CULTURAL AND LINGUISTIC COMPETENCE ASSESSMENT

New Mexico Department of Health

NMDOH Health Equity Workgroup

2016

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HEALTH EQUITY WORKGROUP
Aiko Allen
Ana Maria MacDonald
Brenda Alvarado
Britt Catron
Carol Hanson
Claudia Macias
Danielle Reed
Danny Maxwell
Dawn Hunter
Jerry Montoya
Jordan James
Karen Dugas
Karen Gonzales
Lisa Storti
Marangellie Trujillo
Maura Shuttleworth
Pamela Brommer
Rosalie Nava
Terry Shumaker

OFFICE OF HEALTH EQUITY
Ana Maria MacDonald
Rosalie Nava

OFFICE OF POLICY AND ACCOUNTABILITY
Dawn Hunter
Terry Bryant
Marangellie Trujillo
Shannon Barnes

New Mexico Department of Health
1190 South St. Francis Drive
Santa Fe, NM 87502
www.nmhealth.org

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Introduction

The New Mexico Department of Health (NMDOH) is a centralized state health department. The main office is located in Santa Fe, New Mexico (NM). There are 54 public health offices, five regional offices,[1] and seven program areas[2] that serve 33 counties and 23 federally recognized tribes, pueblos, and nations. NMDOH has approximately 3,805 staff positions. At the time of this survey, an estimated 3,303 positions were filled.[3]

NMDOH's mission is to promote health and wellness, improve health outcomes, and assure safety net services for all people in NM. Over fifty percent of New Mexicans self-identify as a racial or ethnic minority. NMDOH is committed to understanding the various cultures of the population it serves. NMDOH continues to learn how beliefs and traditions affect decisions about health, health behaviors, and health care services. NMDOH is committed to assessing and improving the quality of services it provides.

The most recent cultural and linguistic competency assessment was conducted in 2014. As a result of that assessment, the NMDOH Office of Health Equity (OHE) made several changes. First, the health equity workgroup reconvened. Staff interested in advancing health equity were recruited to become part of this group. Second, with help from the workgroup, OHE created and updated many staff resources. These resources include:

1. A 16 module *Public Health Spanish Course* to develop and improve Spanish language skills;
2. Two on-line Culturally and Linguistically Appropriate Services (CLAS) courses that are accessible to staff and partners (http://nmdohcc.org/); and
3. A *Language Access Toolkit,* which includes language, cultural, and training resources.

History

In 2010, NMDOH created a policy that supports the use of the Culturally and Linguistically Appropriate Services (CLAS) in Health and Health Care Standards. The CLAS Standards were developed by the United States Department of Health and Human Services Administration (HHS), Office of Minority Health (OMH). These standards were created to help guide organizations to combat racial and ethnic health disparities. In 2013, OMH *enhanced* the CLAS standards to "recognize the nation's increasing diversity and ensure relevance with new national policies and legislation."[4] The updated standards went beyond racial and ethnic issues to include other marginalized cultures.[5] In 2015, NMDOH acknowledged the OMH updates by incorporating the

[1] Northeast, Northwest, Metro, Southeast, and Southwest but for administrative purposes, the Metro region is part of the Northwest region
[2] Administrative Services, Public Health, Epidemiology and Response, Office of Facilities Management, Developmental Disabilities Supports, Health Improvement, and Scientific Laboratory
[3] NMDOH Training Unit, reported data from 2015 on 4/27/2016 via email correspondence
[4] Office of Minority Health (April 2013) National Standards for Culturally and Linguistically Appropriate Services for Health and Health Care: A blueprint for advancing and sustaining CLAS policy and practice. HHS
[5] Including but not limited to people living with disabilities and Lesbian, Gay, Bisexual, Transgender, and Queer

enhanced standards into updated training and revising policy. As part of the efforts to support the enhanced CLAS Standards, NMDOH conducted a new department-wide cultural and linguistic competence assessment.

Purpose

The purpose of the assessment was to:

1. Evaluate the Department's social, cultural, and linguistic competence.
2. Study the factors that can help, improve, or block the success of the NMDOH service delivery system.
3. Create a baseline of what employees know about the Department's policies, procedures, and practices.

Cultural and Linguistic Competence Assessment

The Cultural and Linguistic Competence Assessment of 2016 was based off the 2014 NMDOH assessment. The prior assessment survey was created from guidance material provided by the National Center for Cultural Competence.[6] This assessment was conducted as part of the national public health accreditation process for the Department. The accreditation process includes Measure 11.13 that states the NMDOH must:

> Maintain socially, culturally, and linguistically appropriate approaches in health department processes, programs, and interventions, relevant to the population served in its jurisdiction.

In the spring of 2016, the workgroup reviewed the 2014 culture and linguistic survey and tailored the survey to better serve NMDOH needs. For example, sections for comments were added and the survey was shortened. Prior to sending the survey out to staff, the workgroup created a focus group of approximately 50 staff. The focus group represented a variety of programs and divisions throughout NMDOH. This focus group reviewed the survey. Additional edits were made based on the group's feedback. The edits included removing questions and adding qualifiers, if questions were identified as confusing.

The survey was sent to all employees with an NMDOH e-mail account. The assessment was delivered via a Survey Monkey link contained in an e-mail. Staff were given 20 days to respond to the survey. Computers were made available to accommodate staff who did not have regular access to a work computer. The survey was opened on April 11, 2016 and closed on May 6, 2016. There were 791 respondents. Participation was voluntary and anonymous.

