituencies. The Advisory Committee thought this approach would enhance the level of responsiveness to requests for program information. The Health Department made requests for information to state government and local health departments while the Health Forum targeted individuals and groups on its own mailing list and contacts identified through other pan-Asian groups.

Given the short three-month time frame, the initial plan was to collect program descriptions for projects addressing five chronic diseases and specifically targeted to two groups--Laotian and Vietnamese. It became apparent many programs served a broader Southeast Asian community and a broader net could be cast to collect pertinent information for all Southeast Asian groups at one time. Thus, the data collection form asks about target populations served, giving 18 Asian/Pacific Islander ethnic group choices, and asks the availability of written and oral language translation capability for six Asian languages. Eighteen specific program topics, rather than five chronic disease programs, are possible choices. The ethnic identifiers match census groupings.

The product developed from the database is the Southeast Asian Health Information and Resource Directory of Chronic Diseases. Program descriptions follow the format of the data collection form and include name, contact, address, phone, program areas and activities, Asian and Pacific Islander group served, language capabilities, settings, target population, goals and objectives, funding, and available information materials. The directory index sorts programs by ethnic group (Cambodian, Chinese-Vietnamese, Hmong, Laotian, Mien and Vietnamese) and by chronic disease and associated risk factors (cancer, cardiovascular diseases, diabetes, exercise/fitness, hypertension/stroke, nutrition, and smoking and tobacco).

The initial plan was to develop a computerized database and from that produce a directory available on CD-ROMs as well as in print. Questions were raised by staff and the Advisory Committee about community based organizations' ability to retrieve the collected program data either from CD-ROM devices or through on-line connections to the computerized database. Instead, a hard copy looseleaf directory was published describing each of the programs. Even at the state level, lack of hardware capacity and programming expertise led to retyping the entire program description database to produce the directory, rather than being able to download a file for production.

Since the intention of the project was to develop a database that was compatible with the CDC Combined Health Information Database (CHID), staff chose the same software used by CDC, **ProCite**, for easier export and import into the CHID. This bibliographic retrieval software has proven challenging because it is not user friendly for entry but has greater sorting and indexing capabilities. CDC has provided extensive technical assistance to make fuller use of the **ProCite** system. The learning curve on data entry and retrieval processes contributed to the 7 month delay in production of the program directory. Staff turnover also contributes to the need for constant training.

Over 350 copies of the original survey instrument were distributed, but the final directory listed only 69 programs. Many organizations did not have pertinent programs, and some entries were not codeable. Most responses came from areas with higher known concentrations of the target populations; the actual level of nonresponse due to lack of programs, as opposed to lack of responsiveness, is not documented. Follow-up efforts were made, particularly to the Health Forum contacts, in an attempt to increase response rates but these follow-ups met with limited success.

D. Funding

Staff indicated that in-kind staff time from OMH as well as the extra effort required by Health Forum staff far exceeded the \$20,000 BAP grant. Staff costs were and have continued to be the biggest expense as liaison work and data entry are labor intensive. Printing costs for the directory of programs were also substantial.

E. *Staffing*

The original BAP request included .6 FTE Research Assistant and 1 .0 FTE Graduate Intern positions both for Health Forum staff, however, this does not fully embrace all of the staffing requirements either of the Health Forum or OMH. There is no specific documentation of staffing provided by OMH under BAP although it is estimated that at least 1 FTE of OMH staff was dedicated to the project. These staffing figures also do not reflect the considerable administrative time requirement for the Director of the Health Forum for liaison among partner groups, advisory committees, reporting and oversight. Start-up efforts, either for the BAP grant or for the current network enhancements, require substantially more intensive time commitments by both Health Forum and OMH staff than maintenance of effort will.

F. *Technical Assistance*

The BAP funded project required technical assistance in two major areas--training in software for database development and identification of and liaison with Asian and Pacific Islander groups. CDC provided continuous support in the use of **ProCite** software; these efforts overlapped with the BAP funded grant and were instrumental in structuring the database and publication of the directory. The Asian & Pacific Islander American Health Forum contributed its specific knowledge of the target communities and lists of constituents involved in health programming for Asian and Pacific Islanders. The Health Forum also ran the day-to-day operations of surveying and compiling data.

G. *Documenting Success*

The BAP funded project set three short-term goals for itself:

- develop an operational database with information related to at least two Southeast Asian groups;
- apply for funds for an expanded database;
- distribute the directory.

Each of these tangible goals was met and exceeded although it took longer than the three months originally envisioned.

Database development proved somewhat overly ambitious to be accomplished in the initially funded project period of July to September 1993. The Office of Multicultural Health (OMH), California Department of Health Services was not officially established until August of 1993 although staff worked on the BAP project prior to its establishment. The product of the BAP project, Southeast Asian Health Information and Resource Directory of Chronic Diseases, was not published until May 1994, considerably after the official BAP project period was over and after the CDC award for development of a Health Information Network in October 1993.

The Office of Multicultural Health's first major task was the development of the database and publication of the directory. This activity coupled with OMH work on managed care gave OMH high visibility within state government. A month after publication of the directory, OMH was elevated to the Office of Director, California Department of Health Services.

Only anecdotal information suggests that the directory itself was a valuable product. There was no formal tracking of requests for information or referrals to health programs serving Asian American communities. Staff indicated that from time to time people indicate that they still refer to the directory. Suggested measures of utility, made by OMH and Health Forum staff include tracking the number of requests and searches, the nature of requests, and the number of referrals made.

Staff indicated that the greatest legacy of the BAP project was not the directory produced but the infrastructure for the current expansion (data collection forms, mailing lists, database software and relationships). The BAP project was the prototype for other collaborative effort between OMH and community based organizations. The relationships have led to increased communication between state government and each of the target groups as well as building new relationships among the separate ethnic partners. This has been a springboard to work together on issues of common concern like the implementation of Medicaid managed care.

H. *Continuation of Effort*

The development and expansion of a multicultural health information network continues to be a primary focus of the Office of Multicultural Health. Three of the five elements of its 1996 mission statement specifically apply:

- create and strengthen information networks between DHS programs and ethnic/racial communities;
- build capacity through training, technical assistance and strategic planning; and
- support the development and dissemination of information, strategies and resources contributing to the improved health status of California's diverse communities.

Dissemination of Directory Information

The primary audience for the directory produced under the BAP grant were state and local health departments and other organizations who answered the survey questionnaire. Approximately, 500 copies of the directory were printed and distributed. Little marketing of the directory was done to make its existence known beyond this limited audience. This circumscribed distribution was due to limitations in budget and staffing as well as concern that the delay in publication had made some of the material dated. Staff still deemed that the directory had merit

despite the delay, and did mention its existence and the ongoing Multicultural Health Information Network in newsletters and at conferences.

Staff believe that one of the downsides of a published directory, as opposed to on-line data, is that by the time it gets published much of the information is already out of date. Programs listed in the directory disappear as funding sources dry up. But value remains in the identified agency's commitment to serve different cultural groups; even if a specific chronic disease prevention program does not persist, the organization is still likely to be serving the target group and can be a valuable contact for those seeking information on program development or health education materials.

CDC reviewed the elements in the database and entered selected chronic disease programs into the Combined Health Information Database. This information system has a user fee although CDC indicated that the information is not copyrighted and the federal OMH Resource Center would be free to put the information collected into its database.

Neither OMH or the Health Forum serves as a centralized repository of health education materials listed in the directory. They see their real function as that of a facilitator of contacts between people rather than being a repository themselves. Some survey respondents did send in their health education documents, but they were not systematically evaluated. Staff determined that it was beyond their personal capability to read and assess documents in the multiple languages, and there were insufficient funds to have focus groups or expert panels to do this.

At the time of the BAP project, the staff and Advisory Committee believed that community based organizations did not have the capability to access CD-ROMs or to go on-line with a modem. A needs assessment of hardware and software capability is underway. This effort is intended to identify the type of information and health education materials users want, what channels they currently use to gather this information, and what type of computer hardware and software is available. The results of this needs assessment will inform the dissemination strategy for the Multicultural Health Information Network. Preliminary indications are that 50% of the agencies are familiar with CD-ROMs and modems.

2. Database Expansion

The BAP initiated effort continued beyond the term of the BAP grant, both to finish the project started with BAP funding and to expand the project into the Multicultural Health Information Network. The basic infrastructure (database elements, survey forms, software) built under the BAP project supports all of the expansion efforts. OMH and the Health Forum have continued their collaborative relationship and expanded their vision of the program resource database. They have brought in new partners to broaden the program resource database to include programs serving the needs of multiple constituent groups. These new partners include the California Rural Indian Health Board (CRIHB), California Black Health Network, and Latino Coalition for a Healthy California. A parallel information database listing individual bilingual and

bicultural experts, as opposed to programs, called the Resource Rolodex is also under development. These programs are to reach completion in the summer of 1996.

Then, a marketing consultant will be hired to develop a dissemination strategy for whatever product emerges from the expanded network. One of the new distribution strategies is to place the product in the hands of reference librarians so that a directory is not looked at once and then left to linger on someone's shelf.

The initial BAP funded work set the direction of the expansion now funded by CDC and the state preventive health services block grant. OMH staff agreed that BAP funding was instrumental in helping OMH gain additional funding. OMH applied for CDC funding around the same time as the BAP funds, but since the BAP funds became available so quickly OMH was able to initiate building the infrastructure for future system enhancements.

OMH maintains the subcontracting relationship with the Health Forum that was initially spelled out in an agreement under the BAP grant. The Health Forum has expertise not only in its knowledge of Asian and Pacific Islander groups but also in the skills required for database entry and maintenance. Under the current arrangement, the Health Forum provides training and technical assistance to build capacity among the new multicultural partners' staffs.

As under the BAP project, direct federal grant funds do not cover the full costs of ongoing data collection and enlargement of the database. CDC funds have totaled \$90,000 over three years; with 1996 being the last of the three years. Currently, the OMH receives approximately \$400,000 over two years from the Preventive Services block grant to fund its activities with the California Multicultural Health Information Network being a major focus of the office. For the period of the current fiscal year, \$252,000 was directed toward expansion of the network. The Health Forum retains \$117,000 to provide assistance to the new partners as well as expand the Asian and Pacific Islander component. Each of the three new partner groups receives \$45,000.

Each of the new ethnic/racial groups, as well as the Health Forum, have updated the original survey questionnaire and adapted it to their groups' needs. The questionnaires each seek information in the same categories of reproductive health, risk factors, diseases/conditions, violence prevention, and substance abuse. One example of differences between group questionnaires is that under the category of diseases/conditions the Native American questionnaire asks about fetal alcohol syndrome and the Black Health Network form asks about sickle cell disease.

Each of the partners have performance standards written into the subcontracts specifying the number of new program and personnel entries they must provide for the database from their individual constituencies. If met, the size of the database should be substantially increased. The Health Forum has to achieve a minimum of 200 program descriptions and 150 individual experts. CRIHB has to provide 50 program entries; the Latino Coalition and Black Health Network must each provide 100 program entries.

HEALTH ACCESS BY LANGUAGE ADVOCACY (HABLA)

Colorado Department of Health Migrant Health Program (Delta)

The team of Cheryl Ulmer and Suzi Rodriguez visited the Migrant Health Program in Delta, Colorado and interviewed the former Project Coordinator for HABLA, three HABLA trainees and staff of the migrant health office. Subsequently, a telephone interview was held with the Director of the Migrant Health Program in Denver.

Key points that emerged from the site review include:

- The project developed a curriculum for basic medical terminology in Spanish and English, and basic interpreting skills.
- The goal was to train people who would be highly employable so that the HABLA program would have lasting value; the training gave the candidates credibility with employers, allowing them to attain better paying jobs than they held previously (e.g., moved from working in fruit packing shed to being bilingual receptionist in health clinic).
- Some of the HABLA trained interpreters found employment in provider offices, increasing bilingual capacity within the local rural health care system.
- Working partnerships in this project involved public health, employment services, an educational institution, private medical providers, and the migrant health program.
- Community planning for and implementation of the HABLA program helped to influence the shift of most of the translation burden from the Migrant Health Program to community providers.
- Having on-site interpreters in primary care settings, usually performing another function such as a receptionist, was more cost effective than paying intermittent interpreters; for example, there was no longer a need to pay for transportation and office waiting time for the interpreter.
- Steps were taken to institutionalize the HABLA program, but although it is listed in the Delta Vocational Technical School catalog, there has not been sufficient demand. Similarly, there was limited response to offers of training others throughout Colorado in the HABLA approach.

- The program was not able to train interpreters for the Cora and Huichol Indian migrants because the project could **find** no candidate who had sufficient English or Spanish to keep up with **the** pace of the course.
- Training in cultural competency reached 80 health service providers, although no physicians, in Phase I.
- In Phase II, a core of 17 instructors across the state of Colorado received “train the trainer” instruction in cultural competency to bring an infusion of expertise into rural parts of the states.

A. *Project Background*

The Health Access by Language Advocacy (HABLA) initiative proposed to train interpreters to assist monolingual, Spanish speakers when they seek medical care and to improve **the** cultural competency of providers who work with these clients. The Migrant Health Program wanted to develop this capacity within the community, but had not been able to locate a curriculum that addressed this need. The Phase I BAP grant supported development of a curriculum, its use in training interpreters, and sponsorship of cultural competency training for providers and others. The second phase of BAP funding supported an additional medical interpretation course and “train the trainer” sessions for replication of cultural competency training. The emphasis of the HABLA project was on capacity building within the permanent community of primary care health service providers and reducing the costs of interpretation services to the Migrant Health Program.

The Migrant Health Program (**MHP**) in Delta, Colorado tries to make existing community resources accessible and acceptable to migrant and seasonal farmworkers, as opposed to creating a separate system of care for them. At the time of the BAP grant, most health services were available through voucher or contract arrangements with community providers who did not have bilingual, bicultural staff. A survey of community physicians found that they depended on the MHP or migrant family members for interpretation rather than employing bilingual staff. The monolingual population of the area had increasingly put demand on the Delta Migrant Health Program office to provide interpretation services whenever their clients accessed health care services in the community. The MHP office in Delta coordinated 2,063 hours of translation for health-related services in 1992; **this** was considered a fraction of **the** need, but still a costly burden for **the** office.

It is useful to understand how health services are delivered to clients of the Migrant Health Program (**MHP**). MHP staff primarily act as case managers for migrant program clients. MHP staff screen clients for eligibility and provide a baseline health risk assessment as well as extensive health education activities. Direct health services are minimal (e.g., blood pressure screening, teaching how to do breast exams). In the summer, additional medical services teams come into the community to work directly in the migrant camps. But MHP relied on the Delta County

Health Department, the Montrose County Nursing Service and Delta Family Physicians as year round direct health service providers for perinatal and primary care services; none of the organizations had bilingual staff.

Since the Immigration Reform and Control Act of 1986, many of the 6,000 to 9,000 migrant and seasonal farmworkers in Delta and Montrose County service area have settled out of the migrant stream. As the workers settled out of the migrant stream, many brought their families, resulting in increased demand particularly for perinatal and pediatric services. The proposal states that the number of migrant perinatal clients increased by 508% from 1988 to 1992. The actual number of perinatal clients increased to around 40 in 1993. As a marker of health care needs, the proposal notes the poor prognosis for many babies born to migrant mothers (statewide data):

- Congenital anomalies - 11.1% of newborns (1991)
- Teen pregnancies - 26% (1990); 20% (1991)
- Toxemia - 6.7% of deliveries (1991)
- Low birthweight - 13.3 % of newborns (1991)

Although the proposal emphasizes services to perinatal clients, the resulting project focused on primary care services in general, not perinatal services. Perinatal statistics are often used to reflect health status in the migrant community because the outcome can be more easily documented in a mobile population.

The following excerpt from the proposal exemplifies the philosophy of the project organizers:

CMHP (Colorado Migrant Health Program) is aware that, in providing . . . assistance with translation, transportation, and the like that there is considerable risk of promoting **dependency** within the community and target population upon outside resources, as opposed to promoting increased **responsibility, commitment, and empowerment** of both communities and clients.

The HABLA medical interpreter training program was seen as a new approach to building capacity, eventually transferring the financial burden to the community provider and to the client. It was hoped that providers would recognize **the** benefits of hiring bilingual staff trained in medical terminology.

B. *Role of Minority Organizations*

A Local Advisory Committee, composed of providers of services but not members of the migrant community itself, was established to address local implementation issues. It was composed of representatives from the Delta Migrant Health Program, the County Health Department, Rocky Mountain SER (Service, Employment and Rehabilitation), West Central BOCES, and Delta Family Physicians. A State Advisory Committee addressed "big picture" issues such as replicability and critical review of implementation. A local bilingual person was hired to develop the curriculum. The Migrant Health Program served as a proxy for the target community. The local Advisory Committee thought that clients should be willing to pay part of the cost of translation services. While the MHP held occasional focus groups on issues of health in which the farmworkers had expressed a need for better communication with providers, the Local Advisory Committee did not ask migrants about some critical implementation issues such as their willingness to pay for interpretation services.

C. *Project Implementation*

The Colorado project spanned two phases with activities overlapping the phases. In Phase I, the HABLA curriculum was developed, one medical interpreter training session and cultural competency workshop for health care providers was held. In Phase II, an additional medical interpreter training session was held as was a 'train the trainer' workshop in cultural competency.

1. Interpreter Training Project

A total of 18 interpreters were trained in the HABLA program. The HABLA curriculum stressed medical terminology and a professional interpretation style that allowed face-to-face contact between client and provider. The former is apparent in the published syllabus, "BASIC INTERPRETING SYLLABUS Medical Terminology." The latter cannot be gleaned from the published guide, but is an important construct in how the course was organized and taught. The skills for this apparently came from the University of Arizona video, "How to Use Interpreter Services," which the trainer and trainees deemed an essential part of the course. HABLA staff were very comfortable with the curriculum they used and felt it accomplished the task they set out to perform, but the richness of the course is not apparent from the syllabus alone.

The course was a combination of 27 hours of classroom work and four hours of supervised interpretation services during actual provider/client encounters. The curriculum employs a variety of techniques including: (1) learning Spanish and English vocabulary of anatomy, body functions, dental terms, and simple signs and symptoms; (2) memorization exercises; (3) role playing as providers, patients, and interpreter; and (4) videotaping interpretation skills of students. The same pre and post tests measure student progress in learning the course content.