[6] http://nccc.georgetown.edu/

Limitations

There are several limitations to this assessment that should be noted.

The assessment was voluntary, which is both a limitation and a strength. The limitation was that each program area was not sufficiently represented in the survey. For example, NMDOH operates seven health facilities that employ approximately one-third of NMDOH staff, but less than 10% of facility staff participated in the survey. The survey was opened for two additional weeks to solicit facility participation but the extra time did not produce additional participants. The strength represents an open approach to the assessment. The survey was completely voluntary and there were no incentives offered other than knowing that feedback would help guide future health equity work throughout the department.

Participants did not answer the survey consistently. The percentage reported for each question is based on the number of responses to that question. The percentages reported throughout the survey are not the same for all responses. [7]

The survey grouped participants into standard racial, ethnic, and cultural categories.[8] These categories may not capture how many New Mexicans self-identify. For example, numerous families identify as being of mixed racial and ethnic backgrounds. The groups used in the survey represent a wide range of people who may or may not share the same cultural beliefs, practices, or languages as everyone else in the same group. This makes it difficult to gauge knowledge on inequities, trends, and cultures. Also, there is a large group of people that may or may not be captured by this survey. According to the US Census, over 255,482 people living in NM identify "other" as their racial and ethnic group.[9]

> "Any cultural work needs to be put in context. I have a grandson from San Juan (Ohkay Owingeh) and their practices differ from other pueblos. Sometimes when we put a program in place it's a one-size fits all approach!" (Q33, Comment 1)

Not all recommendations from the focus group were implemented. For example, the group felt the questions were too focused on public health and health promotion. They stated that additional questions should be added to incorporate other direct services. Participants in the survey echoed the focus groups' sentiments in their comments:

[7] For example, in one question 65% could equate to 514 responses. In another question 65% could equate to 239.
[8] American Community Survey (ACS) demographic and housing estimates, 2010-2014 American Community Survey 5-Year Estimates
[9] ACS demographic and housing estimates, 2010-2014 American Community Survey 5-Year Estimates

- "…focus appears to be public health." (Q16, Comment 1)
- "…I am not sure the questions are relevant to DDSD." (Q16, Comment 22)
- "This survey mostly does not apply to our work. It is more for Public Health." (Q33, Comment 58)

Respondents did not interpret every question in the same way. For example, in question 3, participants were asked to list their "geographical service area." The purpose of the question was to elicit the name of the community, town, or county where the person worked. Seventeen percent (17%) of the respondents used the generic term (i.e. town, village, and county) or left the question blank. A second example is the interpretation of the words "translation" and "interpretation." Many respondents used these terms interchangeably. The workgroup tried to clarify the questions by adding definitions and qualifiers (e.g. translation refers to written language), but as shown by the responses, some questions were still open to multiple interpretations.

- "Is 'support staff' a noun or a verb phrase" (Q8, Comment 39)
- "Needs to be a policy for LGBTQ; need to revise EHR to reflect SO/GI…" (Q16, Comment 12)
- "I know they have translators but not written documents." (Q28, Comment 8)

Assessment Response

Themes and Findings

Current and Projected Demographics Trends

Understanding trends, health disparities, and views on health helps NMDOH to better serve its population. It ensures that services and materials address cultural and language differences. In the demographic section we asked staff to rate their knowledge about specific groups.[10]

The majority of respondents stated that they were familiar with current and projected Hispanic and non-Hispanic White[11] demographic trends (74% "strongly agree" and 71% "agree"). Almost 60% stated that they were familiar with American Indian trends and 55% stated that they were familiar with Black/African American trends. Respondents were less familiar with Lesbian, Gay, Bisexual, Transgender, Queer, and Questioning (52%); Immigrant and Refugee (42%); and Asian/Pacific Islander (38%) populations.

When it came to describing health disparities and the ways illness and health are viewed, answers mirrored the demographic question. Staff reported that they were most familiar with the views of Hispanics, Whites, and Native Americans and less familiar with other populations. The

[10] Hispanic; Black or African American; Asian or Pacific Islander; American Indian or Alaskan Native; White; Lesbian, Gay, Bisexual, Transgender, Queer and Questioning (LGBTQ), Immigrant/refugee
[11] Hereafter referred to as White

group staff were least familiar with were Asian or Pacific Islander. This group accounts for about 42,656 New Mexicans.[12]

- "I believe there is an Asian population in the community that is being missed. Possibly r/t they do not interact with the rest of the community" (Q33, Comment 19)

Organizational Philosophy

The survey asked about staff perceptions of NMDOH's organizational philosophy. Over 75% of staff stated that they felt NMDOH's mission statement supports diverse culture and language needs. About two thirds (66%) of repondents reported that there is policy to support staff training on culture, however, many stated that they felt the policy was not inclusive of all populations.

- "It does for staff to acquire knowledge about Native Americans, but not for multiple populations." (Q8, Comment 15)
- "It only focuses on a couple of groups, blatantly discriminates against others and does not foster inclusive practices" (Q8, Comment 29)

Over 60% of respondents indicated that their program has - and ensures – that relevant procedures are in place to deliver culturally competent services. Sixty-four percent (64%) stated that their office has signs and materials in languages other than English. Over 70% of respondents reported that they felt their program hires staff that reflects the diversity of NM.

Direct Practice

Over 60% of respondents indicated that they have direct interaction with the public. These respondents were asked if they felt NMDOH provided necessary attention, methods, and tools to address cultural and linguistic differences in direct service delivery. Respondents reported that they felt best equipped to provide direct practice services that cater to the cultural and linguistic needs of Hispanic and White communities and less prepared to serve other cultural, racial, and ethnic groups.

- "We need to better serve people [whose] primary language is not English. State of NM has resources that are in Spanish but need to provide other languages also." (Q31, Comment 11)

Over half (53%) stated that resource materials, including social media, are culturally and linguistically appropriate. Sixty-four percent (64%) indicated that their program ensures written

[12] ACS demographic and housing estimates, 2010-2014 American Community Survey 5-Year Estimates

materials are at appropriate reading levels. Over two-thirds (68%) indicated that their program provides staff with the resources they need to serve clients who do not speak English as their primary language.

Participants also mentioned that they felt the current NMDOH social media policy is not well known nor understood. Staff indicated that the NMDOH social media strategy is confusing and under-utilized.

> "We would like to use social media more but are having a hard time understanding DOH's social media strategy. We have [strategies] per our grants but sometimes the messages on DOH's do not align with our purpose or sometimes our items are posted in an untimely fashion. We know that some of special populations prefer to get their information this way." (Q33, Comment 60)

Translation and Interpretation Services

NMDOH, Office of Health Equity, has one full-time and one part-time Spanish translator on staff. The translators provide free Spanish translation services for NMDOH. According to respondents, Spanish is the most common language heard from people seeking NMDOH services. Over a third of the respondents stated that they encounter a non-English or limited English proficient (LEP) person at least five times a week. Eighty-three percent (83%) of respondents stated that they are aware that NMDOH provides Spanish translation, but 43% indicated that they do not know how to request this service.

- "I believe I was informed at first but I have forgotten if I was." (Q29, Comment 7)
- "It has changed frequently and this is an issue…" (Q29, Comment 9)

Many respondents indicated that they have not requested services because they have bilingual colleagues who provide interpretations or translations for their program. When asked if respondents had suggestions to improve the translation service, a common theme was adding

- "Add Native American translators" (Q32, Comment 14)
- "Provide translation services in more languages" (Q32, Comment 28)

additional languages. Respondents also shared insight into the barriers they face when trying to provide meaningful language and cultural access. These barriers include the perceived cost, not knowing how to access an interpreter, and not having a trained interpreter as part of the treatment team.

Discussion

The survey revealed many factors that affect the performance of the NMDOH service delivery system. A strength included having bilingual staff. A weakness was staff reporting that they do not have adequate access to interpreters and translators. NMDOH continues to address these and other issues raised in the survey. The assessment gives these issues a voice.

- "We have a lack of interpreter services, especially in treatment team meetings with parents" (Q23, Comment 6)
- "We are a treatment program. A person who speaks a language other than English would need to have someone with them throughout programming each day, which is 9am to 8:30pm, which is unrealistic, due to cost." (Q23, Comment 16)
- "I don't feel like I know much about this. We serve our population as best we can, but in Rehab, we would need to have access to interpreter services or translation in a live setting; as it is like a school and the consumer would need translation or interpretation through the entire rehab (school) day. Consumers have 6-10 classes per day. They have assessments, treatment plans, treatment plan updates, team meeting also during their stay. They are here for 6-28 days" (Q33, Comment 21)

As NMDOH continues on the road to providing culturally competent services, it seeks guidance from the National Center for Cultural Competency (NCCC). According to NCCC, a culturally competent organization must:

- Have a defined set of values and principles, and demonstrate behaviors, attitudes, policies, and structures, that enable them to work effectively across cultures;
- Have the capacity to (1) value diversity, (2) conduct self-assessment, (3) manage the dynamics of difference, (4) acquire and institutionalize cultural knowledge, and (5) adapt to diversity and the cultural contexts of communities they serve; and
- Incorporate the above in all aspects of policy-making, administration, practice, and service delivery, and systematically involve consumers, families, and communities.[13]

Conducting an annual assessment helps NMDOH gauge whether or not staff believe the values and principles of NMDOH are supported by its mission statement. Based on the results of this assessment, the majority of staff responding to the survey stated that the mission statement embraces cultural competency. The majority of respondents also stated that they felt that NMDOH employees reflect the diversity of the state. This is an important and vital component in understanding and working effectively across cultures because it increases NM populations' ability to connect and relate to NMDOH staff providing services in NM communities.

[13] http://nccc.georgetown.edu/projects/sids/dvd/continuum.pdf

The assessment process also allowed NMDOH to acknowledge training gaps as pointed out by staff throughout the state. Although a large number of participants stated that there is policy to support cultural training, staff reported that they felt it was inconsistent and not inclusive of all populations. Many staff requested professional development and help in maintaining the educational requirements of their professional licensures.

OHE in partnership with the Tribal liaison currently offers up to 14.5 free continuing education credits for social workers and professionals certified in public health. Current training offerings include a sixteen module Public Health Spanish Course that was designed to help improve language access and service delivery for multiple skill levels. The Tribal Liaison launched an NMDOH specific "Working More Effectively with Tribes, Pueblos, and Nations" training. Attendees learn how to effectively collaborate and communicate with NM sovereign nations. OHE also launched a new training for staff and community members called "Closing the Gap – Cultural Competency in Health and Human Services." The training is designed to explore ways to improve service delivery and meet federal and accreditation mandates through culturally and linguistically appropriate services. Based on the survey results, many staff are still unaware of the offered training options. This presents an opportunity for NMDOH to improve outreach to staff and connect them to these training opportunities. As NMDOH improves its communication methods by updating and promoting the intranet, it may be easier to engage staff and solicit leadership support.