The medical terminology in the curriculum was derived from a variety of sources, but students were asked to purchase a Spanish-English/English-Spanish Medical Dictionary as a

standard reference. The written curriculum was merely a jumping off place. The teacher encouraged students to offer different ways that things are said by their families and friends so that they could share differences in dialects. Most of these dialect differences would not be documented in a dictionary and are not documented in the course syllabus, but are an essential part of learning to interpret for the community of migrants who come from different areas of Mexico. Trainees were advised to keep their own written glossary of terms in addition to the formal syllabus. Trainees indicated that confidentiality of the patient/provider/interpreter relationship was stressed in the course. Confidentiality rates only two sentences in the syllabus.

Content on how to interpret came from the University of Arizona video rather than the syllabus. The video shows vignettes of how and how not to interpret for the Spanish-speaking patient. Some of the major points made in the video are:

- The interpreter should stand behind the physician or the patient so that the physician and the client maintain eye contact.
- Interpretation should be as close to what the patient and physician actually say, keeping paraphrasing to a minimum.
- The provider is responsible for explaining medications and treatments and should not delegate that to the interpreter.

The approach to translation taught was word for word translation of patient and provider spoken words, in a consecutive but not simultaneous United Nations style. But in practice it is recognized that a translator may have to go beyond the spoken words to reassure the patient and provide some additional explanation of procedures. For example, a woman may never have had a pelvic exam, and the interpreter may have to reassure the client that this is a normal procedure.

To give additional validity to the employability of those completing the course, the HABLA course was developed in affiliation with the **Delta/Montrose** Vocational Technical Training Center. This affiliation offered some benefits but also had drawbacks. On the plus side, the course had instant credibility because of its affiliation with an educational institution; the institution could award certificates of Achievement and two credit hours. The school offered a classroom setting with access to human anatomy models from its nursing program. The Nursing Program Coordinator at the school was instrumental in outlining the type of activities that were appropriate for an accredited course and in helping find materials.

On the other hand, placement at the school made it necessary to charge tuition; they sought to keep tuition under \$100 to make tuition bearable for the target population of trainees. The number of class hours were limited to 27 which would translate into a tuition of \$95. This limitation in hours translated into a limited scope in curriculum. In the end, tuition should not have been a determinant because most students received partial or full reimbursement either from HABLA, Rocky Mountain SER or their employers. The advertisement for the courses published

the tuition and may have deterred some qualified applicants from applying for the training. The vocational school is on a major highway, but is not served by public transportation. Students received some reimbursement for attendance which helped defray transportation and child care costs.

The course was offered twice, once in each Phase, but the timing differed among courses. In the first course, the class met twice a week for three hours at a time over 4 1/2 weeks; the second time, the class met three times a week, finishing in three weeks. The timing of the first course appeared preferable to trainers and trainees to allow more time to review class materials and learn vocabulary.

All candidates were screened in person or by phone before they were accepted into the class; it appeared that candidates were screened for success. From the beginning, the Local Advisory Committee stressed that they wanted to train people who would be highly employable so that the HABLA program would have lasting value. They wanted to find trainees who were bilingual and already had experience interpreting. They did not want to give community providers the opportunity to continue to use the excuse that they "didn't hire anyone because there was no one qualified."

All candidates had at least finished high school; the project coordinator indicated that the candidates needed to be intelligent, but did not indicate how this was assessed. While cultural awareness was less of an emphasis in the course, the screening process sought to determine if the candidates were aware and sensitive to the migrant culture. Written and spoken language ability was critical; two candidates were accepted into the course knowing that they did not have the requisite Spanish ability and would only receive certificates of attendance rather than of achievement as an interpreter.

Maturity was cited as an important characteristic for an interpreter because of the sensitive and sometimes awkward nature of the medical visit; maturity is not solely determined by age. It was also a characteristic that staff was not able to evaluate in advance, but became more apparent in class and during internships. For example, not all of the women trainees were comfortable translating for male clients.

The three trainees interviewed during our site visit had previous experience translating for family and friends, and one translated for the court system. The HABLA project had three enticements: receiving certification as an interpreter, possibility of getting dollars to cover tuition, and payment for interpreting hours. The three trainees interviewed indicated that the possibility of getting paid for something they already did and enjoyed doing was attractive. Two of the three women we interviewed were bilingual, but characterized themselves as Anglos who developed cultural knowledge through marriage/relationships with settled out migrants.

The Program set a goal of training at least one Cora Indian in medical interpreting. While the program was able to recruit one Cora man in Phase I, he did not complete the **HABLA**

training because neither his English nor his Spanish were fluent enough to keep up with the pace of the class. Project organizers were not able to recruit a Cora for Phase II. Similarly, the project was not able to recruit any Huichol Indian interpreters.

A supervised 4-hour interpretation internship helping in a provider-client encounter was required at the completion of the class. The logistics of this were difficult to arrange because as each class finished, everyone wanted to do their internship immediately, but there was only the one classroom trainer who was qualified for supervision. The times when clients needed interpretation services were not always predictable, further making scheduling difficult.

The internships in various providers' offices gave physicians an opportunity to view a professional interpreting style, that maintains eye-to-eye contact between the provider and patient dyad. Physicians also needed to learn that interpreters are not nurses and not to expect them to give medication instructions on their own, but only to interpret the directions of the physicians. The internships also provided an opportunity to convey techniques to providers on how to validate, not assume, communication was effective, particularly when addressing a client with low literacy skills.

The medical interpreter training enhanced the job prospects of trainees in a couple of ways. The trainees had certification in an academic area; this provided them with something to put on a resume. Their demonstrated skill in the classroom and in providers' offices allowed observation by people who could provide an informal job referral network; whenever the trainer or project coordinator heard of an appropriate opening, they called trainees and recommended them for the job.

In Phase II, the Colorado Migrant Health Program contracted with the Southeast Colorado Area Health Education Center for a workshop in La Junta to train instructors in the HABLA curriculum and approach. Despite initial enthusiasm from prospective trainees, only two individuals signed up for the workshop, and it was cancelled.

2. Interpretation/Translation Services

In Phase II, the Migrant Health Program Office organized a Referral Network for interpreters. Trainees interviewed liked the interpretation assignments they received, but they had concerns about liability for transporting clients, not receiving any reimbursement for mileage, personal safety and cultural issues (i.e., females transporting male patients). They were less concerned about the hourly rate of \$5 to \$6 per hour than the part time and irregular nature of the work. Those we interviewed opted for a more dependable work schedule in a health provider's office, whether it was full or part time. As discussed below, demand for the referral services also leveled off.

3. Cultural Competency Training

Arranging the training program for providers on cultural competency proved much more difficult than the medical interpreter training. The project tried to get CME credit for the course, but the local hospital chief of staff felt the course did not have sufficient merit to achieve CME status. Phase I Cultural Competency training was offered in a one day workshop for health workers in Delta, cosponsored by the Colorado Migrant Health Program, Denver-based LARASA, and the Western Colorado Area Health Education Center. COSSMHO's *Proyecto Informar* training curriculum provided the basis for the sessions, but was reduced from 2.5 days to one. No physicians signed up for the class although staff working in their offices came, including three mid-level providers. Eighty people in all attended the training. The session, presented by one person, was provocative, creating an awareness of difficult issues. It appears that the presenter may have focused on the discriminatory barriers facing the migrant population and not on issues specifically related to health which some of the attendees were looking for.

In Phase II, a 2 day cultural competency workshop provided training to 17 trainers from rural areas throughout the state. Materials used included COSSMHO's manual "Delivering Preventive Health Care to Hispanics," COSSMHO's Trainer Manual for *Proyecto Informar*, and a video "Racial and Cultural Bias in Medicine" from the Committee on Minority Health Affairs (American Academy of Family Physicians), and local demographic data comparing Hispanics with other groups. A variety of faculty provided presentations, from organizations such as LARASA (Denver) and the Clinical Director of Plan de Salud del Valle. This training session was followed within a month by a follow-up session. In the interim, all were expected to do turn-around training in their localities. Four of the 17 were able to present a cultural competency workshop in their local areas; in retrospect, staff believed they should have had a longer interval to allow trainees more time to organize workshops. We interviewed a representative of the Delta Migrant Health Program who attended the training; she continues to make frequent presentations on cultural competency, up and down the western slope of the Colorado Rockies.

D. Funding

In Phase I, most of the BAP funds went to project staff (\$8,957), tuition grants for trainees (\$1000); travel (\$2000); and cultural competence training for providers (\$1800). Rocky Mountain SER provided another \$2,840 to support trainees, and the MHP and Delta County School System provided some in-kind support for copying materials, phone, space, and clerical support.

In Phase II, \$8,872 was requested to (1) train another class of interpreters and replicate the interpreter training program through a "train the trainers" approach; (2) \$10,340 for developing a health educator/interpreter and comparing this person's effectiveness with use of an interpreter; and (3) \$9,480 for a "train the trainer" approach to providing cultural competency information to providers. Many of the activities of Phase II did not take place, there was little response for the replication of the interpretation program, and the health educator position was not filled. The Migrant Health Program believed these funds were reprogrammed to support the

cultural competency training. Since the grants were on a cost basis, the funds may have been returned.

E. *Staffing*

The Medical Interpreter Training spanned Phase I and II. For Phase I (February-June 1993) and Phase II (July-September 1993), staff consisted of a full time Project Coordinator and Interpreter Trainer. The Director of the Colorado Migrant Health Program donated 80 hours for oversight; he was responsible for hiring the local Project Coordinator, a dentist who had recently returned to the **community** after retiring from the Air Force. The Project Coordinator had extensive experience in the military in developing and implementing training programs, but his knowledge of Spanish and of the current community was limited.

The Interpreter Trainer was selected from among 30 applicants across the state who responded to recruitment efforts. Advertisements were placed in Spanish and English language newspapers and radio. The person selected was bilingual, local to the community, and an LPN; further, she had experience interpreting. Since funds were limited, the use of someone local to the community was considered more cost effective and more convenient for developing working relationships.

F. *Technical Assistance*

The Migrant Health Program office in Denver and the Area Health Education Center provided ideas for resource materials, including the videos used, and people to assist in the training activities. The COSSMHO curriculum was adopted for use in both phase I and II for cultural competency training of providers and trainers. The **Delta/Montrose** Vocational Technical Training Center Nursing Director give advice on how to structure the interpretation course to meet certification requirements and also provided access to medical illustrations, books and anatomical models. The syllabus developer was able to attend a training course for interpreters in Denver given by the Asian Pacific Center.

G. *Documenting Success*

The HABLA project set numerous objectives: development of medical interpretation curriculum; conducting two medical interpretation training sessions; employment of trainees; and training trainers in medical interpretation and cultural competency. The Colorado Migrant Health Program found that the HABLA interpreter training curriculum was more rigorous than any training CMHP had previously conducted. The curriculum was developed in conjunction with the **Delta/Montrose** Vocational Technical Training Center which planned to continue to offer the course. In Phase I, seven of 8 candidates finished the course; the Cora Indian did not have the language skills to follow the course requirements. In Phase II, the objective was to train at least 6 more interpreters; 11 interpreters were trained.

Successful placement of trained interpreters was the overarching criteria by which the HABLA program set itself out to be judged. The Local Advisory Committee sought to have HABLA recruit and train individuals who could be employed when an opening developed in a doctor's office, health department or other agency. In Phase I, the objective was to develop bilingual capacity in at least two agencies, programs or health provider offices, and have at least one interpreter hired. Four of the 7 HABLA Phase I trained interpreters were hired and bilingual capacity was established in the Olathe Medical Clinic (Montrose), Montrose County Nursing Service, and Delta Memorial Hospital. For example, the one placed in Delta County Memorial Hospital was a nurse's aide; HABLA was cited as critical to her selection over others since translation for Spanish speaking clients would be part of her duties. The hospital had tended to use cleaning staff to provide interpretation services even though they have no medical knowledge or interpreter training. At the initiation of the HABLA project, even the County Health Department did not have bilingual staff, but subsequently hired one of the Phase II HABLA trainees after the Delta County Commissioners approved funding for a part-time interpreter. At least 4 of the trainees were still employed in some capacity in the health care system in 1996; some of the other trainees have moved, and others have used the knowledge of interpretation in other settings such as business and human service/education programs such as Head Start.

Some physician groups in Delta had not yet seen any economic advantage in having bilingual staff to attract additional monolingual clients nor were they concerned about civil rights or medical liability issues with the client population. While businesses in town saw the migrant population as a source of revenue, health providers typically viewed serving migrants as an economic loss. Given this environment, the HABLA program had some disappointments. The project was not successful in convincing the only OB practice in town, who delivers all migrant babies, to hire one of the interpreters even though a representative of the group sat on the Local Advisory Committee. This group continues to depend on migrant Health Program Staff, particularly in its OB clinic, and one staff bilingual medical records assistant available only during morning hours. This family practice group before 1995 had the MHP primary care contract, but the MHP no longer contracts with them for anything except OB.

Resistance to the HABLA program efforts to recruit providers for cultural competency training may also have had something to do with local competition for primary care clients. An application for a HRSA/Community Health Center grant was a collaborative effort of a number of human service providers in the Delta/Montrose area. The application was successful. The two new clinics in Delta (Tres Rios) and Montrose (Olathe Clinic) now employ HABLA trainees, and view having bilingual, bicultural staff as an essential part of their mission. The project coordinator for the HABLA program has been president of the board overseeing both of these clinics. They were under development at the same time that the HABLA program was trying to recruit providers for cultural competency training.

The goal of training at least 15 health care providers in cultural competency during Phase I was met by the one-day *Proyecto Informar* training session which reached 80 persons working in health-related areas. Due to compression of the training into a one-day session, the organizers

decided not to spend time on pre and post testing of knowledge; anecdotal feedback on the sessions indicated that the sessions were provocative. The Phase II "train the trainers" workshop in cultural competency was considered "a significant infusion of expertise into rural parts of the state where Hispanic advocates have previously not had the tools to educate others regarding cultural issues;" 17 instructors were trained. The train the trainer session for medical interpretation was not carried out; only two signed up for the workshops, but no efforts were made to recruit participants more actively.

Although the project had set the ambitious goal of measuring the impact of interpreter presence on client adherence to health care regimens, this objective was not able to be addressed. Specifically, the objective had been to document that appointment failure rates had decreased by at least 20 % in at least three provider offices. The short time frame of the project and the intensity of effort required made accomplishment of this task unrealistic, although staff did feel that client adherence should be enhanced by the presence of bilingual staff.

Initially, the proposal was to develop interpreter/health advocates, not just interpreters, but that did not prove feasible in either Phase I or Phase II. It became apparent to the Project Coordinator and Local Advisory Committee that to be a Health Advocate, a trainee would need additional course work in health care. The preferred avenue would be to take LPNs or Medical Assistants and help them gain interpretation skills. But the salary that the MHP was able to offer on-call interpreters after completion of the training program, was limited to \$5/hour and no coverage of mileage. It was estimated that a bilingual health advocate with interpreter training should command \$10-15 per hour.

H. Continuation of Effort

The Local Advisory Group first grappled with how to conduct interpreter training in a way that would result in lasting improvement in capacity rather than fostering dependence on outside funding. Their strategy was to develop a training program in conjunction with the local educational institution. The Delta/Montrose Vocational Technical Training Center continued to offer the interpreter train course in its catalogue, but did not attract enough students to hold the class again. Although some of the trainees came to the HABLA program through seeing the ads for the course in the newspaper or hearing them on radio, the HABLA trainer also did active recruitment, asking people in the community who might be good candidates for the training. This proactive approach and the availability of tuition assistance may have contributed to successful recruitment during the BAP grant period.

For a short time, the Migrant Health Program maintained a very active interpreter referral service using the HABLA trained interpreters until demand for these services dropped for a variety of reasons. First, some of the interpreter trainees found jobs within the local primary care health care system, thus bilingual assistance was built into system infrastructure. There was less need for interpretation in perinatal services as the number of pregnancies per year dropped from 40 to 20; this decrease in births was attributed by staff to the success of the MHP family planning

education programs. The community also gained additional primary care providers with bilingual capability (e.g., Tres Rios Community Health Center). The MHP continues to provide interpretation, but only an average of one hour per week so they rarely need to call on their interpreter pool, except for instance when a client needs specialty care in Grand Junction, an hour long drive. It is also possible that the requirement that clients pay half of the interpreter fee may have deterred continued use.

The availability of the HABLA curriculum was broadcast in the “Migrant Health Newslines” published by the National Migrant Resource Program. It is not known how many copies might have been requested or disseminated. The intent of the Colorado Migrant Health Program was to make the medical interpretation syllabus available to anyone who could use it, but controversy over who owned the rights to **the** materials caused a rift between the Project Director and the HABLA Trainer. The Trainer wanted personally to copyright the syllabus she developed, but the position of Colorado MHP was free dissemination” Guidelines of who owns the copyright is one area that would benefit from additional clarification at the outset of a project. The syllabus developer and primary trainer was unwilling to meet with us despite repeated inquiries, apparently because of remaining hard feelings toward the project.

HISPANIC IMMUNIZATION INITIATIVE (HII)

City of Waterbury (Connecticut), Department of Public Health

The team of Cheryl Uhner and Suzi Rodriguez visited the City of Waterbury Department of Public Health on May 13, 1996 and met with the Immunization Coordinator and Immunization Outreach Worker. A subsequent interview was held with the former Research and Development Coordinator of the Hispanic Coalition of Greater Waterbury.

Key points that emerged from the site review include:

- The Hispanic Immunization Initiative brought bilingual and bicultural staff into the Health Department; it demonstrated to the Health Department that it could accomplish its mission better by understanding the culture and language of the people it serves.
- The initiative produced tangible products, a calendar and posters, that addressed the very specific immunization needs of the Hispanic community.
- The Health Department was willing to give significant control of the project to members of the targeted community; the opinions expressed by the focus groups are clearly reflected in the products produced by the Hispanic Immunization Initiative.
- The process of developing the materials was as important as the material end product since it promoted a positive, trusting relationship between the Health Department and the Hispanic community that had not existed before.
- It gave the Health Department experience in how to engage the community in the design and evaluation of programs through the use of focus groups and satisfaction surveys.
- Linking the calendar with ongoing Immunization Outreach under the Immunization Action Plan is a plus as it links an initial one-to-one health education contact about immunization with the ongoing reminders in the pages of the calendar.
- The calendar continues to be published yearly under CDC immunization funds, but still prominently features HRSA as a funding source.