The NMDOH health equity workgroup plans to share this assessment with NMDOH leadership, community partners, and staff. Leadership could use the assessment to guide development or implementation of policies for staff to have improved access to interpreters and translators. Community partners may help us identify, learn about, and connect with the people of diverse cultures that make up the State. Staff are NMDOH's greatest asset. NMDOH needs to continue to support their professional growth and acknowledge their skills. There are significant language and culture skills that remain untapped.

In addition to this assessment, another tool for NMDOH to use as it moves forward on its cultural competency journey is the cultural competency continuum. This conceptual framework helps both individuals and organizations gauge where their awareness, knowledge, and skills fall along the process leading towards cultural competency. It is based on the work of Cross, Bazron, Dennis, and Isaacs (1989) and supported by NCCC. The continuum is dynamic and individuals and organizations may be at different stages at different times with varying populations and groups.

The cultural competence continuum is divided into six stages:[14]

1) *Cultural destructiveness* is characterized by attitudes and practices within the organization that are destructive to a cultural group. Behaviors typical of this category may include not noticing differences or disregarding civil rights.

[14] The Cross Culture Health Care Program, 2015 & A Guide to Infusing Cultural & Linguistic Competence in Health Promotion Training, National Center for Cultural Competence

2) *Cultural incapacity* is the lack of capacity of the organization to respond effectively to the needs, interest, or preferences of culturally and linguistically diverse groups. Behaviors may include devaluing other cultures, promoting superiority of own culture, or demeaning other cultures.

3) *Cultural blindness* is an expressed philosophy of viewing and treating all people as the same. Behaviors may include ignoring cultural strengths, encouraging assimilation to the dominant culture, or applying helping approaches of the dominant culture universally.

4) *Cultural pre-competence* is a level of awareness within systems or organizations of their strengths and areas for growth to respond effectively to culturally and diverse populations. Behaviors may include seeking information about new cultures, recognizing and exploring differences, and being comfortable that there is not one right answer.

5) *Cultural competency* is characterized by a set of attitudes, practices and/or policies that respects and accepts difference. Behaviors may include paying attention to the dynamics of difference, adapting services and plans to meet the needs of different cultures, and seeking advice and consultation from different cultures.

6) *Cultural proficiency* is not only cultural competency but continually seeking to add to the knowledge base of the agency. Behaviors may include adapting to many different cultural situations, advocating for cultural competence through policies of the agency, and mediating for improved relations in cross-cultural conflicts.

The following comments suggest that staff are in different stages in the cultural competence continuum. However, it is important to note that NMDOH is a large and diverse health agency, and the work is very different from one program area to another.

- "But all of our services are equally given to all cultures." (Q16, Comment 3)
- "I [e]nforce regulations that are the same for all cultures in NM." (Q16, Comment 21)
- "I do not work in an area where I interact with diverse groups" (Q8, Comment 28)
- "Our protocols are standardized" (Q17, Comment 11)
- "I'm a trainer and also a surveyor. I am bilingual. I have found some nursing homes frown on their employees speaking their native language during work hours." (Q27, Comment 8)
- "The practice of cultural humility in the management of employees and services is nonexistent." (Q 33, Comment 52)

The way the survey questions were asked and interpreted will need to be adjusted in future assessments in order to take into account the differences in service delivery throughout NMDOH.

For example, the survey asked questions such as whether or not staff have used or have access to health practice protocols that are adapted for diverse populations (Q16). For the Division of Health Improvement (DHI), a regulatory entity providing compliance oversight, standardized protocols are an important part of their daily operations. Staff who work in DHI may answer the question very differently from staff who serve in the Public Health Division, where staff contact is more focused on individual client interactions. Standardized protocols are an important part of agency operations and NMDOH may need to conduct further evaluation to determine whether existing protocols are unknowingly having an adverse effect on certain populations.

Some survey respondents stated that they do not work with diverse groups (see comments above). However, New Mexico, like the United States is rapidly becoming more diverse. According to 2014 population estimates, 2,080,085 people live in New Mexico. The two largest racial and ethnic groups in New Mexico are Hispanic and White. The next largest, according to the U.S. Census Bureau, is "some other race." Details or information regarding the other race(s) were not captured in this survey. The "other race" population accounts for 255,482 people living in NM (12.3%). NMDOH staff are increasingly likely to encounter diverse groups in their daily practice.

Recommendations and Next Steps

The results of the assessment are intended to support NMDOH on: a) improving health care access and utilization; b) enhancing the quality of services provided to New Mexico's culturally diverse and underserved communities; and, c) promoting cultural and linguistic competence as essential approaches in the elimination of health disparities in New Mexico.

One way NMDOH has committed to achieving these goals is using the CLAS Standards as a guide to better serve its population. The Standards are divided into three themes and one principal standard. The principle standard is overarching and may be achieved if the other themes are followed.

> The Principle Standard: Provide effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs.

The following recommendations and next steps are grouped by the three CLAS themes:

Governance, Leadership, and Workforce

- Create a standard policy requiring all new employees to successfully complete NMDOH approved cultural competency training.
- Reduce barriers for cultural trainings by ensuring senior leadership buy-in. Leadership must support participation of staff at all levels in cultural competency training.
- Inform and educate staff on social media policies and explore the possibility of better utilizing technology for outreach and communication efforts.

- Review and evaluate standardized protocols to ensure that they are respectful of cultural differences and responsive to community needs. Utilize resources such as the HHS Office of Minority Health & NCCC for guidance. Make updates and changes as needed. Enlist leadership support for Department-wide adoption.

Communication and Language Assistance

- Update the existing translation policy to be more inclusive of a broad range of translation and interpretation services (including American Sign Language). Enlist leadership support for Department-wide adoption.
- Continue to offer, recruit trainers, and train staff in Medical Interpreter and Public Health Spanish courses.
- Promote and distribute a list of NMDOH employees who have completed Medical Interpreter training and develop a protocol for trained employees to be used in this capacity.
- Poll staff and clients to identify languages spoken and levels of proficiency throughout the Department.
- Promote the use of the NMDOH Language Access Toolkit.
- Evaluate current assessment, intake, and consent forms to ensure they are written at appropriate levels.

Engagement, Continuous Improvement, and Accountability

- Continue to improve the cultural and linguistic competence survey through staff and community feedback.
- Continue to assess and understand the culturally diverse groups living in New Mexico and using NMDOH services.
- Share survey results with leadership, community partners, and NMDOH staff.
- Develop next survey in partnership with a community workgroup.
- Identify ways to solicit community feedback on culturally competent service delivery at the point of service.

Conclusion

NMDOH is committed to understanding the diverse cultures of the population it serves, and how beliefs and traditions affect decisions about health, health behaviors, and health care services. NMDOH is also committed to assessing and improving the quality of services it provides. This includes working with its own employees and community partners and consumers.

Cultural competence involves valuing diversity. It includes conducting self-assessments, avoiding stereotypes, and managing the dynamics of difference. NMDOH is committed to quality and diversity in the workplace as a way to improve the health of all New Mexicans. The annual cultural and linguistic competence assessment helps NMDOH gauge strengths and weaknesses in its efforts to provide quality services, to improve access to care, and to create a place where

people are proud to work. The knowledge gained also helps promote cultural awareness within the organization and among the people served. Each year, the survey presents new information. It is a learning process, and NMDOH will be able to use these results to support its workforce, improve services, and improve the health of all New Mexicans in a culturally sensitive manner.

Appendices

Definitions from the Office of Minority Health[15&16]

Cultural and Linguistic Competency: The capacity for individuals and organizations to work and communicate effectively in cross-cultural situations through the adoption and implementation of strategies to ensure appropriate awareness, attitudes, and actions and through the use of policies, structures, practices, procedures, and dedicated resources that support this capacity.

Cultural Competency: A developmental process in which individuals or institutions achieve increasing levels of awareness, knowledge, and skills along a cultural competence continuum. Cultural competence involves valuing diversity, conducting self-assessments, avoiding stereotypes, managing the dynamics of difference, acquiring and institutionalizing cultural knowledge, and adapting to diversity and cultural contexts in communities.

Culturally and Linguistically Appropriate Services (CLAS): Services that are respectful and responsive to individual cultural and religious health beliefs and practices, preferred languages, health literacy levels, and communication needs, and employed by all members of an organization (regardless of size) at every point of contact.

Culture: The integrated pattern of thoughts, communications, actions, customs, beliefs, values, and institutions associated, wholly or partially, with racial, ethnic, or linguistic groups, as well as with religious, spiritual, biological, geographical, or sociological characteristics. Culture is dynamic in nature, and individuals may identify with multiple cultures over the course of their lifetimes.

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

Interpreting: The process of rendering a message spoken in one language into one or more other languages.

Translation: The conversion of a written text into a corresponding written text in a different language.

[15] National Standards for CLAS in Health and Health Care: A Blueprint for Advancing and Sustaining CLAS Policy and Practice, OMH, HHS, April 2013) & https://hclsig.thinkculturalhealth.hhs.gov/Content/Glossary/Glossary1.asp
[16] https://hclsig.thinkculturalhealth.hhs.gov/Content/Glossary/Glossary1.asp

Q1

Please identify your division.

Answered: 752 Skipped: 39

Answer Choices	Responses	
Administrative Services Division	11.17%	84
Public Health Division	43.22%	325
Epidemiology Response Division	7.31%	55
Office of Facilities Management	9.84%	74
Developmental Disabilities Supports Division	13.16%	99
Division of Health Improvement	9.97%	75
Scientific Laboratory Division	5.32%	40
Total		752

Q2

Please identify your region.

Answered: 759 Skipped: 32

Answer Choices	Responses	
Northeast	20.29%	154
Northwest	8.17%	62
Metro	18.97%	144
Southeast	9.88%	75
Southwest	17.13%	130
All	25.56%	194
Total		759

Q3

We define "your geographical service area" as the community, town, village, or county where you provide public health services. Please identify the area served by your office.

Answered: 690 Skipped: 101

Q4

I am familiar with the current and projected demographic trends among the following diverse groups in my service area.