A. *Project Background*

The Hispanic Immunization Initiative focused on developing culturally and linguistically appropriate childhood immunization materials for the Hispanic community of Waterbury. Childhood immunization levels were far below desired levels, and the growth in the Hispanic community made it necessary to develop materials targeted to this group.

A retrospective study of 269 Waterbury children seen consecutively at two city clinics found that 31% were delayed one month or more according to American Academy of Pediatrics guidelines for childhood immunizations. For children, who were regular users of the clinics or the emergency room for primary care, the results were worse; 57% were delayed or **un(der)** immunized. Similarly, state statistics indicated that urban immunization levels stood at 65 % , far below the 90% goal of the National Health Promotion and Disease Prevention Objective for childhood immunization by age 2.

The need for bilingual materials was apparent. Analysis of health and demographic indicators showed:

- Due to recent immigration in the 80s and 90s, 13.4 % of the population is Hispanic. 85 % noted that Spanish is their primary language, and 50% indicated that they do not speak English well;
- Approximately 20% of births in Waterbury were to Hispanic women;
- The Health Department lacked bilingual and bicultural personnel; of the 60 people employed in the public health nursing division, only one person was bilingual;
- Available Spanish language health education materials were not linguistically or culturally sensitive to the target population of Waterbury.

The City of Waterbury was charged to develop an Immunization Action Plan (IAP) in response to the Centers for Disease Control and Prevention and Connecticut State Department of Public Health and Addiction Services initiative to increase immunization levels of children under two years of age. An IAP Coordinator was hired in January 1993 to begin development of the plan that was to have four components: (1) immunization service delivery; (2) information and education services; (3) evaluation and assessment activities; and (4) minimum immunization program goals. The Waterbury AIDS program director knew of the USCLHO funds and recommended that the new Immunization Coordinator apply for them. An application was submitted in mid March 1993; its focus was on developing a health education product about childhood immunization directed toward the Puerto Rican and Dominican communities of Waterbury.

B. *Role of Minority Groups*

In the BAP proposal development stage, the Hispanic Coalition of Greater Waterbury provided input from the target community. This organization came into existence in 1988 to provide a means for advocacy and empowerment in the Hispanic community, particularly for economic development, health (AIDS and mental health), culture, and youth. It is a volunteer driven organization with only part-time staff. In general, the Health Department was not viewed favorably by the Hispanic **community** , but the Health Department AIDS Prevention Program had

built a positive relationship through intensive community outreach. The personal recommendation of the AIDS Program Coordinator was instrumental in Hispanic Coalition willingness to join forces for the Hispanic Immunization Initiative.

Specific guidance was sought throughout project implementation from the target community in two ways, continued alliance with the Hispanic Coalition and use of community focus groups. In the beginning, the Immunization Coordinator was particularly dependent on the efforts of the Hispanic Coalition staff person, because she had limited command of Spanish and was not as knowledgeable of community resources. This initial contact proved beneficial; it developed trust and a common sense of project goals and implementation.

The Hispanic Coalition provided the in-kind services of its Research and Development Coordinator. A letter of agreement formalized his time contribution to a few hours per week. He helped: (1) recruit and interview staff for the immunization initiative, and (2) organize community focus groups by identifying appropriate sites and recruiting diverse representation from the target community.

One of the goals of the BAP initiative was to develop bilingual, bicultural capacity in the Health Department. The BAP grant would allow the Health Department to have a part time Hispanic Health Facilitator (HHF). The person hired for the HHF position was already giving health education lectures in the community on a volunteer basis. She is a pediatrician from the Dominican Republic. The Health Department willingly took a risk on her because, although she spoke almost no English, they found her Dominican heritage, medical background and community knowledge compelling. The Health Department specifically wanted to reach out into the predominantly monolingual Dominican community; they felt that the Puerto Rican community had more bilingual speakers as many had been in the U.S. longer. After BAP funding ceased, the position did not continue. The Dominican born doctor is now, however, employed by the state health department. The Hispanic Coalition representative commented that the BAP project had developed a wonderful resource for the community and state by taking a chance on her when others may have been unwilling.

C. *Project Implementation*

The BAP funded project focused on producing health education materials on immunization for use in the Dominican and Puerto Rican communities. To ensure that the materials were responsive to the **community**, focus groups reviewed existing materials, made suggestions for new materials and reviewed newly drafted materials. The initial plans to develop multiple health education materials were overly ambitious. Originally, a brochure, calendar, posters, and videos were considered, but there was neither time nor money to produce all of these elements. A USCLHO site visit team recommended narrowing the objectives of the project to focus on production of a calendar and posters.

1. Focus Groups

The original networking and development process was very labor intensive, and required flexibility and additional time commitment by both Health Department and Hispanic Coalition staff. Scheduling focus groups at appropriate times became an issue; some focus groups had to be rescheduled for evenings and weekends to ensure better attendance. Five focus groups were held, with a total of 40 attendees. Attendees at each group were a mixed representation of Puerto Ricans and Dominicans, doctors, parents, grandparents, teens, community elders, business owners and church leaders.

Neither the Hispanic Health Facilitator, the Immunization Coordinator, nor the Hispanic Coalition representative had ever directed focus groups, and found after the first group that they needed to change their approach to questioning and to reduce the size of each group. They received advice from their mentor, a New York City health department expert, on use of focus groups.

Under the revised approach, the Hispanic Health Facilitator began focus groups with general open-ended questions about health care access, barriers and health education materials, and then narrowed the groups' discussion to the area of childhood **immunization**. The Health Facilitator solicited the groups' responses to current immunization materials and their recommendations for designing new materials. Previously, materials that the Health Department had purchased were simply Spanish translations of pre-existing English language materials. The focus group participants indicated that they were not in the dialect of the Puerto Rican and Dominican population. The materials were overly complex in their presentation of ideas and in their reading level.

The Health Department learned that its ivory tower perceptions are sometimes wrong, leading to programs that do not fit the community. For example, the Health Department learned that community members did not know that they could receive free vaccinations. They found out that child care and whether patients could be understood were barriers to accessing care. They also learned that a positive upbeat approach in the materials would be more user friendly. The collaboration with the community produced a program that the Health Department feels works.

The three posters and calendar produced for the BAP initiative clearly show the input of the focus groups. The consensus of the focus groups was that newly developed materials should reflect bright colorful images, children of the **community**, island colors, and immunizations messages that would be positive, upbeat and easy to understand. A mock-up of the calendar was done in black and white, and this was presented to a focus group, comprised of all the individuals from earlier groups, for final comment.

Refreshments were served, and attendees each received a T-shirt with an immunization message, and eventually the calendar when it was produced. The T-shirts are worn by the

children on the cover of the calendar. Every focus group participant has continued to receive a calendar each year.

2. Description of Product

The slogan for the project is, "**VACUNELOS!**" meaning "Vaccinate them!" Each of the three posters has a different message: "**EL VACUNAR A TIEMPO ES SALUDABLE!**" (It's healthy to vaccinate now); "**LA IMPORTANCIA DE LAS VACUNAS ES LA SALUD DE NUESTROS NIÑOS!**" (Vaccines are important for the health of all children!); and "**ESTA FELICIDAD PUEDE CONTINUAR, DE TI DEPENDE.**" (If happiness is to continue, it depends on you.). These and other slogans on the calendar came directly from focus group comments. The posters and calendars feature children of Waterbury from the target community. Words and phrases that the focus groups thought inappropriate, such as injection, were avoided.

In the calendar, each month of the year focuses on one childhood disease describing its symptoms, cause, ways to prevent harm if a child is not properly immunized. January features the vaccine schedule. A calendar was chosen as the primary educational vehicle rather than a brochure because it could serve the dual purpose of educating the community about vaccine preventable disease and the importance of immunization, and serve as a functional calendar ensuring that it would be used throughout the year.

The 500 posters and 1500 calendars were ready by mid-October 1993. They were initially distributed to local churches, health care providers, civic and social organizations, and local businesses that target the Hispanic Community. Since then the distribution strategy for the calendar has been more focused on one-to-one distribution by the Immunization Outreach Worker, public health nurses during prenatal and postnatal visits, and WIC staff who provide an educational message on immunization along with handing the clients a calendar.

3. Producing a Professional Product

The city bidding process was lengthy, and separate bids needed to be secured for a graphic artist and a printing company. The Health Department was required, not surprisingly, to contract with the lowest bidder for production, but staff recommended that an additional requirement should have been familiarity with the Spanish language. Since the Immunization Coordinator was not fluent in Spanish herself, she felt this additional requirement would have helped ensure that there would not be any grammatical errors, and would have resulted in additional culturally relevant suggestions (e.g., holidays important to the target community would have been included on the calendar). Subsequently, the Health Department staff discovered some minor misspelling and omissions of accent marks. The needed changes were made in the 1995 calendar. In retrospect, the project coordinator would also recommend that graphic designer be involved in at least some of the focus groups.

D. *Funding*

Development of the immunization materials in Spanish was a new endeavor for the Health Department, but complementary to the Immunization Action Plan that had been initiated in January 1993. The BAP project originally received \$21,000 for a 5 month term starting in April of 1993. USCLHO staff made a site visit in August of 1993. They recognized the need for an extension of the project term because of the amount of time absorbed in hiring staff, setting up focus groups, and the city bidding process for printing the calendars and posters. USCLHO provided an additional \$8,000 which was dedicated primarily to paying for calendar and poster production but also some additional staff time. HRSA is prominently displayed on the calendar and posters as grant funding source.

Federal CDC immunization dollars flow through the state to the City of Waterbury Health Department. The city first received these funds in January 1993 to fund its Immunization Action Plan. The \$90,000 received from CDC goes primarily to staff support. In years subsequent to the BAP initiative, the educational materials line item (\$8,000) in the CDC budget has been wholly dedicated to reproducing the Hispanic immunization calendar. The Immunization Coordinator indicated that the successful reception of the BAP produced materials made it possible to justify use of the entire educational materials line item for calendar production.

E. *Staffing*

The availability of BAP and CDC immunization funds brought bilingual, bicultural staff to the Health Department. BAP funds supported the part-time Hispanic Health Facilitator (HHF), and CDC funds supported the Immunization Coordinator and an Immunization Outreach Worker. The Immunization Coordinator, Hispanic Health Facilitator, Outreach Worker and the Hispanic Coalition representative worked closely together as a team. The Hispanic Health Facilitator (HHF) was to be responsible for conducting focus groups of community members and to review existing immunization and well child materials for their applicability to the **community**. The role of the Outreach Worker was to track **un(der)** immunized children, and to get them in for care.

The HHF and outreach positions were advertised in local English and Spanish language newspapers, English and Spanish radio stations, and word of mouth in the community by the Hispanic Coalition. The persons eventually hired for both the Hispanic Health Facilitator (HHF) and the Immunization Outreach Worker positions were bilingual and bicultural. Additional criteria considered in hiring were knowledge of health care, community advocacy, public speaking ability and organizational skills. The Immunization Coordinator, who was in charge of the overall IAP and the BAP project, is supported through CDC dollars. She has a B.S. in public health and is an MPH candidate. She has developed some Spanish language capacity, but does not consider herself fluent.

Staff indicated that the BAP effort easily needed a full time rather than a part-time (20 hours per week) HHF for the duration of the BAP project. The Immunization Coordinator

estimates it took 60% of her time in addition to the HHF's commitment, although originally only 20% of her time had been allocated to the effort.

F. *Technical Assistance*

This initiative was assigned a mentor by the USCLHO; neither the mentor nor the Health Department were given any guidance on the role of the mentor. Unfortunately, this assistance was not as timely as it could have been. Although there was some communication through weekly telephone conference calls and fax communications, there was no face-to-face assistance until one two-day site visit in July, more than two months after the start of the project. The project coordinator felt the concept of a mentor was good but that logistically it was difficult to develop a timely relationship when the mentor was physically distant and extremely busy in her own job. Making time available to the Waterbury project appeared to be problematic for the mentor. Clarifying the role and expectations for mentors at the initiation of the project may have led to more timely assistance. The project coordinator acknowledged that she did not really know what she needed assistance with at the start of the project.

The mentor, a specialist in cross cultural affairs for the New York City Health Department gave advice on how to make more effective use of focus groups. She advised:

- reducing the size of each gathering from 15-20 people to less than 8;
- leading with questions on general health issues and then focusing in on immunization;
- asking the community what they liked and did not like about existing materials; and
- posing open-ended questions rather than closed-ended questions with negative connotations (For example, "Tell me what you know about immunizations. " rather than "Why is there a significant problem with immunization?")

Although twenty communities within the state of Connecticut had developed Immunization Action Plans, no other community in Connecticut was focusing on an immunization initiative on a special population or neighborhood. The Project Coordinator sought technical assistance from USCLHO through weekly, often daily telephone and mail contact. USCLHO staff made a site visit and helped focus the project on development of the calendar and posters. After the BAP project was completed, the coordinator found out about the existence of La Raza and COSSMHO.

G. *Documenting Success*

The Health Department set evaluation objectives in its initial **workplan** which contained basic process measurement elements such as holding focus groups and producing the calendar. Staff realized that they would like to do a more extensive evaluation that contained client feedback

on the calendar and to examine methods to assess the childhood immunization levels in families receiving the calendar.

The Health Department employed both informal and formal feedback mechanisms to gather client input on the calendars. First, client responses to the calendar were gathered by persons who distributed the calendars. Client responses included: liking the bright colors and use of community children; ease of flipping to immunization schedule; easily understood information; and use as a functional calendar. Second, a call back written survey tool was employed. The survey was reviewed by the Hispanic Coalition and Immunization Outreach Worker for readability. One hundred surveys were distributed; 52 surveys were returned qualifying these respondents for a \$10.00 gift certificate at the local Shop Rite supermarket. The Health Department deemed "this project successful in the respect that on the whole, individuals liked the information, used the calendar regularly, and would like to see the calendar reprinted in the future. " The overwhelming majority (97 %) found the calendar useful and easy to understand, and had read the immunization information.

The project coordinator found that it was logistically impossible to ascertain whether the immunization histories of children whose families received the calendars improved compared to those who had not. Furthermore, it would be difficult to separate the effects of the calendar from other confounding variables such as the health care provider, the influence of family and friends, and the knowledge base of the individual. However, they did ask parents to recall whether their child had received immunizations (94.9% said yes); had received DTP (85.3 % yes); and received polio (5 1.5 % yes).

The project yielded a number of other outcomes beyond producing the calendar. The Hispanic Immunization initiative helped to bring together a coalition of persons working together for a common purpose--healthier children in Waterbury. The local distribution network is willing to continue to redistribute the calendars as they are printed. Requests continue to come in for materials from communities around the country. As noted in the staffing section, the BAP project succeeded in bringing additional bilingual, bicultural capacity into the Health Department.

When the immunization initiative began in 1993, there were no baseline statistics on immunization levels. In a 1994 survey by the health department, approximately 39-53% of children in the St. Mary's Pediatric Ambulatory Clinic, Stay Well Health Center and the Health Department Public health Nursing Division were up-to-date by age two for the 4:3:1 immunization series,¹ far from the goal of 90%. Now the clinics monitored have from 75 to 90% completion rates, with the St. Mary's clinic having the highest rating. In 1995, the on-time completion rate for Hispanics overall in each of the clinics is 88 % . The improvement is credited to intensive outreach, tracking and education efforts which started with the BAP funded initiative.

¹By age 2, children should receive 4 DTP, 3 OPV and 1 MMR. The biggest drop-off in compliance with immunizations is after 12 months; the Health Department finds that the period between 12 and 15 months in a child's life is a crucial time for outreach. The drop off at 12 months is a trend observed nationally.

The entire immunization program (outreach, education and tracking) has been judged a model project. Most of this recognition is due to the Immunization Coordinator's efforts to promote the project in a variety of forums throughout the state and nation (including U.S. Conference of Local Health Officers Conference and CDC's National Immunization Conference). She commented, that in economically depressed Waterbury, receiving positive press has been most welcome by the community and its leaders. The Health Department has received special commendations from Former First Lady Rosalyn Carter and Governor Lowell Wicker for its immunization outreach efforts and has been awarded the 1994 Healthy Mothers, Healthy Babies Achievement Award.

H. *Continuation of Effort*

The BAP grant provided the basis for the ongoing immunization education campaign. Calendars were distributed for 1994, 1995, and 1996, with the initial year supported by the BAP grant. About 500 posters and 1500 calendars were produced in the first year. In the subsequent years, 1500 calendars have been printed yearly. This calendar has been incorporated as the primary educational outreach vehicle to the Hispanic Community for the city Immunization Action Plan. The Health Department current dissemination strategy in the community is based on direct person-to-person contact. Calendars are given to families individually, along with an explanation of the importance of immunization and regular preventive health care.

The calendar has also been used as an entry vehicle to educate providers on updated American Academy of Pediatrics Immunization Guidelines. Approximately, 150 calendars were distributed through private OB/GYNs and pediatricians. The Health Department contacted all providers and indicated the availability of free vaccines, and also of the Health Department's availability to provide immunizations. They advised that simultaneous administration was accepted as was giving immunizations when a child had a cold.

The Immunization Coordinator plans to reprint the calendar in Spanish for 1997 and hopes to print one in English as well. Second generation Hispanic mothers are more likely to know English, and they have asked for a calendar in English as have others in the community (i.e., African American mothers). If funds become available, this would be one priority. Staff would also like to redo the Spanish calendar to improve some of the images and messages, as the medical terminology is still too technical in some areas.

Whether the calendar will continue to be printed as it is now, is a decision that is made each year in November when the CDC funds become available. That late in the year, it would be difficult to turn around to produce a new calendar based on focus group input.

1. Dissemination in the Community

It is useful to understand the operation of the Waterbury Health Department and its relationship to other providers of well child care and immunization in the city to visualize the

approach of the IAP. Two hospitals deliver all of the city's babies--Saint Mary's and Waterbury Hospital. Typically, children born at St. Mary's will either receive their pediatric care through the St. Mary's Pediatric Ambulatory Care Center or a private provider. Most children born at Waterbury are followed through the Stay Well Health Clinic or private provider. The Stay Well Health Center was part of the Waterbury Health Department until two years ago, but is now an independent Federally Qualified Health Center. Stay Well has been trying to establish itself as a separate entity; the clinic has been without a pediatrician for over a year.