Answered: 660 Skipped: 131

	Strongly agree	Agree	Disagree	Strongly disagree	I don't know	Total
Hispanic	24.92% 164	49.39% 325	8.81% 58	2.74% 18	14.13% 93	658
Black or African American	10.00% 64	44.84% 287	21.56% 138	3.59% 23	20.00% 128	640
Asian or Pacific Islander	5.79% 37	32.08% 205	30.20% 193	4.69% 30	27.23% 174	639
American Indian or Alaska Native	12.15% 78	46.57% 299	19.00% 122	3.27% 21	19.00% 122	642
White	20.59% 133	50.46% 326	10.68% 69	2.63% 17	15.63% 101	646
Lesbian, Gay, Bisexual, Transgender, Queer, and Questioning (LGBTQ)	11.46% 74	40.40% 261	22.60% 146	4.02% 26	21.52% 139	646
Immigrant/refugee	8.63% 55	32.97% 210	27.63% 176	5.65% 36	25.12% 160	637

Q5

I am able to describe health disparities among the following culturally diverse groups in my service area.

Answered: 658 Skipped: 133

	Strongly agree	Agree	Disagree	Strongly disagree	I don't know	Total
Hispanic	21.83% 143	47.02% 308	10.99% 72	2.90% 19	17.25% 113	655
Black or African American	12.27% 79	43.63% 281	19.88% 128	2.95% 19	21.27% 137	644
Asian or Pacific Islander	5.83% 37	27.56% 175	32.76% 208	5.20% 33	28.66% 182	635
American Indian or Alaska Native	14.49% 93	44.70% 287	16.98% 109	3.89% 25	19.94% 128	642
White	17.70% 114	47.52% 306	13.20% 85	3.26% 21	18.32% 118	644
Lesbian, Gay, Bisexual, Transgender, Queer, and Questioning (LGBTQ)	11.46% 74	39.16% 253	22.14% 143	4.02% 26	23.22% 150	646
Immigrant/refugee	9.91% 63	29.40% 187	29.72% 189	5.50% 35	25.47% 162	636

Q6

I am able to identify the way illness and health are viewed by the following culturally diverse groups in my service area.

Answered: 659 Skipped: 132

	Strongly Agree	Agree	Disagree	Strongly disagree	I don't know	Total
Hispanic	19.18% 126	46.73% 307	13.85% 91	2.89% 19	17.35% 114	657
Black or African American	8.07% 52	40.22% 259	26.55% 171	3.26% 21	21.89% 141	644
Asian or Pacific Islander	4.25% 27	25.31% 161	36.64% 233	4.56% 29	29.25% 186	636
American Indian or Alaska Native	10.11% 65	39.50% 254	24.73% 159	3.42% 22	22.24% 143	643
White	16.10% 104	47.68% 308	14.86% 96	3.10% 20	18.27% 118	646
Lesbian, Gay, Bisexual, Transgender, Queer, and Questioning (LGBTQ)	8.99% 58	34.57% 223	28.53% 184	4.03% 26	23.88% 154	645
Immigrant/refugee	7.02% 45	26.52% 170	33.23% 213	5.93% 38	27.30% 175	641

Q7

NMDOH's mission statement incorporates cultural and linguistic competence in service delivery.

Answered: 642 Skipped: 149

Answer Choices	Responses	
Strongly agree	14.95%	96
Agree	60.75%	390
Disagree	7.79%	50
Strongly disagree	2.18%	14
I don't know	14.33%	92
Total		642

Q8

NMDOH maintains policies to support staff to acquire knowledge about the cultural beliefs and practices of diverse groups.

Answered: 642 Skipped: 149

Answer Choices	Responses	
Strongly agree	12.93%	83
Agree	52.80%	339
Disagree	13.86%	89
Strongly disagree	3.89%	25
I don't know	16.51%	106
Total		642

Q9

My program has relevant procedures in place to help me serve diverse cultural and linguistic needs of community members in my service area.

Answered: 640 Skipped: 151

Answer Choices	Responses	
Strongly Agree	13.75%	88
Agree	50.16%	321
Disagree	17.97%	115
Strongly Disagree	2.97%	19
I don't know	15.16%	97
Total		640

Q10

My program ensures that our procedures are relevant to delivery of culturally competent services.

Answered: 638 Skipped: 153

Answer Choices	Responses	
Strongly Agree	13.17%	84
Agree	53.45%	341
Disagree	13.95%	89
Strongly Disagree	2.98%	19
I don't know	16.46%	105
Total		638

Q11

In my opinion, my division/bureau as a whole, provides culturally and linguistically appropriate services to diverse groups in my service area.

Answered: 639 Skipped: 152

Answer Choices	Responses	
Strongly agree	12.83%	82
Agree	51.33%	328
Disagree	13.62%	87
Strongly disagree	2.82%	18
I don't know	13.30%	85
Not applicable	6.10%	39
Total		639

Q12

In my office there are signs and materials in languages other than English.

Answered: 639 Skipped: 152

Answer Choices	Responses	
Strongly Agree	15.34%	98
Agree	49.14%	314
Disagree	22.38%	143
Strongly Disagree	5.95%	38
I don't know	7.20%	46
Total		639

Q13

My program recruits, retains, and promotes staff that reflect the cultural diversity of the community.

Answered: 639 Skipped: 152

Answer Choices	Responses	
Strongly Agree	15.49%	99
Agree	55.56%	355
Disagree	12.99%	83
Strongly Disagree	3.76%	24
I don't know	12.21%	78
Total		639

Q14

My program's staff at all levels and disciplines receive training in culturally- and linguistically-appropriate service delivery.