St. Mary's Pediatric Ambulatory Care Center is viewed in the community as more receptive to the Hispanic residents and is the Health Department's main partner in the Immunization outreach to the Hispanic community. They have more bilingual staff than Stay Well. Its location is proximate to where most Hispanics live. It is physically located only a few blocks from the health department and near public transportation. Although St. Mary's staff were not interviewed directly, others interviewed indicated that besides a "mission to serve the community," economic forces may have induced St. Mary's to be cooperative with the Health Department immunization venture. Vaccination outreach is a good marketing wedge into the community. As facilities compete for the Medicaid managed care market, St. Mary's has built a name for itself in the community for its care of children. Health Department staff estimate that St. Mary's cares for about 75 % of the people on Medicaid in the city.

7 The Health Department did not operate a regular immunization clinic until January of 1995, and it is held for 3 hours only once per month. The clinic time slot has not been steady so it could not be published on the calendar. The number of children served is only 30 children per quarter, although the number jumps in the quarter prior to the school year to about 100. The clinic primarily serves those children who do not yet have a regular primary care provider, or a source of payment.

The Immunization Outreach worker gives calendars to families she meets in the Pediatric Ambulatory Care Center (about 800 calendars a year) at St. Mary's where she goes daily. Calendars are also available from staff at the Stay Well Health Center (200), the three WIC offices (200), the prenatal clinics at St. Mary's (150) and Waterbury Hospital (100), Head Start, the Department of Social Services, the Healthy Start program and some private practice physicians. Each site provides a person-to-person message on the importance of immunization as well as the calendar. Each site is monitored for the number of calendars it gives away so that an appropriate number can be given in the following year.

The major distribution effort is in November, December and January because that is when most people are looking for a new calendar. However, the calendars are available until the stocks are used up. Throughout the rest of the year, posters hang in all of the above sites as well as local community centers, and businesses. During National Immunization Week and during the Month of the Child, the Health Department provides radio and newspaper features on the importance of immunization.

The outreach worker also monitors the immunization status of all babies born at St. Mary's. The outreach worker follows any child that falls behind until they have completed the recommended 4-3-1 primary immunization series. She currently follows 200 children; this is a revolving caseload as children finish the series and new ones enter her rolls of underimmunized children. If any child fails to show up for his/her two week postpartum visit or is a no-show for any other scheduled immunization appointment after that, the immunization outreach worker personally calls or visits the family to determine the reason for any delays, and help them with transportation and child care to facilitate access to care.² There has not been sufficient funds to support an immunization outreach worker for Stay Well Health Center.

2. Dissemination Nationally

As noted earlier, the Immunization Coordinator has taken the initiative to disseminate the calendar and posters in national meetings and to apply for recognition awards for the city immunization efforts. After presentation of the Hispanic Immunization Initiative in a poster session at a National Immunization Conference, the Health Department started receiving a manageable number of requests for the posters and calendars from others around the country. These requests were primarily from Health Departments rather than community-based organizations.

Eventually, the Health Department was deluged with requests to buy hundreds of calendars at a time. The Health Department had to turn down bulk requests (except for a request from Danbury Connecticut for 500 calendars) because they could not distribute that many for free, and had no mechanism for selling them. Requestors could receive individual copies and use the idea to replicate it in their community. The numerous requests were an unanticipated consequence of the success of the project, and one that the Project Coordinator indicated that staff was not prepared to deal with. The requests and the responses placed a considerable time burden on the staff. The Immunization Coordinator suggested that if the grant had gone to the Hispanic Coalition then the Hispanic Coalition could have reproduced and sold as many calendars as were requested, but the Health Department was constrained by local government procurement procedures.

While the Project Coordinator was happy to share the results of the project--calendars and posters--she stressed to requestors that the process of developing the materials was as important as the materials themselves since the process promoted a positive relationship between the Health Department and the Hispanic community that had not existed before. She advised that communities replicate the development process not just duplicate the calendar. It was important for the Waterbury community to know that it was their children depicted and that their focus

² HD staff estimates that 80% of the babies born at St. Mary's come in for the first two week appointment; about 20% need prodding.

group comments had been visibly folded into the final document. The community also appreciated that the language was in their own dialect; they knew it had been written for them.

Recipients of the Waterbury calendar should note that the language is primarily applicable to Puerto Rican and Dominican communities, although much of technical medical language tends to be the same across dialects. Most of the other Spanish language health education materials that the Health Department located and had the focus groups review were directed toward people of Mexican descent. Also many of the materials had simply been translated from English into Spanish without taking into account literacy level or idiom.

Because the Health Department found that some people were using their images and putting different messages on them in the press and elsewhere, the Health Department copyrighted the calendar to protect the integrity of the calendar message and to ensure that the Health Department and its **funders** received credit for the project. Their intent in pursuing the copyright was not to prohibit anyone from using the material in the way it was intended (that is, to promote immunization), but to ensure that they had some recourse if the calendar or posters were used inappropriately. The funders of the project are prominently displayed on calendars and posters.

LATINO CULTURAL COMPETENCY TRAINING

Women's Preventive Health Branch, DMCH North Carolina Department of Environment, Health and Natural Resources

The team of Cheryl Uhner and Suzi Rodriguez visited the Women's Preventive Health Branch, DMCH, North Carolina Department of Environment, Health and Natural Resources on June 17, 1996 and interviewed the fiscal administrator of the **Latino** Cultural Competency Training Project and a Health Department trainee. A subsequent interview was held with the consultant who developed the curriculum, networked with the target community, and organized the training workshops.

Key points that emerged from the site review are:

- **Latino** Cultural Competency Training (LCCT) project accomplishments include:
 - development of a **Latino** Cultural Competency Curriculum;
 - four Workshops and Social/Cultural Events;
 - compilation of Spanish/English health education materials into a Resource Manual;
 - building state networks through the Advisory Committee; and
 - developing new strategies for gaining **Latino** community input.
- The LCCT built on the needs assessments and collaborative community planning process of Project REACH (Rural Education, Advocacy & Care for HIV), a Ryan White Title II Special Project of National Significance (199 1-1 994).
- Relationship building both (1) among statewide health providers, educational institutions and policymakers and (2) between local health departments and their communities were essential features of this project.
- The composition of the Project Advisory Committee was a purposeful selection to build a statewide network that would aid in replication of the curriculum and workshop.
- The project demonstrated the value of training sessions ("Stories of Everyday **Latino** Life" and "The Talking Circle") driven by the personal experiences of participating **Latino** community members.
- The selection process for Resource Manual health education materials included review by bilingual **health** professionals for accuracy and by community users for preferences.
- The consensus of the Project Director, Advisory Committee, and consultants was that the project timeframe was too short given its goals, and that state fiscal procedures were not

compatible with the **timeframe** nor for dealing with small ethnic businesses who could not afford to deliver services without immediate reimbursement.

- The project had a multi-faceted evaluation of program outcome and program impact (e. g . ,pre/post training, community reputation surveys).

A. Project Background

North Carolina has the fifth largest migrant farmworker population in the United States; providing health services on a year round basis to an increasing number of migrant farmworkers who chose to “settle out” posed a challenge to local Health Department staff. Since almost 92% of the migrant population is Spanish speaking, increasing sensitivity to this community became the focus of the BAP sponsored initiative known as the **Latino Cultural Competency Training (LCCT)** project. The Women’s Preventive Health Branch¹ surveyed the 28 county health departments across the state about the type of assistance needed to provide effective access to the migrant population. Two of the identified needs set the direction for the BAP funded project: (1) delivery of cultural competency training for local health department staff and (2) compilation of Spanish language health education materials at a lower literacy level.

The **Latino Cultural Competency Training (LCCT)** project consisted of two phases:

- Phase I (February to June 1993) concentrated on development of the cultural competency curriculum and a resource manual of health education materials for health care providers. One cultural competency training session was held.
- Phase II (July to October 1993) focused on replication by implementing three more cultural competency workshops statewide and on more extensive evaluation.

The first training workshop targeted Health Department staff in a five county area (Duplin, Harnett, Johnston, **Robeson**, Sampson); 35 % of the migrants in the state reside in these counties. All are rural counties with approximately 50% of land use for agriculture. Each is in a Health Manpower Shortage Area, and faces increasing cases of HIV, TB syphilis, hepatitis B and teenage pregnancies as well as other indicators of increased morbidity and mortality. The remaining workshops focused on other rural sections of the state where health care resources were similarly limited.

The BAP proposal builds on community connections and a needs assessment developed under Project REACH (Rural Education, Advocacy & Care for HIV), a Ryan White Title II Special Project of National Significance (1991-1994). The collaborative community planning

¹ The Women’s Preventive Health Branch is the locus of the state family planning program and does not include other women’s preventive health services.

process of Project REACH served as a model for planning the Latino cultural competency training sessions.

The LCCT developers consulted with the infrastructure of community health advisors and community coordinators developed by Project REACH in the design and implementation of the BAP sponsored cultural competency training. The training curriculum is based, in part, on the Project REACH assessment of needs that emerged from community focus groups, and a conference on culturally appropriate, community-based HIV education. The person who spearheaded the LCCT program for the Women's Preventive Health Branch also served on the Ryan White Consortia Steering Committee and was intimately familiar with Project REACH efforts.

B. *Role of Minority Groups*

The LCCT project had a two-tiered advisory structure: a state level committee composed of organizational and government representatives and local area advisors in each of the communities where workshops were held. The state-level project Advisory Committee consisted primarily of Health Department staff and representatives of the Coastal, Wake and Mountain AHECs; while four of the members were bilingual or **Latinas**, no representatives from the migrant or settled out community served on this committee. The rationale for this composition was that most of the representatives were connected to established educational/training networks throughout **the** state and that would facilitate statewide implementation of training in Phase II of the project. The Advisory Committee assisted in planning, implementation and evaluation of the project; they each attended the Project REACH Cultural Diversity Conference to network with local health department staff and community representatives. Members of the target communities identified through Project REACH and other community members assisted in planning individual workshops, identifying community representatives for attendance, selecting patient education materials, and evaluating both the workshops and the Health Department's reputation in the communities.

Members of the migrant and settled out communities took an active role in presentations at the workshop. A social event in the tradition of rural Mexico brought health department staff and the community together. **Latino** musicians and food vendors were engaged to immerse health department staff further into the culture and to promote community-based ethnic businesses.

C. *Project Implementation*

Project implementation included development of the LCCT curriculum, holding four workshops, and compiling health education materials in Spanish and English for a Resource Manual.

1. Latino Cultural Competency Training (LCCT) Curriculum and Workshops

The training curriculum and workshop format was designed to increase the cultural competency and sensitivity of health care professionals serving **Latino** clients. The workshop format provided a chance to interact with Latinos from the community and to explore together "Latino traditions, beliefs, and attitudes that can affect health care service" and to develop individual and organizational strategies to improve services for the **Latino** community. In Phase I LCCT was offered in the initial five county target area with the highest migrant impact; Phase II served to **refine** the curriculum and replicate the workshop in three other sections of the state.

The seeds of the LCCT curriculum approach can be seen in the agenda for the Project BEACH AIDS workshop; Phase I of the BAP project sponsored attendance at the AIDS workshops for the LCCT Advisory Committee members and a few others. The first LCCT Advisory Committee actually took place at the AIDS conference. This experience gave the Advisory Committee additional firsthand exposure to local **Latino** community representatives including migrant farmworkers and other **Latino** and bilingual health care professionals from the initially targeted five county area. A component of the conference, the two "Talk Circles" ("A Day in the Life of a Migrant Farmworker" and "A Settled-Out Latino"), served as a prototype for part of the LCCT training. Contacts made in the AIDS meeting led to continued dialogue; 15 of the 20 people in the "Settled-Out Latino" Talk Circle continued to meet over the next several months and participate in planning for the LCCT meeting. Additionally, the Project Director noted that attendance at the AIDS workshop offered an opportunity to "market" the concept for the LCCT (Each person sponsored by BAP funds had a special notation on their name tag that promoted the LCCT).

The two-day workshop format had a variety of more didactic presentations supplemented with more experiential sessions (e.g., *Convivio* and Talking Circles). The workshops culminated in drafting local action plans for Health Departments to improve the cultural competency of their organizations. Presentation topics included **Latino** cultural values; stereotypes and prejudices; demographics and health status of Hispanics in North Carolina; and the barriers faced by Latinos in accessing health care. Throughout the workshop, Spanish phrases were taught, and attendees sampled ethnic food.

On the evening of the first day, a *convivio* was held; *convivio* is the term used in rural Mexico to connote a gathering and sharing/conversation of people in a community. The *convivios* were advertised in the community and were attended by a broader scope of people than just those participating in the workshop. Its purpose was to allow health department staff and the **Latino** community to interact in a different setting and build bridges that would lead to better communication. On the second day, community members came as "invited guests" to share in the Talking Circles typical working and living experiences and the problems encountered in accessing health care.

A total of **157** persons received LCCT through the four workshops. The initial session was by invitation with preference given to Health Department staff (including key **policymakers** to effect change) followed by other local health and human services providers (e.g., staff from rural, migrant, and community health centers). **Latino** community representatives included health care professionals, lay health advisors, teachers, church leaders, and members of the migrant and settled out communities.

Each workshop was a learning experience requiring refinement of the approaches used in previous sessions. The Project Coordinator and Training Consultant had foreseen **this** need and required presenters at the first workshop to meet together twice post-training to write notes for facilitators of future workshops. These notes are now an integral part of the curriculum package.

Planners intended that participation in the workshop be 50% **Latino** and 50% **non-Latino** health care staff to enhance the cross-cultural experience and to expand the understanding of cultural health beliefs on care seeking behavior. There was difficulty attaining this goal, even for the first invitational conference (later conferences were first come, first served). The perception of many potential participants was that the training would be valuable only for non-Latinos and non-Spanish speakers; however, post training evaluations suggested the need for increased cultural competency for all. For example, a **Latina** health care provider indicated that she had never thought of **Latino** cultural values before in this context and that the workshop had “put everything into a new perspective and gave her a new understanding of herself.”

Two of the workshop components (“Stories of Everyday **Latino** Life” and “The Talking Circle”) required participation by **Latino** community members for these approaches to be successful; Advisory Committee members were unsure whether it would be worth the time investment to identify and recruit community members and whether they would share enough to be provoke meaningful discussions. The workshop evaluations indicated that these sessions were among the most valuable and meaningful. The Project Coordinator indicated in her final report that the “time and energy are well-spent” on this portion of the project and that implementation is feasible if sufficient time is invested in field work in the community ahead of time.

The short project period and the state’s inability to funnel the BAP funds to consultants and vendors created several problems. The project consultants demonstrated an incredible amount of goodwill in proceeding with the projects without contracts and financial support to allow the project to meet the proposed schedule. The selfemployed consultants paid for meeting space and materials, food vendors, and child care out of their own pockets until they were reimbursed months later. Phase I extended from February to June; on May 14, the Project Director reported to ASTHO that consultant contracts had finally been approved. By this time, the curriculum consultant had already been working in the communities and developing the curriculum so that the project could hold the workshop by the end of June. Similarly in Phase II, the rapid succession of three workshops required up-front money that the state could not provide until its lengthy fiscal procedures had been completed (e.g., **six** weeks to set up an account for **the** grant; no payment until services are rendered and then time for processing payment).

The Project Director, in her final report, noted that flexibility in state fiscal procedures is particularly important when dealing with small ethnic businesses who cannot afford to deliver services without immediate reimbursement. Working with local **Latino** community vendors was part of the strategy of fostering stronger links between the Health Department and the community. For example, ethnic food and music were an integral part of the workshops, but the caterers could not afford to carry the costs of providing 75-100 meals and, therefore, required cash on delivery. Similarly, community representatives received a small honorarium (\$3040) for their participation which was seen as important if they incurred lost wages, and/or transportation and child care costs; waiting for two months for an honoraria check was not compatible with their lifestyle and **cashflow** (e.g., changing addresses, women with no driver's licenses to cash checks). State policies require both a Social Security number and a permanent address, both of which were problematic. Many community representatives were reluctant to provide their Social Security number to a representative of state government.

2. Resource Manual

Development of a model Resource Manual of bilingual health education materials was another tangible way to help reduce language barriers between health department staff and Latinos. While all of the health departments surveyed prior to the project indicated that they had some Spanish language materials, these often were not used either because the literacy level was inappropriate or staff were not comfortable in distributing the materials because they did not know what they said. Simply supplying resource lists to these providers was considered insufficient, because the providers did not have the time or expertise to evaluate materials themselves. After a preliminary collection of patient education materials, Advisory Committee members field-tested them, and the curriculum consultant surveyed **Latino** users of health departments for their preferences among the materials.

The model resource manual contains copies of materials (usually in both English and Spanish) covering the following topics:

- Pre/post Natal Care and Breastfeeding
- Family Planning/Contraception
- STD and HIV/AIDS
- Other Health Topics (e.g., immunization, pap smears, breast/colon cancer).

In addition, the **Que Paso? An English/Spanish Guide for Medical Personnel** was included. Cost constraints limited production to only one resource manual for each participating organization; however, information on where to order additional copies of materials is listed. Because trained medical interpreters are difficult to find in these areas, one recommendation for the Resource Manual was that it serve as a mini-library of background material for **interpreters**

(e.g., volunteer and family member interpreters). The value of the Resource Manual was recognized across state offices; the Office of Rural Health and Resource Development, the Office of Migrant Health, and the Office of Minority Health all supplemented BAP funds to ensure that the manual would be available to all participants.

D. Funding

Phase I funding was \$15,000, with the bulk going to two activities. Almost half (\$7,000) supported development of the training curriculum, resource manual and the first training workshop. Another \$4,000 supported attendance at the Project REACH Cultural Diversity Conference for 12 LCCT Advisory Committee members; five health department staff from the target area; a Ryan White consortia member, three community representatives (e.g., **Latino** Pastor and a translator). The Community Coordinator Assistant hired for the project received \$2,300 to coordinate activities at the local level.

Phase II included \$24,800 for the Project Consultant to coordinate and implement the three remaining training sessions. The balance included a minimal amount (\$1,000) for speaker honoraria and \$4,200 for printing workshop materials and the resource manuals. Additional funds (amount not specified) were made available from co-sponsors of the workshop to support training and additional copies of the Resource Manual.

E. Staffing

The State Training Coordinator for the Women's Preventive Health Branch oversaw the LCCT project and hired two consultants to develop major components of the project: (1) the curriculum and its implementation through four training sessions around the state and (2) the development of evaluation instruments used in different phases of the project. A preferential criteria in hiring the consultants was that the person be **Latino** or Spanish-speaking and/or experienced with the migrant population. Despite hiring two consultants, the tight timeframes required almost full-time participation of the Project Director, creating difficulties for her. Comments during site visit interviews indicated that others in the Women's Preventive Health Services Branch thought she was not meeting her other commitments during this period. (The Project Director is no longer in this office, and was not available for an interview.)