Answered: 639 Skipped: 152

Answer Choices	Responses	
Strongly Agree	10.33%	66
Agree	43.04%	275
Disagree	25.20%	161
Strongly Disagree	5.32%	34
I don't know	16.12%	103
Total		639

Q15

Do you have direct interaction with people seeking services from NMDOH?

Answered: 641 Skipped: 150

Answer Choices	Responses	
Yes	60.53%	388
No	39.47%	253
Total		641

Q16

I use or have access to health practice protocols that are adapted for each of the following culturally diverse populations.

Answered: 359 Skipped: 432

	Strongly Agree	Agree	Disagree	Strongly Disagree	I don't know	Not applicable	Total
Hispanic	13.65% 49	49.03% 176	13.65% 49	1.95% 7	10.58% 38	11.14% 40	359
Black or African American	9.43% 33	41.43% 145	21.14% 74	3.14% 11	12.57% 44	12.29% 43	350
Asian or Pacific Islander	6.05% 21	28.24% 98	28.82% 100	4.61% 16	17.58% 61	14.70% 51	347
American Indian or Alaska Native	7.69% 27	39.03% 137	23.08% 81	3.42% 12	13.68% 48	13.11% 46	351
White	15.14% 53	48.00% 168	12.86% 45	2.00% 7	10.57% 37	11.43% 40	350
Lesbian, Gay, Bisexual, Transgender, Queer, and Questioning (LGBTQ)	8.91% 31	37.07% 129	22.13% 77	4.02% 14	14.66% 51	13.22% 46	348
Immigrant/refugee	7.16% 25	31.23% 109	26.65% 93	4.30% 15	16.62% 58	14.04% 49	349

Q17

I use or have access to health promotion and disease prevention best-practices/protocols that are adapted for diverse groups.

Answered: 355 Skipped: 436

	Strongly Agree	Agree	Disagree	Strongly Disagree	I don't know	Not applicable	Total
Hispanic	13.52% 48	46.20% 164	14.08% 50	1.69% 6	10.99% 39	13.52% 48	355
Black or African American	10.89% 38	38.40% 134	19.77% 69	2.58% 9	14.04% 49	14.33% 50	349
Asian or Pacific Islander	7.60% 26	28.07% 96	27.78% 95	3.51% 12	17.84% 61	15.20% 52	342
American Indian or Alaska Native	9.80% 34	38.62% 134	21.33% 74	2.59% 9	13.83% 48	13.83% 48	347
White	14.94% 52	44.83% 156	13.22% 46	1.72% 6	11.78% 41	13.51% 47	348
Lesbian, Gay, Bisexual, Transgender, Queer, and Questioning (LGBTQ)	10.14% 35	37.10% 128	21.45% 74	2.61% 9	14.20% 49	14.49% 50	345
Immigrant/refugee	9.01% 31	31.40% 108	24.71% 85	3.78% 13	15.41% 53	15.70% 54	344

Q18

My program collaborates with community-based organizations to address the health related needs of the culturally and linguistically diverse groups in my service area.

Answered: 355 Skipped: 436

Answer Choices	Responses	
Strongly agree	15.77%	56
Agree	48.17%	171
Disagree	12.68%	45
Strongly disagree	3.38%	12
I don't know	14.37%	51
Not applicable	5.63%	20
Total		355

Q19

My program uses resource materials (including social media) that are culturally and linguistically appropriate to inform diverse groups about health related issues.

Answered: 356 Skipped: 435

Answer Choices	Responses	
Strongly Agree	10.11%	36
Agree	43.26%	154
Disagree	18.54%	66
Strongly Disagree	5.90%	21
I don't know	16.29%	58
Not applicable	5.90%	21
Total		356

Q20

I am able to identify the languages and dialects expressed by the following diverse cultural groups in my service area.

	Strongly Agree	Agree	Disagree	Strongly Disagree	I don't know	Total
Hispanic	29.86% 106	56.62% 201	5.63% 20	2.25% 8	5.63% 20	355
Black or African American	20.81% 72	54.34% 188	13.01% 45	2.89% 10	8.96% 31	346
Asian or Pacific Islander	8.82% 30	27.94% 95	42.06% 143	4.71% 16	16.47% 56	340
American Indian or Alaska Native	13.04% 45	41.16% 142	29.86% 103	4.06% 14	11.88% 41	345
White	31.25% 110	56.25% 198	4.26% 15	2.27% 8	5.97% 21	352
Lesbian, Gay, Bisexual, Transgender, Queer, and Questioning (LGBTQ)	17.92% 62	50.00% 173	15.03% 52	3.47% 12	13.58% 47	346
Immigrant/refugee	13.49% 46	31.09% 106	31.38% 107	5.57% 19	18.48% 63	341

Q21

Which languages are spoken by the people who use the services in your office? Please list.

Answered: 335 Skipped: 456

Q22

On a weekly basis, how often do you interact with non-English or limited English proficient speakers at work?

Answered: 357 Skipped: 434

Answer Choices	Responses	
10+ times	18.77%	67
5-10 times	15.41%	55
0-5 times	50.70%	181
None	11.48%	41
I don't know	1.68%	6
Not applicable	1.96%	7
Total		357

Q23

My program provides me with the resources I need to serve clients who do not speak English as their primary language.