A Community Coordinator Assistant was hired to work part-time in the communities and to bring community members into the training process as well as identify the most convenient time for training in view of the farming season (April to October). Another specific task for the project Community Coordinator Assistant was to establish baseline information about the local health department reputation in the initial target community and conduct an informal survey of these five county health departments to document availability of resources and services for the target group.

F. *Technical Assistance*

The project benefitted from formal and informal technical assistance from a variety of sources. The training consultant had expertise in mounting cultural competency training, but she and the Project Director also consulted ASTHO, COSSMHO, Project REACH, and the University of North Carolina (UNC) School of Public Health. The project director attended an ASTHO grantee meeting in Washington, DC which provided contacts for additional resources. The consultant met with a representative of UNC to draft the agenda for training that would meet the content requirements for continuing education credits, and also to outline contents for the resource manual. COSSMHO staff provided, via a telephone conference call, advice on how to implement and evaluate training as well as materials (HRD Cultural Diversity Training Curriculum, COSSMHO Hispanic Health Slide presentation). The influence of Project REACH has already been addressed earlier.

G. *Documenting Success*

In pursuit of its overall goal of strengthening the state and local health department infrastructure to meet the needs of **Latino** clients, the LCCT project set two major objectives:

- delivery of **Latino** cultural competency training for local health department staff, and
- compilation of Spanish language health education materials at a lower literacy level.

They met these objectives by producing a replicable training curriculum and a model resource manual compiling Spanish/English materials on pregnancy and family planning. Other goals that emerged and were achieved during the process: (1) building a network across the state through the Advisory Committee to advocate for training; and (2) developing new strategies for gaining Latino community input.

The effort to measure success in this project employed multi-faceted approaches to evaluate the impact of the training on individual participants, health department changes, and community perceptions of the health department. A variety of instruments were developed and used at different stages throughout the project.

1. Workshop Evaluation

At each training session, participant evaluations of the workshops strongly agreed that (1) the workshop met its objectives; (2) the materials were beneficial to participant's jobs; (3) participants had gained knowledge and increased their interest in cultural competency. Did the training actually increase cultural competency and sensitivity of Health Department staff in serving the target population? Participants acknowledged that prior to the workshop their job performance did not meet the level of the cultural competency shared in the workshop. Analysis of pre and post tests administered to participating Health Department staff showed statistically significant

changes in knowledge of **Latino** culture and health beliefs and decision-making for specific health care scenarios. When responses were categorized by type of position, the medical group had the lowest pre-test-scores, and the greatest improvement after training. Similarly, responses among those who were not bilingual or had never had any cultural competency training also showed greater improvement over their comparison groups (bilingual persons, those previously trained). Quotes from attendees are perhaps even more telling than the statistical analysis:

- “Program convinced me of things I need to change. ”
- “My desk faces the front door of the clinic and in the past, whenever I have seen someone who looks like they speak Spanish come through the door, I confess that I would look down and try to avoid them...sometimes I’d even get up and leave. I didn’t know any Spanish and just didn’t know how to help them. But in the last two days, I see that they are people too.. **they** have feelings and needs too, just like us. And they can read body language and can tell if someone cares, even if that person doesn’t speak Spanish. So after today, when I go back, when I see someone who looks like they speak Spanish come through the door, I will look right at them and give a big smile.. **even say "Hola!"** .. I will try to let them know through my body language that I care about them and will try to help them the best I can! ”
- “The morning sessions with locally settled or migrant Latinos were especially valuable to help ease the “fear of the unknown” of dealing with people who are different. ”

Community representatives were affected as well, with the interchange being characterized as “healing and helpful. ” For example, one man got to verbalize for the first time how difficult it was to get a TB x-ray for work and his appreciation for the opportunity to share his frustrations. At the workshop another woman, who up until then was characterized as very shy, withdrawn and unwilling to open up to Health Department staff about the problems she faced, shared openly with great emotion her frustrations with the system. Now when she come to the clinic, “She is very outgoing and demonstrative. ”

2. Local Action Plans

The last activity of the workshops was brainstorming ideas for action plans for improving cultural competence in local health departments. These county specific action plans were to include at least two changes to its environment, policies, or resources that would make the health department more culturally responsive. Prior to the training in Phase I, the **five** county Health Departments in the initial target area were surveyed with respect to availability of bilingual staff and **resources**.² These surveys helped identify ideas for the action plans as did interviews with

² **Two of the five** indicated that they had some full-time bilingual staff; the others depended on part-time interpreters **even in one county where 15% of the clients were Hispanic. One county Health Director indicated that 1 to 2%** of the clients seen were Hispanic while other staff indicated that it was more likely 25%. None of the

Latino community leaders. In the month following training, some of the actions carried out included:

- “getting a list of farmers and delivering packets of info to the camps, ”
- “using the Spanish-English materials in the Resource Manual in the Health Department (e.g., ordering Que *Paso?* for every clinic), ”
- “contracting with a Spanish-language instructor.. . to teach “basic” language skills/translation, at the Health Department for Health Department and hospital staff, ” and
- identifying priority technical assistance needs.

Two months after the pilot workshop, a more detailed case study of needs and barriers was conducted in the county with the greatest number of participants in the training, including its Health Director. These findings funneled into the future action plans at local and state level both for the Women’s Preventive Health Services Branch and for Office of Minority Health.

3. Community Reputation

One strategy for gaining community input in evaluation was to assess the reputation of the Health Department in the community. This approach was chosen as opposed to a typical patient satisfaction survey used by Health Departments because this type of instrument was not seen as effective in gathering the true feeling of Latinos because of discomfort in being critical at the time and place of service delivery. Furthermore, community reputation was considered important because of reliance in this community on word-of-mouth referrals. While the initial purpose of these surveys was to demonstrate change, this proved too ambitious given the short timeframe of the project. However, it did prove useful to provide a baseline for future evaluation and to identify potential areas that workshop participants could incorporate in their action plans. At the end of Phase I, 20 Spanish speaking community leaders were interviewed using the survey in an effort to establish community satisfaction and willingness to seek care at health departments; these ideas were used by workshop facilitators. A sample survey in Spanish was developed in conjunction with an Interviewer’s Guide so that local Health Departments could administer this survey themselves.

counties had policies to hire bilingual staff. All had some pamphlets in Spanish. Few had incentives for encouraging staff to seek cultural and linguistic competency training. Providers faced lack of interpreters and funds to pay for these services.

4. Advisory Committee Self-Assessment

Advisory Committee members were also asked to evaluate their participation in the project; clearly the collaboration model worked to broaden interest in the health problems facing Latinos. Sample feedback include:

- "I personally gained through the networking of various agencies.. . These contacts give me more resources for making (my agency) more "Latino friendly" regarding the development of new programming. I also personally benefitted.. . as a facilitator in getting to know more public health staff and developing appropriate training skills. "
- "The working relationships established and the knowledge gained about the various agencies and resources has helped strengthen our state's infrastructure and will continue after this Project's completion. Also, our understanding of the needs and gaps in services has become clearer. This will help us be more effective advocates for serving Spanish-speaking clients. "

H. ***Continuation of Effort***

Phase II was viewed as a way to replicate the program to a wider audience. Demand for registration exceeded the 30-35 person limit for each workshop, suggesting greater need. The final report for the grant indicated that University of North Carolina would offer the workshop again in the spring of 1994 (we were not able to confirm whether this took place). There was a close relationship between project staff and UNC throughout the project, suggesting that the curriculum probably was offered again. UNC School of Public Health provided Continuing Education Units for attendance at the workshop; its Office of Continuing Education provided the graphic design for the cover of the Curriculum and Resource Manual; some of the presenters at the workshop came from the School of Public Health and served on the Advisory Committee. Another follow-up activity occurred in February of 1994, the Women's Preventive Health Services Branch and the North Carolina Office of Minority Health jointly sponsored a four hour Cultural Competency Conference for Public Health Policy/Decision-makers featuring a speaker who was instrumental in implementing a statewide cultural competency plan for the mental health system in Michigan.

While the Women's Preventive Health Services Branch had trouble locating a copy of the LCCT curriculum for our site visit, they did indicate that they routinely survey health departments for their training needs and that cultural competency is always on the list. Staff interviewed during the site visit suggested that the threads of the LCCT curriculum were seen in their other training efforts, but the state branch has not mounted the same format with a ***convivio*** and talking circles including community representatives.

Other participating agencies may have benefitted from sharing the curriculum through their own training activities. The workshops had joint sponsorship from the Office of Minority Health,

the Migrant Health Program, Office of Rural Health, North Carolina Primary Health Care Association, UNC School of Public Health, and Area Health Education Centers.

Many of the findings and recommendations gathered throughout the project during the community networking, curriculum development, and training phases were incorporated into the North Carolina Office of Minority Health's assessment of Hispanic/Latino health service needs. This office was newly formed about the time of the BAP grant, and staff from that office participated on the LCCT Advisory Committee.

One of the requirements established for the Training Consultant at the outset of the project was that the final curriculum package needed an organization and format that would make the training easy to replicate by others. Part of the process of organizing the first workshop was to have the presenters meet together at least twice with the curriculum consultant to write up each segment of the training including tips for future facilitators. In phase II, the curriculum underwent at least two review and edit cycles as they gained more experience. Both the curriculum presentation package and the Resource Manual are professionally prepared and attractive. The federal OMH Resource Center had a copy of the curriculum in its library.

The extent of dissemination is hard to determine given that we were not able to interview the Project Director; however, the joint sponsorship of the workshops suggests that at least those organizations may have received copies of the curriculum as well as the Advisory Committee Members. The Women's Preventive Health Services Branch was unable to locate a copy of the curriculum in their own files because they had recently moved offices. Eventually two copies were located for us; one in the North Carolina Office of Minority Health and at the Washington County Health Department where one of the Advisory Committee members now works.

MEDICAL INTERPRETER TRAINING ACADEMY (MITA)

Rhode Island Department of Health Office of Minority Health

The team of Cheryl Uhner and Kim Oanh Cook visited the Providence Ambulatory Health Care Foundation (PAHCF) and the Rhode Island Department of Health on June 10, 1996 to discuss the Medical Interpreter Training Academy. They interviewed current and former staff of the Office of Minority Health and of PAHCF, as well as several participants in the training program.

Key points that emerged from the site review are:

- The project provided one-time training in medical interpretation to 23 **bilingual/bicultural** individuals involved in health care settings.
- The Medical Interpreter Training Academy has not continued; however, some of the materials (i.e., videos purchased) continue to be used for in-house training at PAHCF.
- The 23 individuals completing the 32 hour training sessions represented a wide spectrum in the community: Hmong, Cambodians, Laotians, Vietnamese, Russians, Portuguese, Armenians, and Latinos .
- Clarification of the role of interpreter was a major focus of the training; however, different views of this role persisted even after the training, based on interviews with trainees.
- The project supported a one-time in-service training session for 60 health professionals, mainly nurses, on effective use of interpreters; there was difficulty in attracting physicians to the training.
- Based on the interviews conducted, there is interest in resurrecting the concepts of the Interpreter Academy, but to place it within an educational setting (e.g., community college) so that there would be a more formalized certification process.
- The curriculum and its instructors were subject to evaluation by the trainees, but there was little specific evidence reported of what the trainees themselves gained from the training.
- The curriculum manual is a collection of materials and basic outlines of instructions handed out for the sessions; many of the handouts copied from copyrighted materials from other sources.

A. *Project Background*

The Rhode Island Office of Minority Health (OMH) received the BAP grant to: (1) implement a Medical Interpreter Training Academy which would provide bicultural, bilingual interpreters already working in health care settings with more formalized medical knowledge and (2) provide in-service training for health professionals on effective use of interpreters. Although there had been movement in Rhode Island toward hiring **bilingual/bicultural** individuals within the public and private health care system, there had never been a medical interpreter training program in the state prior to the BAP initiative. Rhode Island OMH, in concert with the Health Department Minority Health Advisory Committee and Providence Ambulatory Health Care Foundation (PAHCF-a network of community health centers), recognized that specific training in medical interpretation would enhance the delivery of care to persons with limited English proficiency.

Several specific events triggered more attention toward the issue of medical interpretation:

- Growth in ethnic and linguistic communities, particularly the influx of Southeast Asians.
- The American Association of Retired Persons (AARP) release of a Health Watch study concluding that many health providers were in violation of civil rights laws and regulations as a result of failing to provide interpreters in health care settings.
- The Rhode Island Department of Health (RIDH) and PAHCF reported improved patient outcomes related to more effective access due to trained bilingual, bicultural patient representatives under a 3 year demonstration grant.

Each of these is discussed below in further detail.

In the 1980s Rhode Island became more ethnically and linguistically diverse, with **Latinos** and Asians making up 5 % and 2 % of the population respectively. While these numbers appear small, the percentage increase in the previous decade was 132-247% for various linguistic groups, and these populations are concentrated in Providence.

The American Association of Retired People (AARP) heightened awareness of the potential for civil rights violations by health providers when medical interpretation was not provided. For six months in 1990, AARP studied the barriers presented to older members of linguistic minorities when they tried to access health care. AARP concluded **that** many health care service providers were in violation of federal law in the following ways:

- “Cases in direct contradiction of Title VI. Violations of this civil rights law include all instances where a client is informed by the provider that it is the responsibility of the client to provide an interpreter.

- Cases related to violation of Part 80) of Title 45, subtitle A-Department of Health, Education, and Welfare: 'Nondiscrimination under programs receiving federal assistance through the Department of Health, Education, and Welfare effectuation of Title VI of the Civil Rights Act of 1964.' Violations of these regulations include special treatment of patients on the basis of apparent national origin such as requests for proof of citizenship.
- Cases that reflect conflicts between organizational system procedures and client's needs. They can fall into three categories: (a) regulations which make interpretation unavailable under certain common circumstances; (b) extremely long waits in emergency rooms while a translator is being located; and (c) use of family members, friends, or other untrained bilinguals as interpreters of first resort.
- Cases that reflect inability of providers to offer culturally appropriate services (with respect) to issues of culture or language. This category is the most difficult to define and therefore, the most frequently underreported. "¹

After the study, community awareness of the issues increased, and there was additional demand for interpreters; however, many providers continue to use untrained workers (e.g., housekeeping staff) as interpreters.

The Rhode Island Department of Health (**RIDH**) and PAHCF had just completed a 3 year demonstration program to train bilingual, bicultural patient representatives in maternal and child health (INSEARCH--Increasing Numbers of Southeast Asians Receiving Comprehensive Health Care Services). Health providers acknowledged that their patient outcomes were improved because the trained staff was able to convey how cultural beliefs and practices had an impact on patient willingness to accept Western approaches to medicine.

B. *Role of Minority Groups*

A Minority Health Advisory Committee was created to advise the **RIDH** on issues related to the health status of people of color in Rhode Island. Its function was not specific to the BAP project, but the members did review the curriculum proposal. Their other functions were to develop a status report on the health of minorities with a view toward reducing disparities by the year 2000; they were also charged with determining how to disperse Minority Health Promotion funds received from a sales tax on non-cigarette tobacco. The Committee included twelve representatives of community-based organizations, four health care providers, representatives from Rhode Island Department of Health and Human Services, and a representative of the Rhode Island Foundation.

¹ Medical Interpreters Training Academy proposal (January 13, 1993).

C. *Project Implementation*

The project had two major activities: (1) development of the Medical Interpreter Academy model and curriculum and (2) provision of training to health care providers on the appropriate use of interpreters.

1. Medical Interpreter Training Academy

Providence and the surrounding areas have become increasingly diverse, and trainees were selected to reflect the diverse multi-cultural complexion of the population. Persons interviewed indicated that the composition of the population is ever changing with newly arrived immigrants necessitating expansion of the range of interpreter languages. The target group recruited for training was bilingual persons already engaged in interpreting for health providers, either formally through employment or community service. Also, some administrators managing medical interpretation programs were included. Each person was intended to be literate in English and a second language. While there was an attempt to get an equal representation of language groups, this was not the outcome.

Ninety-three people applied for the training, and twenty five were selected for training by a Review Committee; 23 completed the training.² The ethnic make-up of those accepted was 11 Southeast Asians (Hmong, Laotians, Cambodians and Vietnamese), nine Latinos, three Portuguese, one Armenian, and one Russian. All were employed as medical interpreters, bilingual/bicultural health aides, or program directors. Trainees that were interviewed during the site visit included those of Cambodian, Hmong, Portuguese, and Puerto Rican heritage.

The announcement of the training opportunity was through flyers to health department and social service agencies, the newspaper (published the day before the application deadline) and mainly word of mouth. This approach resulted in the majority of the applicants being from one of the Providence Ambulatory Health Care Foundation Centers; others represented the Rhode Island Department of Health, St. Joseph Hospital, Rhode Island Hospital, the Department of Human Services and the International Institute. Work supervisors of the selected applicants were notified of their employees acceptance into training. The only fee appeared to be a \$15 enrollment fee.

A pre-training questionnaire revealed certain characteristics of the trainees. The length of time the trainees had worked in interpretation ranged from 14 months to 20 years; similarly experience as a medical or bilingual health worker ranged from 2.5 months to 10 years. Most

² Two of the accepted individuals had lied on their application about the nature of their work so they were dropped from the course; if repeated again, the organizers indicated that they would request a letter from the person's supervisor as part of the application for training.

indicated that they used their bilingual skill from 6 to 10 times a day and that their skills are fully used within their work place.

Course content was very comprehensive in view of the limit of 32 class hours. Eight separate presenters gave lectures in their particular areas of expertise. Course content included: medical terminology; basic anatomy and physiology, including body systems and related diagnostic procedures; medical interpreter theory and practice; cross-cultural communication; medical interpretation and the law; domestic violence/child abuse; emergency room; infection control; mental health including psychiatric diagnoses; and death, dying and grieving. Twelve of the 32 hours was spent on medical terminology as it refers to anatomy and physiology, and 9 hours were spent on the role of the interpreter; the remaining topics each received one to three hours. Course content derived in part from evaluation focus groups with the bilingual, **bicultural** workers from the **INSEARCH** (Increasing Numbers of Southeast Asians Receiving Comprehensive Health Care Services) project.

The curriculum manual primarily is a collection of materials handed out for the sessions; the text of the lectures is not available nor are scenarios for the role playing exercises. Students were required to take notes to capture the context of lectures. Many of the materials in the manual are **xerox** copies of copyrighted materials from multiple sources, predominantly anatomical drawings taken from text books. It was up to individual students to construct a glossary of terms in their own language; students were advised to purchase a medical dictionary, but these were not always available in the target languages. In some cultures, the words are not available because the disease is not in the experience and literacy level of the culture (e.g., lead poisoning where the interpreter would have to explain all of the symptoms because there is no specific words for lead poisoning). The manual also included a copy of a code of ethics for medical interpreters adapted from the Code of Ethics of the Registry of Interpreters for the Deaf which deals with issues such as confidentiality.

The training sessions provided the first time for most of the trainees to discuss the actual role of interpreting in a medical setting. They had **many** questions about the role of an interpreter (e.g., should they provide transportation to clients), and their questions suggested that many of them were confused about what that role was. The role as defined in the manual was:

To transmit verbal, non-verbal, factual and affective messages accurately to patients and health care providers who do not share language and/or culture.

The basic method promoted was a triad relationship in which the interpreter keeps a low profile but there is a balance of power among the provider, patient and interpreter as opposed to a dyad relationship where the interpreter is more invisible. An emphasis was placed on the professionalism required of interpreters. As a cultural broker, the interpreter would need to convey not only exact language as spoken by a patient but also its context. For instance in the Hmong and Vietnamese cultures, body organs are often used to define feelings--saying I have a

yellow liver, in one culture, means I am not feeling well, not that one has hepatitis or jaundice. Similarly, in the Vietnamese culture, someone with a bad intestine is perceived as wicked.

Among the trainees interviewed, it was clear that they held different views of the role of interpreter. One preferred being somewhat invisible, only serving as the voice of the patient; the other got more involved, spending five minutes at the outset to get to know the patient, making sure that the patient followed-up with the provider's advice, setting up appointments, and reviewing medications. These approaches may reflect the primary job of the individuals. The former person would be on call to provide interpretation services while the later was more of a **bilingual/bicultural** health assistant who saw health education as part of her duties, especially with older patients.

The Minority Health Advisory Committee had advised that the approach to training should be a "collaborative pedagogy" that would maximize input from participants and trainers as well as illicit strategies from the participants on what works in their daily contacts and expand the bank of approaches each interpreter can call upon in their work. They recommended that training be designed to include practicums in interpreter techniques, triad dynamics, role playing and case studies. While these elements were included the emphasis seemed to be on direct lecturing, which caused problems for some trainees. The structure of the medical interpreter training academy was to have been a series of sixteen two hour training sessions for a total of 32 hours in a lecture/discussion format; while the total number of hours remained at 32 hours, the program ended up being presented in two intensive weekend sessions of full eight hour days. The long weekend hours (8:30--6:00) not only presented a problem for maintaining concentration, but also for securing child care, even though it was partially subsidized. The gap among trainees in terms of medical background, knowledge and education made it difficult for some of the trainees to consistently follow the content during these very long and intense sessions. Our cross-cultural consultant noted that taking educational level and level of acculturation into account are key when designing cross-cultural training programs.

The project organizers found it difficult to negotiate state government procedures in a timely manner to spend money on the trainers, project coordinator, caterer, and ordering the bilingual medical interview tapes. To facilitate payment of child care expenses, money was transferred from the RIDH to PAHCF.

2. Training Providers to Work with Interpreters

The initial proposal was to provide an eight hour training session for health care providers (physicians, nurses and other health support staff) on how to use medical interpreters; but instead the time was cut to two hours to accommodate physicians and fit within the regularly scheduled Grand Rounds at St. Joseph's Hospital. Although the lecture attracted 60 health professionals, they were mainly nurses; physicians remained difficult to interest in cross-cultural medicine.

Interviewees indicated that to a certain extent the training provided for health professionals was like preaching to the choir, as the attendees were the ones already aware of many of the potential pitfalls in communication and were using some of the offered techniques in their own practice. Those interviewed during the site visit suggested that to get more physicians to participate consideration should be given to making training a licensing requirement and/or a requirement for all new residents and interns.

A physician from Boston City Hospital and a developer of the Bilingual Medical Interview videos offered his comments on the importance of the interpreter to health care delivery, their appropriate role, cultural beliefs of different groups, and some of the stereotypes associated with persons having LEP (limited English proficiency). This speaker apparently was very successfully received, with attendees requesting that he return to provide additional lectures.

D. *Funding*

The bulk of the \$14,326 requested was for consultant time (\$11,200). The remainder was for direct training session expenditures (duplication of materials, refreshments and child care). OMH time, space, and ancillary support (secretarial, office supplies, telephone) were in-kind contributions.

E. *Staffing*

The Minority Health Coordinator, had primary responsibility for administration of the project, using consultants to develop and provide the training. She contributed approximately 10 percent of her time to the project. An intern in her office also assisted in organization and evaluation of the program. Her time contribution is not documented.

F. *Technical Assistance*

OMH hired a consulting firm, whose principals served as directors of medical interpretation at Boston City Hospital and University of Massachusetts Medical Center, to develop the curriculum, coordinate and hire the trainers, and provide all of the training. The Rhode Island OMH project coordinator and her intern attended a 3-day training session in Boston conducted by the same consultants. The consultants had the expertise and could pull together the desired program in the short time-frame of the BAP grant.

Although pleased with the training received at the time, the interviewees indicated that if offering a similar session again they would use local people. They thought the expertise to present the subjects covered in the training were available within the community and it would be easier to have access to local people.

G. *Documenting Success*

The three main objectives for this project were:

- To provide training to upgrade the skills of individuals employed as interpreters.
- To provide training for health care providers who work with interpreters.
- To develop resource lists of medical interpreters and to develop a resource bank of materials related to medical interpretation in the Rhode Island Department of Health Library.

The BAP sponsored projects met its objectives in terms of providing the training. The interviewees were not aware of any resource list of medical interpreters that was still in existence.

Evaluation of the Medical Interpreter Training Academy activities focused on the use of pre and post-training questionnaires. Some of the themes that ran through the pretraining questionnaire were the desire to learn additional medical terminology and to be recognized as an important professional asset in the health care field.

- Did the project upgrade the skills of the person employed as medical interpreters? More than half of the trainees responding to the post training survey indicated that the sessions had definitely provided them with skills that could be of immediate use in performing their jobs.³ The remainder indicated that it had "for the most part." There were additional anecdotal reports of OMH having received phone calls from the trainees' supervisors who indicated that there had been a positive effect on the trainees' work; the nature of that effect is not specified. The compressed nature of the workshop exposed the trainees to a great deal of information; how much they were able to assimilate in such a short time and apply to their jobs probably varied from trainee to trainee based on their own motivation and their ability to comprehend the presented materials. Some testing of knowledge appeared to have taken place, because it is listed in the course outline, in certain spots, but no prototype tests are in the manual. One recommendation from the survey responses suggests that testing was not consistently administered for each subject and recommends that there be a quiz after each presentation.
- Did the training help trainees in understanding their roles as interpreters? While improved understanding was not explored in the post testing, the training helped interpreters dispel the feeling of isolation they had in their work. They gained a greater understanding of the role of an interpreter for themselves, and two-thirds indicated that the course had definitely

³ Twenty-one trainees returned the post-training evaluation.

met their learning objectives; and the remainder indicated that it had “for the most part.”

Trainees raised concern about the tempo and scheduling of the course. Trainees “for the most part” recommended that the sessions be kept to 24 hour sessions spread over a longer time-frame; some recommended that it be offered during work hours. The course as presented was a very intense addition to full time jobs during the week. The intensity gave little time to review the materials and absorb it. Some trainees also suggested that additional time could be spent in testing to see if the material was absorbed and more time should be added for discussions and role playing. The trainees felt that instructors created an atmosphere that welcomed questions, but that everyone was aware of the time constraints and that put a damper on questioning. Additional time for sharing may also have reduced the shortcomings noted by survey respondents in the approach to cross-cultural training.

Evaluation of the Grand Rounds presentation, on how to use a medical interpreter, was through the use of pre and post test questionnaires. The seminar was attended by 60 people; 19 completed the pre-seminar form and 14 the post seminar evaluations. Did the presentation improve the skills of health professionals who work with medical interpreters? The pretest answers indicated that the professionals in attendance were already aware of the role of the medical interpreter and concerned about the lack of trained medical interpreters (e.g., provider said “We do not have them available in the facility where I work. Housekeeping is often used. ”). Reasons cited for needing to use trained interpreters ranged from improvement of communication between provider and patient to an interpreter’s ability to save the provider time and reduce the risk of a malpractice incident. What health care professionals found useful about the workshop were statistics on the potential cost savings associated with use of interpreters and different styles of interpreting. Overall, the feedback appeared positive.

H. *Continuation of Effort*

The BAP Project Coordinator left OMH (a one person office) shortly after the completion of the BAP project, and no one replaced her for a year. In the meantime, ideas for continuation fell by the wayside (e.g., forming a Medical Interpreter Association for Rhode Island to end feelings of isolation among interpreters). The training was never repeated; however, at the time of our interviews, OMH, the Providence Ambulatory Health Care Foundation and the International Institute were contemplating putting forth a proposal to revive the idea of training medical interpreters and would seek funds for the planning phase from the Rhode Island Foundation. Their approach to training, however, would differ in that it would place the training within an educational setting (e.g., community college) to ensure accreditation. Among the trainees we interviewed, there were differences of opinion about whether such a program would appeal to them. The interpreter with a college degree was less inclined to enroll in this type of program while the health assistant without a degree indicated that she would prefer taking training that would build toward a degree, with the hope that it would eventually enhance her job prospects and salary.

BILINGUAL ASSISTANCE PROGRAM
EVALUATION

Part II: Assessment of Three Training Curricula

Final Report

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BILINGUAL ASSISTANCE PROGRAM EVALUATION
Part II: ASSESSMENT OF THREE TRAINING CURRICULA

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I. INTRODUCTION

The Disadvantaged Minority Health Improvement Act of 1990 authorized the Bilingual Assistance Program (BAP), a three year initiative to improve the health status of racial and ethnic minorities. The Office of Minority Health, Health Resources and Services Administration contracted with MDS Associates for a two part evaluative study of BAP, that:

- examined the experiences of the BAP grantees and lessons learned for future efforts in this area, and
- assessed training curricula used by three grantees to evaluate and determine the replicability of the training curricula.

Findings from the first part appear in "Bilingual Assistance Program Evaluation: Strategies for Reducing Cultural and Linguistic Barriers to Health Care for Hispanic and Asian/Pacific Islander Populations. " This report contains an assessment of each of the three training curricula (one for cultural competency training and two for medical interpretation).

Based on our review, two of the three curricula have potential for further dissemination although each needs some modification to ensure there are no copyright infringements and careful editing to remove potentially offensive language. We found that:

- The "***Latino Cultural Competency Training***" Curriculum is rich in resources on issues of individual and organizational cultural competence, describes strategies for engaging the **Latino** community in dialogue with health providers, and provides step-by-step guidance on organizing workshops, workshop follow-up, and evaluation.
- "***BASIC INTERPRETING SYLLABUS Medical Terminology***" provides a basic list of Spanish and English vocabulary of anatomy, body functions, dental terminology, and simple signs and symptoms. Guidance for the instructor includes a class by class description, suggestions for role-playing and memorization exercises, and **pre/post** tests.

The third curriculum that we reviewed helped the grantee achieve its objective of upgrading the skills of medical interpreters primarily because of its delivery by a team of qualified instructors. Its brief outlines and dependence on copyrighted materials makes it less suitable for further dissemination. One part of the curriculum does deserve further attention and that is its inclusion of a Code of Ethics for Interpreters which helps set expectations for medical interpretation.

A. Study Grantees

Grantees under BAP conducted a variety of activities directed toward the overall goal of increasing organizational capacities to serve cultural and linguistic minorities. These approaches included development of curricula and conducting training in cultural competence and medical interpretation. Of the five sites in the overall study, three sites incorporated these approaches, including:

- Colorado Department of Health, Migrant Health Program project developed “**BASIC INTERPRETING SYLLABUS Medical Terminology**” and trained bilingual personnel in medical terminology and interpretation techniques for use primarily with the settled out Latino migrant population.
- North Carolina Department of Environment, Health & Natural Resources, Division of Maternal and Child Health project developed and implemented a “**Latino Cultural Competency Training**” curriculum for local health departments in addressing the needs of the migrant and settled out Latino population.
- Rhode Island Department of Health gathered training materials for a Medical Interpreter Training Academy to improve the knowledge and skills for medical interpretation among diverse populations, including Hispanic (Puerto Rican, Dominican, Colombian) and Asian (Hmong, Cambodian, Laotian, Vietnamese) communities.

B. Organization of Report

Our assessment of the three grantee-developed training curricula, draws upon:

(1) information obtained during the site visits on the usefulness of the materials to the grantee and
(2) review of the materials by members of our site visit teams, especially drawing on the knowledge of our bilingual, cross-cultural training consultants. The consultants provided an overall assessment of the curricula based on a framework for evaluating the materials (see Appendix A).

Chapter II describes the individual curricula, evaluates their effectiveness and examines in more detail their potential for replication. Chapter III examines lessons learned from this review to provide guidance for the development of future training curricula.

II. DESCRIPTION AND EVALUATION OF INDIVIDUAL TRAINING APPROACHES

Each grantee developed a training approach designed to address a specific local need. This section presents a brief profile of the training materials and how grantees used these products in training. Each curriculum is then assessed for its potential for further dissemination.

A. **Latino Cultural Competency Training (LCCT) Project** **North Carolina Department of Environment, Health and Natural Resources**

The Women's Preventive Health Services Branch received two BAP grants to: (1) deliver cultural competency training for county health department staff and (2) compile Spanish language health education materials at a literacy level appropriate for the target population. This review focuses on the **Latino** Cultural Competency Training curriculum and how it was used to train local health department staff. A Resource Manual of health education materials was distributed to workshop attendees.

Contribution to Grantee's Objectives:

Four two-day workshops were held around the state, targeting areas where the migrant impact was greatest. Total participants in health related jobs numbered 157. In the month after the workshops, each local health department reported some change in its environment, policies, or resources that would make the health department more culturally responsive. There was not enough time during the grant period to determine if there was an overall change in community reputation of the health department.

Overall Approach to Training:

The LCCT format incorporated a variety of more didactic presentations supplemented with more experiential sessions (e.g., *Convivio* and Talking Circles). Steps were taken to avoid a traditional classroom style workshop by incorporating small group work and activities (e.g., talking to migrants about their experiences, learning Spanish phrases in the transition between sessions, having ethnic food at breaks). The workshops culminated in drafting local action plans for Health Departments to improve the cultural competency of their organizations in delivering services to migrant and settled out Latinos. The workshop had a \$25 registration fee for health department participants. **Latino** community representatives who shared their experiences in the Talking Circles received a \$40 honorarium to cover transportation and child care costs. Other **Latino** community members were invited to the *Convivio* social event without charge.

Curriculum Content:

The curriculum package is a rich resource of materials related to issues of individual and organizational cultural competency and fully describes the training approach. Additionally, the curriculum contains strategies for engaging the **Latino** community in a dialogue with health providers and step-by-step instructions for planning and conducting a workshop, information on workshop follow-up, and suggestions for evaluation. The curriculum also includes guidance for compiling a Resource Manual of Spanish/English health education materials and a Participant's Guide, essentially a compilation of handouts from the LCCT curriculum for workshop participants.

The first day agenda covers:

- A Framework for Cultural Awareness;
- Hispanics: Demographics, Health Status, Access to Care, Health Behavior Information;
- **Latino** Cultural Values/Guidelines for Interpersonal Relationships; and
- Stereotypes and Prejudices.

These presentations were attended by health department staff and others in similar service delivery organizations. The curriculum guide contains directions for each presentation, outlining its objectives, physical setting of the room, time requirements, audiovisual materials, handouts, procedures, and commentary for session facilitators, and additional background information and resources. Each slide for overhead projection comes with additional commentary for the presenter.

At the completion of the first training day, a *convivio* was held; *convivio* is the term used in rural Mexico to connote a gathering and sharing/conversation among people in a **community**. The *convivios* also gave the health department a chance to support local **Latino** merchants by using their services for ethnic food and music; organizers also saw them as "important allies in recruiting and advertising the social event." The *convivios* were open to a wider audience of people than just those participating in the workshop, usually twice the number. Its purpose was to allow health department staff and the **Latino** community to interact in a different setting and build bridges that would facilitate more open communications.

On the morning of the second day, a few selected community members came as "invited guests" to share with **health** department staff in "Talking Circles" typical working and living experiences and the problems (including language) encountered in accessing health care. These sessions were conducted in both Spanish and English. The curriculum guide includes: a set of suggestions on how to recruit and recognize community members and (2) a copy of the list of questions (in both Spanish and English) that the community participant received in advance to

prepare her or him for what might be asked in the workshop. Participation by the affected community persons (i.e., non-English speaking migrants who had trouble accessing health care) was a central part of the approach. In the planning stages, LCCT Advisory Committee members had been unsure whether it would be worth the time investment to identify and recruit Latino community members and whether they would share enough to provoke meaningful discussions. The workshop evaluations indicated that these sessions were among the most valuable and meaningful.

The afternoon of the second day was dedicated to how to evaluate whether an organization is culturally competent and to draw up local action plans for each Health Department or participating organization. These sections in the curriculum are fully supported with procedural details, handouts and references.

Trainee Qualifications and Training Accomplishments:

The target audience for training was health department staff at various levels. In an effort to effect longer term organizational change as opposed to changing the attitudes of individuals, the project staff tried to attract policymakers (e.g., local Health Department Directors); unfortunately there is no breakdown on what type of personnel attended. Following the advice of COSSMHO, planners tried to have participation in the first invitational workshop be 50% Latino and 50% non-Latino to enhance the cross-cultural experience, but this was difficult to achieve; the perception of the local Health Departments was that Latino Cultural Competency Training would only be valuable to non-Latino staff. Registration for subsequent sessions was on a first come, first served basis so there was no ability to ensure the registration of a certain percentage of Latinos.

The effect of the workshop on individual knowledge gains, as evaluated by pre and post tests, showed statistically significant changes in knowledge of Latino culture and health beliefs and decision-making for specific health care scenarios. When responses were categorized by type of position, the medical group had the lowest pre-test-scores, and the greatest improvement after training. Similarly, responses among those who were not bilingual or had never had any cultural competency training also showed greater improvement over their comparison groups (bilingual persons, those previously trained).

Trainee Assessment of Curriculum

During the site visit, we interviewed one trainee. He found the workshop a positive, energizing experience, particularly the interaction with the community. The project's final report documents similarly positive comments from community representatives, Advisory Committee members, and health department staff. For example, from a community representative:

“This has been a very good experience for me, I am glad I came. I hope I have been of help to you, because it has been a great help to me. This is the first time,

since my wife and I had the bad experience, that I have had the opportunity to openly express my feelings and frustrations about health services in the area.”

Health Department staff said:

“Program convinced me of things I need to change.”

“The morning sessions with locally settled or migrant Latinos were especially valuable to help ease the ‘fear of the unknown’ of dealing with people who are different. ”

“My desk faces the front door of the clinic and in the past, whenever I have seen someone who looks like they speak Spanish come through the door, I confess that I would look down and try to avoid them.. *sometimes* I’d even get up and leave. I didn’t know any Spanish and just didn’t know how to help them. But in the last two days, I see that they are people too.. *they* have feelings and needs too, just like us. And they can read body language and can tell if someone cares, even if that person doesn’t speak Spanish. So after today, when I go back, when I see someone who looks like they speak Spanish come through the door, I will look right at them and give a big smile.. *even* say “Hola! . .I will try to let them know through my body language that I care about them and will try to help them the best I can!”

These quotes demonstrating changes in attitudes are perhaps even more telling of the impact of training than the statistical analysis of knowledge gains.

Technical Assistance Received During Development

The state agency engaged a self-employed training consultant to develop the cultural competency curriculum and organize the workshops. The Project Director and the training consultant gathered resources and advice from a variety of places (ASTHO, COSSMHO, Project REACH, North Carolina Primary Health Care Association, Area Health Education Centers, and University of North Carolina (UNC) School of Public Health among others). UNC helped draft an agenda for training that would meet the content requirements for continuing education credits. The curriculum acknowledges the contributions of these various contributors, and provides a list of resources with addresses and telephone numbers for others to obtain similar resources.

Consultants' Review Comments:

The curriculum approach is very worthwhile, but is very labor intensive. Substantial effort needs to go into ensuring participation of the target community of Latinos and to developing a sufficient number of trained facilitators for each of the workshop sessions, particularly the bilingual small group sessions with community representatives.

The fact that community representatives had an opportunity to express their feelings about the way they receive services from the local health providers is significant. Rarely are these individuals allowed to articulate to providers the importance of body language, overt and covert discrimination, and difficulties that arise from language barriers. Providing such mechanisms proves to be empowering for the community persons involved in the process. Trust is built. The word is spread. Barriers come down. Cooperative efforts emerge. Local health departments could have further capitalized on this dialogue by building in follow up with the community representatives. Some thought could have been given to how to engage these individuals further as patient advocates or as a member of a patient advisory committee. Failure to have any sort of follow up could convey a sense to these individuals that they did not do a good job.

The experience of participating in the workshops presented an unusual opportunity and challenge for community representatives. Since the success of the second day is so dependent on community participation, this is an area of the curriculum that could benefit from additional guidance. Despite the months of community liaison that went into the identification of representatives of the community willing to participate actively in the workshops, there was only one representative of the migrant community per breakout group. That could be fairly intimidating for anyone, let alone one whose language is not the same as most of the group. The ratio of community persons to training participants (1 to 8 or 10) within the Talking Circles should be changed to have two community representatives to make the situation more comfortable for them. Some type of orientation for community representatives should be built into the process; just providing a copy of questions to anticipate in the workshop is not really sufficient. Without adequately priming community representatives, workshops could be failures. One approach would be to have a focus group with community representatives to familiarize them with the intent of the workshop and allow for "leaders" to emerge naturally who would feel comfortable talking at a workshop.

Similarly, the facilitators/translators need to be committed to substantial preparation, be bilingual, and be skilled in group dynamics not just lecturing. The curriculum provides background reading suggestions and extensive notes for the facilitator(s) to prepare them for their sessions, but the facilitators/translators would benefit from group training prior to the workshops. In North Carolina, most of the facilitators served on the Advisory Committee and had a vested interest in project success.

The need for translation in the sessions with community representatives poses some additional considerations. One is time since conducting a bilingual session takes much more time. But perhaps more importantly, translators must avoid putting their own spin on the dialogue. For example, in one session a participant commented that some of the facilitators "re-interpreted" participants' statements in an effort to dwell on the negative experiences. Many participants recommended expanding the time available for sessions including the community representatives because translating is time consuming. Also introductions in a large group session took 45 minutes, eating away valuable discussion time.

The overall project would have benefitted from more structured follow-up (e.g., a half-day session three to six months later) to ensure both the retention of cultural competency knowledge and skills by individuals and the effectiveness of the local action plans on health departments. Evaluation of participant's immediate individual gains in knowledge is well documented based on a comparison of the pre/post tests, but participants received a lot of background materials to expand their understanding of cultural competency that could not possibly be read until after the workshop; scheduling a follow-up would ensure time to digest these materials and allow a forum for participants to raise issues that they encounter in the literature and their work experiences after training. Only minimal anecdotal information is available to demonstrate whether the local health department action plans met with much success.

The cultural issues, as related to newly immigrated populations, are generally current and accurate as they tend to change little over time. However, some of the resources mentioned in the Resource Manual and Curriculum may no longer be available or have been updated. For example, the ODT materials on cultural diversity cited in the curriculum underwent revision in 1995. One shortcoming in presentation of materials is that there are no answer keys or much information on how individual answers were processed regarding participants' self-assessments of cultural competency and sensitivity. Even the pre/post test for assessing participants gains in knowledge from training does not have a key.

Potential for Replication:

The LCCT curriculum guide has potential for further dissemination of its training approach. As noted in the consultants' comments section, there are a number of enhancements that would make the curriculum even more appropriate although on balance it has many more strong points than drawbacks. The enhancements that would make replication more successful would include: pretraining for facilitator/translators, focus groups and/or orientations for community representatives to prepare them for the experience, and increasing the time allotted to translated sessions.

While much of the guide is Latino and health care specific, many of the resources cited and the approaches used can be applied both to other cultures and to other social service arenas. Particularly attractive features of the project are the outreach to local communities and the attempt to take the learning experience of the workshop further by developing local action plans for changing health department culture. The social aspects of a *Convivio*, under whatever name applies in a community, can be adapted to many different cultures, giving the community and providers the opportunity "to break bread together." The Resource Manual of Spanish/English health education materials could be replicated easily although using focus groups in the community would help identify any language differences or adaptations that would need to be made to the materials.

Across all of the projects, we have observed that grantees make use of pre-existing materials (e.g., videos, journal articles, anatomical drawings). This allows the grantees to avail

themselves of the expertise of others without having to develop all of the materials themselves, but it does create problems for replication. The LCCT guide contains numerous materials which originated from other sources; each of these must be checked to ensure that appropriate permissions for use have been obtained. During our review, we inquired about the potential for use of three materials included in the curriculum. Each publisher had a different approach.

- The materials, Towards a Culturally Competent System of Care,¹ produced by the Georgetown University Child Development Center, are copyright free; they only request that the source of the materials be cited.
- For use of Strategies for Working with Culturally Diverse Communities and Clients, the Association for the Care of Children's Health requires a written request describing the audience it will be used for and if any payment will be received for its use elsewhere.²
- ODT gives permission to reproduce instruments (e.g., self-assessments for "When I Belong to the Dominant Culture" or "Transcultural Communication Skills" only to each organization that purchases the \$99 The Questions of Diversity volume and that permission only allows copying privileges for internal diagnostic work.³

The North Carolina project might have purchased these materials and secured permission to use them in the four workshops they held, but this permission would not extend to any other organization that used the LCCT package. The ODT materials would need to be removed from the curriculum and referenced appropriately. Similar restrictions may apply to other documents.

B. Health Access by Language Advocacy (HABLA) Colorado Department of Health, Migrant Health Program

The Migrant Health Program received two BAP grants to: (1) develop and deliver medical interpreter training for Hispanics and (2) train health providers in cultural competency. This review focuses on the medical interpretation curriculum, "**BASIC INTERPRETING SYLLABUS Medical Terminology**" and how it was used to train bilingual personnel in medical terminology and interpretation techniques for use with Spanish-speaking "settled out" populations. The project location was Delta (Colorado), a rural community on the western slope of the Rockies.

¹ Towards a Culturally Competent System of Care. Volumes I & II. December 1991. Available from CASSP Technical Assistance Center. Center for Child Health and Mental Health Policy. Georgetown University Child Development Center. 3800 Reservoir Road, NW, Washington, DC 20007. (202)-687-8635. Mary Deacon's office.

² Permission requests should be faxed to (301) 986-4553. The author Elizabeth Randall-David is listed as a collaborator on the LCCT project.

³ as advised by Dr. Bob Abramms, ODT. (413) 549-1293 or (413) 549-3505 or 1 (800) 736-1293.

Contribution to Grantee's Objectives:

Two training sessions using the curriculum were held, training a total of 18 bilingual (Spanish/English) persons. From the beginning, the Local Advisory Committee stressed that they wanted to train people who would be highly employable so that the HABLA program would have lasting value. The project exceeded the employment goals it set for itself by finding jobs for 5 of the trainees in medical clinics, the county nursing service, the local hospital and the county health department.

Overall Approach to Training:

The HABLA curriculum stressed medical terminology and a professional interpretation style that allowed face-to-face contact between client and provider. The course was a combination of 27 hours of classroom work and a four hour supervised interpretation internship during actual provider/client encounters. The **Delta/Montrose** Vocational Technical Training Center provided the site for training; this required charging tuition even though the **BAP** grant covered the instructor's salary. To make tuition bearable for the target population of trainees (i.e., under \$100), the number of class hours had to be limited to 27. Most of the trainees received tuition assistance and child care support either directly from **BAP** funds or vocational training funds from Rocky Mountain SER (Service, Education and Rehabilitation).

Curriculum Content:

The curriculum employs a variety of techniques including: (1) learning Spanish and English vocabulary of anatomy, body functions, dental terminology, and simple signs and symptoms; (2) memorization exercises; (3) role playing as providers, patients, and interpreter; and (4) videotaping interpretation skills of students. The same pre and post tests measured student progress in learning medical terminology.

The manual "*BASIC INTERPRETING SYLLABUS Medical Terminology*" was only the starting point for the course. The trainer encouraged participants to share words and expressions in different dialects⁴ during class discussions and add/modify words and expressions in the vocabulary list. The video, "How to Use Interpreters' Services"⁵ was used to demonstrate interpretation style.

⁴ Participants had experience with different dialects through family members, neighbors, or friends who came from different areas of Mexico.

⁵ **Bustamante**, Duran, Rios, Mesiter and Abril. How to Use Interpreters' Services (video-22 minutes). Arizona Area Health Education Center Biomedical Communications, University of Arizona Health Sciences Center (Tucson, AZ 85724).

Trainee Qualifications and Training Accomplishments:

All trainees were to be bilingual, already have experience interpreting, and have at least finished high school. The final report contains no overall analysis of **pre/post** test knowledge gains by trainees to determine the effectiveness of the program components; however, learning by individual candidates was assessed primarily according to:

- **pre/post** tests of medical terminology, and
- instructor observation of trainees in a classroom setting and during the 4 hour supervised internship.

A student had to obtain a passing grade of 80 percent to receive a certificate of achievement; a variety of criteria (attendance, worksheets, quizzes, videotaping, observations and final exam) made up the **final** grade. Two students received certificates of attendance rather than certificates of achievement because their Spanish was deemed insufficient. One student, a Cora Indian, dropped out of the course because of insufficient knowledge of Spanish and English to keep up with the pace of the classes.

Trainee Assessment of Curriculum

The three trainees interviewed during the site visit have very positive recollections of the course, training methods of the instructor, and the camaraderie of the classroom sessions. The trainer's encouragement to share their own knowledge of words and experiences enhanced the trainees' confidence to explore various ways in communicating with patients until they would be able to find words a patient could understand. Former students did raise practical issues with respect to the role of an interpreter that were not addressed satisfactorily in the course. These included: responsibility for transporting clients and the associated liability; and consideration for cultural norms (e.g., a woman translator whose husband found it unsafe or inappropriate for her to transport male clients/patients from one location to another).

Technical Assistance Received During Development

The Migrant Health Program office hired two local residents of the Delta area to develop the curriculum and provide the course for interpreter training. The Project Coordinator was a retired dentist with knowledge of training programs from his career in the Air Force but limited knowledge of Spanish; the curriculum developer and Interpreter Trainer was bilingual and an LPN. The Interpreter Trainer, who would develop the syllabus, was able to attend a training course for interpreters in Denver given by the Asian Pacific Center. The Migrant Health Program office in Denver and the Area Health Education Center provided ideas for resource materials, including videos used. The Delta/Montrose Vocational Technical Training Center Nursing

Director give advice on how to structure the interpretation course to meet certification requirements and also provided access to medical illustrations, books and anatomical models.

Consultants' Review Comments:

The syllabus indicates “the course was intended only to provide instruction in basic interpreting skills and an introduction to basic terminology in both English and Spanish.” The curriculum is adequate to meeting these basic objectives, and the vocabulary is accurate; however, it must be emphasized that the overall scope is very limited. While the 27 hour course time limit may have contributed to some of the limitation in scope of content, other shortcomings in the curriculum package appear due to lack of documentation of what occurred during classroom sessions.

During class sessions, the instructor recognized the “expertise” of the indigenous participants by encouraging them to expand the core, more standard Spanish medical terminology. This is a positive approach to gathering various dialects in use in the community. Unfortunately, the manual does not reflect any revisions in terminology based on this input; capturing this dialogue would have significantly enhanced the medical terminology beyond a typical Spanish/English medical dictionary. Similarly, better documentation of classroom role-playing activities, in the manual or with an accompanying videotape would have benefited replication in other settings.

The emphasis of the terminology and the role-playing exercises in the manual is on the patient making themselves understood to the physician and nothing with respect to physician communication back to the patient. For example, there are no words or scenarios dealing with relatively common procedures (e. g. , immunizations, pap smear, ultrasound, operation/surgery).

Although trainees indicated that confidentiality issues had been discussed, the curriculum manual contains very little guidance in this area. While this is a concern anywhere, the small town atmosphere makes it imperative that confidentiality procedures be incorporated and emphasized. On one hand, it is extremely positive to train and hire individuals who come directly from the target population (they know the language, culture, and major issues), but on the other hand, these are the neighbors, friends and acquaintances of the patients.

Because the scope is so basic, it would appear current. However, there are additional issues that might have enhanced applicability to a migrant population (e.g., exposure to pesticides, emerging problems of abuse and HIV/AIDS).

Observations based on personal judgements by the Project Director and Interpreter Trainer appeared to be influential in which trainees were placed in jobs. The candidates observed to be most promising were referred to jobs through an informal communication network. This is a very small town, and informal communications appear to work well among the mainstream providers although this system may not work as well in other environments.

The needs of the Cora and Huichol Indian members of the migrant community were not able to be addressed by this curriculum. Because, in general, neither population speaks sufficient English and/or Spanish to keep pace with the level of instruction, the one Cora recruit to the course dropped out without finishing. A more individualized and slower pace might have made the medical terminology more accessible to this population as would having an instructor who could communicate in their dialect.

There are a few elements of final presentation that deserve mention: use of anatomical drawings, potentially offensive statements, and misspellings. The manual includes anatomical reference drawings **labelled** in English and Spanish. The sources for these drawings are not listed; we were told that the developer did not use copyrighted materials although it is evident that they were copied and modified from reference manuals.⁶ Without the sources, we cannot verify that these are without restrictions. Several statements in the instructions and materials are somewhat condescending and perhaps offensive. In Exercise #4 Possible Pregnancy, the instructions tell the interpreter to “repeat to the nurse what the patient said, no matter how ridiculous (sic).” One of the issues stated in the manual related to professionalism for interpreters is, “It is also expected that dress and personal hygiene will be such that no one with whom they come in contact should be offended by their presence.” Similarly the sample job description includes (sic):

“a. Dress: Clothing must be neat and Clean when providing services.

c. Personal Hygiene: Interpreters are expected to have bathed recently enough that Body Odors do not interfere. ”

There are a number of misspellings in the document (e.g., **quizes**, mamograms).

Potential for Replication:

The curriculum is probably most applicable where the goal is to enhance very basic Spanish/English medical terminology for persons serving **Latino** clients. All of the trainees who successfully completed the course were fluent in English and Spanish. The manual could serve as a jumping off point for incorporating the dialects of the particular population in whatever community it was used for.⁷ The “**BASIC INTERPRETING SYLLABUS Medical Terminology**” manual, however, needs the support of: the video “How to Use Interpreters’ Services” which provided the basis for teaching the mechanics of interpretation (e.g., where to stand; style and role of interpretation); (2) a book such as Que **Paso? An English-Spanish Guide for Medical Personnel**

⁶ We were not able to interview the curriculum developer despite numerous phone calls and letters. We were told that she had wanted to copyright the manual herself and was not happy with the Migrant Health Program’s stance that the manual should be copyright free and be available to all.

⁷ If the syllabus were revised, space should be allocated in its design for the students/instructor to fill in words of different dialects.

which would help trainees in developing role playing and provide a reference once working; and (3) more complete confidentiality and ethical guidelines for interpreters.*

**C. Medical Interpreter Training Academy
Rhode Island Department of Health, Office of Minority Health**

The Rhode Island Office of Minority Health (OMH) received the BAP grant to:
(1) implement a Medical Interpreter Training Academy which would provide bicultural, bilingual interpreters with more formalized medical knowledge and clarification of their role as an interpreter, and (2) provide in-service training for health professionals on effective use of interpreters. This review focuses on the curriculum developed for use in training medical interpreters serving the diverse cultures of Rhode Island.

Contribution to Grantee's Objectives:

The state had never held a medical interpreter training program prior to the BAP initiative. The Medical Interpreter Academy provided training to one group of interpreters. Of the 25 selected for training by a Review Committee, 23 completed the training. The ethnic make-up of those accepted was 11 Southeast Asians (Hmong, Laotians, Cambodians and Vietnamese), nine Latinos, three Portuguese, one Armenian, and one Russian.

Overall Approach to Training:

The structure of the medical interpreter training academy was two intensive weekend sessions (totalling 32 hours) primarily in a lecture/discussion format with some role playing and viewing of videos. The training academy had a \$15 enrollment fee; students received a stipend to help defray transportation and child care costs.

Curriculum Content:

Course content was very ambitious in view of the time limit. Eight instructors covered: medical terminology; basic anatomy and physiology including body systems and related diagnostic procedures; medical interpreter theory and practice; cross-cultural communication; medical interpretation and the law; domestic violence/child abuse; emergency room; infection control; mental health including psychiatric diagnoses; and death and dying and grieving. The major emphasis of the training was on medical terminology (12 hours) and the role of the interpreter (9 hours). Very brief outlines of lectures are available for the topics. Copies of materials for transparencies (primarily anatomical drawings) address medical terminology as it relates to basic anatomy and physiology. A collection of pertinent journal articles provide background

⁸ Confidentiality regulations differ by state, but the curriculum still would benefit from a more complete discussion.

information on medical interpretation. One notable part of the curriculum package is a Code of Ethics for Interpreters.

Trainee Qualifications and Training Accomplishments:

Trainees were selected to reflect the diverse multi-cultural complexion of the Rhode Island population. All of the trainees were employed as medical interpreters and **bilingual/bicultural** health aides or program directors; each person was also intended to be literate in English and their native language.

Review of the application questionnaires revealed certain characteristics of the trainees. The length of time the trainees had worked in interpretation ranged from 14 months to 20 years; similarly experience as a medical or bilingual worker ranged from 2.5 months to 10 years. Most indicated that they used their bilingual skill from 6 to 10 times a day and that their skills were fully used within their work place.

Some, but not all, of the topic sessions had **pre/post** testing of knowledge gained. No results from these tests are available to determine the effectiveness of the course approach in increasing knowledge or skills.

Trainee Assessment of Curriculum

Evaluation focused on trainee perceptions of the adequacy of topics and presenters. Some of the themes that ran through the pretraining application were the desire to learn additional medical terminology and to be recognized as an important professional asset in the health care field. The training sessions provided the first time for most of the trainees to discuss the actual role of interpreting in a medical setting. In a post-training evaluation, trainees indicated that the sessions had definitely provided them with skills that they could immediately use in performing their jobs; however, what these skill were are not specified. Given the compressed nature of the workshop, trainees expressed difficulty in assimilating so much information in such a short time.

Technical Assistance Received During Development

The BAP OMH Project Coordinator, after attending a 3 day training session on cultural competency and medical interpretation conducted in Boston by a consulting firm, hired these same consultants for the BAP project. The consultants, as directors of medical interpretation at Massachusetts hospitals, had the expertise to pull together the desired program and team of trainers within the time constraints.

Consultants' Review Comments:

The differential among trainees in terms of medical background, knowledge, education, and language ability made it difficult for some of the trainees to follow the content consistently

during the very long and intense sessions. Taking educational level and level of acculturation of trainees into account are key when designing cross-cultural training programs.

The lecture/discussion format conveyed a great deal of information on a broad range of issues, but for trainees whose English language skills and formal education (e.g., knowledge of biology and medicine) is limited, the methods may not have been effective. The manual contains no copies of **pre/post** tests of knowledge for specific topics; also there is no documentation of specific knowledge gained and retained by individual students or overall. In the planning stages, the state Minority Health Advisory Committee had advised that the approach to training should be a “collaborative pedagogy” that would maximize input from participants and trainers as well as illicit strategies from the participants on what works in their daily contacts and expand the bank of approaches each interpreter can call upon in their work. Training should be designed to include practicums in interpreter techniques, triad dynamics, role playing and case studies. While these elements were included to a limited extent, the time pressures apparently forced more emphasis on lecturing and notetaking. The cultural knowledge that each of the attendees came with was not well tapped; increased peer interaction and sharing could have enhanced the experience. Actively engaging trainees rather than having them be passive recipients would have better prepared them to be peer educators when they returned to their workplace.

The trainers appeared to be either from mainstream or Hispanic cultures. Professional technical information was well presented, but lack of understanding of the multiple ethnic communities could have been a barrier. The ethnic make-up of this group of trainees was 11 Southeast Asians (**Hmong**, Laotians, Cambodians and Vietnamese), 9 Latinos, three Portuguese, one Armenian and one Russian. The materials on culture tended to generalizations; more information on health care practice, traditions and beliefs should be gathered to address the diversity of the training population. It can be more useful to use specific vignettes than generalizations. For example, there are substantial differences between the life experiences of persons coming from Vietnam now compared to those who spent years in refugee camps. Some of the journal articles provided to trainees are more than ten years old, but they still contain helpful vignettes to use in discussion issues surrounding interpretation. The articles, however, tend to focus more on Latinos than on Asians.

The curriculum manual primarily is a collection of disparate materials rather than a cohesive document; there are no notes for facilitators. A few but not all of the lectures have outlines of the topics. Most of the materials for transparencies are anatomical drawings from copyrighted textbooks or from unidentified sources. There are no scenarios for role playing exercises.

Potential for Replication:

The consultants engaged by the Rhode Island Office of Minority Health had the expertise to deliver the training, but the package of training materials does not lend itself to replication by others. It cannot stand alone. Replication would have been easier had there been a guide to demonstrate how to use the handouts, more detail on the training content, and better documentation of resource materials.

III. LESSONS LEARNED

Examination of grantees' experiences in developing and implementing their curricula yields some lessons that should be taken into consideration in the development of future training endeavors. The three curricula examined are:

- The Colorado HABLA medical interpretation curriculum, "**BASIC *INTERPRETING SYLLABUS Medical Terminology.***"
- The North Carolina **Latino** Cultural Competency Training (LCCT) Manual.
- Rhode Island Medical Interpreter Training Academy curriculum.

First, we discuss the factors that appear to enhance development of a curriculum suitable for dissemination. Then we explore issues related to making training curricula more linguistically and culturally appropriate.

A. **Developing Curricula Suitable for Dissemination**

Determining whether a curriculum is suitable for dissemination requires looking at the materials from several perspectives:

- Does the curriculum help the organization achieve its objectives?
- How is the effectiveness of the curriculum assessed?
- What are the characteristics of the projects that lend the materials to further dissemination?

Discussion of each of these issues follows.

1. *Achievement of Grantee Objectives*

All of the grantees met the training objectives that they set out for themselves. The scope and approach of each curriculum varied although all were generally constrained by a class time total of 16 to 32 hours. Grantees indicated that these curricula were integral to accomplishing their project objectives. For example,

- Eighteen bilingual persons received training in basic Spanish/English medical terminology and interpretation using the HABLA curriculum. The training provided students with a credential for a resume and connection to a job placement network which resulted in at least 5 trainees finding jobs in medical clinics, the county nursing service, the local hospital and the county health department.

- One hundred-fifty seven persons in the health field, primarily from local health departments, received the **Latino Cultural Competency Training**. The process focused attention on changes local health departments could make to improve effective access to medical care for migrant and settled out Latinos.
- The state of Rhode Island had never had a medical interpreter training program prior to the BAP initiative; 23 medical interpreters from diverse ethnic groups upgraded their job skills.

2. *Assessing the Effectiveness of the Training Curriculum and Approach*

Determining whether the curricula were effective requires deeper probing of outcomes. First, did the training increase trainee knowledge and cultural competence? Secondly, did training appear to increase client access and comfort level? Grantees were better able to approach assessment of the first question rather than the second.

Projects employed the following techniques to ascertain what knowledge trainees had gained: (1) **pre/post** test comparisons (Colorado, North Carolina); and (2) observations during classes and internships (Colorado). Both of these techniques are valuable, but their helpfulness depends in part on the skill of the person developing the test or doing the observation. It appears that grantees would benefit from technical assistance in crafting evaluation instruments. The focus of post-training evaluation needs to be on ascertaining whether specific knowledge and skills are gained not just whether one speaker was better than another. However, the latter information has value particularly when a workshop is to be repeated, but it does not allow assessment of the effectiveness of training program outcomes on individuals. Projects approached these assessments differently:

- The Colorado project followed a traditional classroom grading approach which did capture the specific gains in vocabulary; the internship appeared very beneficial in determining how a trainee would react in a real world encounter. All but three of the 19 trainees enrolled in the Colorado project met the passing grade of 80 and received certification from a local vocational training institution.
- The Rhode Island post-training questionnaire only asked a global question of whether the training would be of immediate help to the trainee in performing his/her job responsibilities. Fifty-seven percent answered definitely, and the remainder said "Yes, for the most part." **Pre/post** tests were used for some but not all of the topics presented, but there was no reporting of the results in the final report.
- In the North Carolina **Latino Cultural Competency** project, comparisons of pre and post tests showed improvements in knowledge of **Latino** culture and health beliefs and decision-making for specific health care scenarios. The North Carolina project had a sufficient critical mass of trainees (157) to examine subsets of data although only the medical group

showed a statistically significant gain in knowledge. Besides these instructor evaluations of trainees, trainees provided feedback on workshop faculty, facilities, program content and teaching methodologies.

It is not possible from these projects to assess trainee retention of the materials over the longer term; a lot will depend on individual trainee motivation to review materials presented in the very intense, time-limited sessions and to read additional resource materials. None of these projects had any type of structured follow-up. Participants indicated a desire for further training, particularly among the medical interpretation programs.

Measuring improvements in client access is even more difficult, particularly for these training projects. Overall, time constraints of the grant period did not leave sufficient time for changes attributable to training to be observed and measured. A further difficulty is that the trainees were not all part of a single organization so that the change in culture of a specific organization would not be as apparent. The projects relied primarily on anecdotal evidence to suggest improvements. Some of the projects developed interesting ideas for measuring improvements in access and comfort level such as:

- Placement of bilingual personnel in the **office** of certain Colorado medical providers would appear to improve the comfort level of limited English speaking clients. The project planned to study changes in medical appointment no-shows, pre and post placement of the bilingual personnel.
- Local health departments in North Carolina reported some changes after cultural competency training (e.g., obtaining further training in Spanish, use of Spanish health education materials). Project organizers also planned to document whether there was any change **pre/post** training in the community reputation of the local health departments.

Neither grantee implemented the more detailed evaluations because of time constraints. It appears that grantees need a longer grant period than the typical 3 to 8 months allotted to BAP projects to conduct this type of evaluation.

3. ***Characteristics of Projects that Lead to Replicable Materials***

Three factors would appear to contribute to the projects producing materials ready for further dissemination.

- ***Develop materials with replication in mind.*** Curriculum guides are more finished looking products containing both course content and instructions for facilitators/trainers to use in implementing the course.
- ***Conduct the training more than once.*** When training was repeated, it gave developers more opportunity for evaluation and modification of materials.

- **Obtain assistance from someone with expertise in training.** A consultant/staff person with experience in the delivery and evaluation of training was involved in development and/or the training; some developers received assistance from an educational institution who helped structure course requirements for credit (college/continuing education).

The extent to which others have adopted the curricula developed under the BAP programs is not known as there is no way to track this over time. But we do know that the grantees themselves had successes and failures in trying to reach more than one group of trainees. Success appeared related to:

- leadership in recruiting both trainees and a network of supporters;
- a population of potential enrollees who recognized the need for the training; and
- availability of tuition support and other funds (e.g., child care, transportation) particularly when recruiting clients with lower socioeconomic means.

For example, the North Carolina Latino Cultural Competency Training project received a second phase of funding to extend the training to three additional sites. They had already garnered the cooperation of various state offices, AHECs, Primary Care Association and others through their Advisory Committee; many of these Advisory Committee members vested considerable time in the implementation of the project by serving as instructors. The inclusion of representatives of AHECs and University of North Carolina School of Public Health on the Advisory Committee helped establish a ready made network for replication around the state. The LCCT had a willing audience in local health department staff because in their yearly assessment of training needs, the health department had placed a high priority in learning how to serve the Latino community.

An issue for HRSA to consider is whether development of a curriculum for use in multiple sites is more desirable than use in only a single site. Preparation by local grantees of a model document suitable for dissemination may require: (1) a greater dollar investment in development of a finished product; (2) a longer grant timeframe for development, testing, and evaluation; and (3) support for technical assistance in curriculum design, material development, evaluation and dissemination strategies.

Recommendation: *If HRSA wishes to continue to support local development of diverse approaches to training, it might consider continuing separate funding phases. Phase one would be to develop and test the curriculum at least once; Phase two funding would be contingent on the suitability of the prototype for further development and replication as well as polishing the curriculum package into a product suitable for dissemination. Grantees should have structured evaluation of training outcomes both immediately post-training and 3 - 6 months later. National Minority Organizations, AHECs training institutions, or contractors might assist grantees in developing evaluation tools and producing products for dissemination, especially when techniques such as developing videos might be appropriate. Alternately, HRSA might review and endorse*

curricula that are already available (e.g., through national minority organizations, or consultants already experienced in specific subjects such as medical interpretation) and foster replication of these thus spending less time in development activities for those languages and cultures that materials are more readily available.

4. Potential for Disseminating Reviewed Curricula

Two of the three curricula reviewed have potential for further dissemination although, at a minimum, each needs some modification to ensure that there are no copyright infringements (Colorado, North Carolina) and careful editing to remove potentially offensive language (Colorado). In summary,

- The **Latino Cultural Competency Training (LCCT) Curriculum** is rich in resources on issues of individual and organizational cultural competence, describes strategies for engaging the **Latino** community in dialogue with health providers, and provides **step-by-step** guidance on organizing workshops, workshop follow-up, and evaluation.
- **“BASIC INTERPRETING SYLLABUS Medical Terminology”** provides a basic list of Spanish and English vocabulary of anatomy, body functions, dental terminology, and simple signs and symptoms. Guidance for the instructor includes a class by class description, suggestions for role-playing and memorization exercises, and pre/post tests.

The third curriculum that we reviewed helped the grantee achieve its objective of upgrading the skills of medical interpreters primarily because of its delivery by a team of qualified instructors. Its brief outlines and dependence on copyrighted materials makes it less suitable for further dissemination. One part of the curriculum does deserve further dissemination and that is its Code of Ethics for interpreters.

There are still improvements that can be made to both the LCCT and Interpreting Syllabus. The North Carolina materials are quite detailed; this appears to be due to the project director’s experience as a director of training and her foresight in setting aside time after each of the workshops (four in total) for reviewing and updating the materials with all of the course facilitators/lecturers. Recommendations on enhancements to this curriculum are noted in Chapter II. The Colorado HABLA Interpreting Syllabus does not capture the entire dynamic of the classes offered and does not fully support the discussion of the role of an interpreter without the aid of a referenced video.

Recommendation: HRSA could consider dissemination of the LCCT and HABLA materials after modifications are made to address the issues raised in Chapter II with respect to the materials.

B. Developing Linguistically and Culturally Appropriate Curricula

Grantees employed staff or consultants whose time was specifically dedicated to the development and implementation of the training programs. Each site had the same basic criteria that the developer be bilingual and/or experienced with the target population(s). The projects had a preference for local consultants, but staff also called upon national organizations (minority focus organizations and ASTHO), AHECs, and local training institutions for help in designing curricula. Grantees depended on the individuals hired to provide a culturally and linguistically appropriate program. Advisory Committees generally commented on the general outline, but not the specific details of content, except in the North Carolina project where the Committee was more intimately involved.

Our review of the curricula generally found the materials directed toward issues of **Latino** culture and language (North Carolina, Rhode Island, and Colorado) appropriate but the materials about Asian culture in the Rhode Island project were somewhat limited and prone to generalization. The biggest problem that emerged in the trainings is how to deal with the needs of atypical immigrant populations, for example, the Huichol and Cora Indians of Colorado. Classes directed to students with more mainstream educational attainment and understanding of English appeared to function better in the fast-paced medical interpretation courses. These intensive workshops did not meet the needs of those without very good English language skills and some background in science or medical practice (i.e., particularly Rhode Island).

Recommendation: HRSA could consider assessing different models of training that recognize the needs of interpreters from different ethnic groups and with different degrees of acculturation.

We encountered different models of medical interpretation (dyad v. triad; simultaneous v. consecutive; interpreters serving as lay health educators v. strict word-for-word translators) in two projects. Even trainees exposed to the same curriculum differed with regard to what their role as an interpreter should be. While increasing the availability of interpreters of any kind appears necessary from the grantees' perspective, an evaluation of the varying effectiveness of the different models for cross-cultural communication might provide assistance to organizations developing programs.

Recommendation: HRSA could convene a panel to examine: (1) the state of knowledge with respect to the effectiveness of different modes of medical interpretation; (2) the practical realities that HRSA grantees face in recruiting, training, and paying medical interpreters; and (3) what agencies can realistically expect to achieve in one-time v. ongoing training for medical interpreters. Grantees also need assistance in developing tools for health education particularly for emerging and aging immigrant populations.

Appendix A: Consultant Framework for Evaluating BAP Materials

Agency _____

1. Overall Description of Type of Materials and Presentation:

2. Currency:

- Is the material up-to-date?
- Does the material have a time limit on its usefulness?
- Give specific examples if material appears dated.

3. Accuracy

- How accurate is the content?
- How accurate is the translation?
- How accurate is the cultural context?
- Give specific examples of any areas of concern.

4. Appropriateness

- How appropriate are the materials and presentation to the type of trainee (e.g., nurse practitioner v. community liaison)?
- How appropriate are the materials and presentation to the culture'?
- How appropriate are the materials to be used by clients'?
- Give specific examples of any areas of concern and suggestions for improvements.

5. Usefulness

- Describe how the grantee determined whether the materials were useful to trainees, users and clients.
 - » What measures of usefulness were employed (process and outcome)?
 - » What other measures (process and outcome) would appear appropriate to assessing usefulness?
- Describe your perception of the usefulness of the materials to trainees, users and clients.

6. Applicability to Other Settings

- Are the materials/approach subject specific (e.g., prenatal only'?
- Are the materials/approach locale specific (e.g., rural v. urban;

North Carolina v. Colorado)?

- Are the materials/approach culture specific (e.g., Mexican v. Caribbean migrants)?
- To what extent do socioeconomic level, degree of assimilation, and acculturation affect applicability to trainees or clients in other settings?
- What type of revisions are recommended before wider dissemination?
- What expertise is needed to provide the BAP grant services (e.g., medical knowledge v. community knowledge) in other settings?
 - » Do trainers need training themselves in order to use the materials? Or can they be self-taught by the materials themselves?

7. Other Issues Needing Consideration Prior to Dissemination

- Are there confidentiality issues that need to be addressed?
- Are there specific role guidelines (e.g., for medical interpreters) that are an essential part of the curricula'?
- Are there any other issues specific to this project'?

8. Consultant's Summary Recommendation Regarding Dissemination