Answered: 354 Skipped: 437

Answer Choices	Responses	
Strongly Agree	14.69%	52
Agree	53.67%	190
Disagree	15.54%	55
Strongly Disagree	6.50%	23
I don't know	9.60%	34
Total		354

Q24

Does your program use the following to provide interpretation services:

Answered: 358 Skipped: 433

	Always	Sometimes	Seldom	Never	I don't know	Not applicable	Total
Bi-lingual staff who have not received medical interpreter training	27.37% 98	37.71% 135	12.29% 44	5.59% 20	12.57% 45	4.47% 16	358
Family and/or friends of clients	12.75% 45	44.48% 157	15.58% 55	9.92% 35	12.18% 43	5.10% 18	353
Certified medical interpreters	10.34% 36	24.71% 86	15.80% 55	19.25% 67	22.41% 78	7.47% 26	348
Trained medical interpreters	12.25% 43	22.51% 79	14.53% 51	20.80% 73	23.65% 83	6.27% 22	351
Sign language interpreters	7.12% 25	18.52% 65	15.38% 54	25.64% 90	25.64% 90	7.69% 27	351

Q25

Does your program:

Answered: 357 Skipped: 434

	Always	Sometimes	Seldom	Never	I don't know	Not applicable	Total
Offer consents or educational materials in different languages	35.39% 126	34.55% 123	10.39% 37	5.34% 19	9.83% 35	4.49% 16	356
Assure written materials are at the appropriate reading levels	28.29% 101	35.85% 128	8.96% 32	6.72% 24	17.09% 61	3.08% 11	357
Have a way to know clients understand materials or consents	27.17% 97	33.05% 118	12.32% 44	5.32% 19	18.21% 65	3.92% 14	357

Q26

My program conducts activities tailored to engage the following culturally diverse communities:

Answered: 346 Skipped: 445

	Strongly Agree	Agree	Disagree	Strongly Disagree	I don't know	Not Applicable	Total
Hispanic	20.29% 70	45.80% 158	9.86% 34	0.87% 3	15.94% 55	7.25% 25	345
Black or African American	10.88% 37	37.35% 127	19.71% 67	3.24% 11	20.88% 71	7.94% 27	340
Asian or Pacific Islander	5.99% 20	21.56% 72	30.24% 101	4.49% 15	27.54% 92	10.18% 34	334
American Indian or Alaska Native	10.62% 36	38.05% 129	20.35% 69	2.36% 8	20.35% 69	8.26% 28	339
White	20.70% 71	45.48% 156	9.04% 31	0.87% 3	16.33% 56	7.58% 26	343
Lesbian, Gay, Bisexual, Transgender, Queer, and Questioning (LGBTQ)	11.54% 39	31.66% 107	22.19% 75	3.55% 12	21.89% 74	9.17% 31	338
Immigrant/refugee	9.52% 32	27.08% 91	22.92% 77	4.17% 14	25.00% 84	11.31% 38	336

Q27

My program engages the following individuals, groups, or entities in health promotion and disease prevention initiatives:

	Strongly Agree	Agree	Disagree	Strongly Disagree	I don't know	Not Applicable	Total
Places of worship and spiritual leaders	8.24% 28	28.82% 98	19.12% 65	5.00% 17	22.65% 77	16.18% 55	340
Traditional healers	5.00% 17	22.65% 77	26.47% 90	5.00% 17	26.18% 89	14.71% 50	340
Mental health providers, dentists, chiropractors, or licensed midwives	10.79% 37	44.90% 154	10.50% 36	3.79% 13	17.20% 59	12.83% 44	343
Providers of complimentary and alternative medicine	4.12% 14	25.88% 88	22.94% 78	6.18% 21	26.76% 91	14.12% 48	340
Ethnic publishers, radio, cable or television stations or personalities, or other ethnic media sources	5.00% 17	27.94% 95	20.29% 69	7.06% 24	24.71% 84	15.00% 51	340
Human service agencies	12.35% 42	50.29% 171	7.35% 25	2.35% 8	15.29% 52	12.35% 42	340
Tribal, cultural, or advocacy organizations	7.33% 25	36.66% 125	16.13% 55	3.52% 12	23.46% 80	12.90% 44	341
Local business owners (e.g., barbers, sports clubs, restaurateurs, casinos, and other ethnic businesses)	6.45% 22	27.27% 93	19.06% 65	6.16% 21	26.69% 91	14.37% 49	341
Social organizations (e.g., civic/neighborhood associations, sororities, fraternities, ethnic associations)	8.26% 28	32.15% 109	17.11% 58	4.13% 14	23.89% 81	14.45% 49	339

Q28

Did you know that NMDOH provides Spanish translation services (i.e. translating written documents)?

Answered: 600 Skipped: 191

Answer Choices	Responses	
Yes	82.67%	496
No	17.33%	104
Total		600

Q29

Are you aware of the process for requesting translation services?

Answered: 599 Skipped: 192

Answer Choices	Responses	
Yes	56.93%	341
No	43.07%	258
I don't know	0.00%	0
Total		599

Q30

Approximately how many times in the last 6 months have you submitted a translation request?

Answered: 341 Skipped: 450

Answer Choices	Responses	
5+ times	2.05%	7
3-5 times	3.23%	11
1-3 times	14.08%	48
0	37.24%	127
Never	43.40%	148

Q31 How satisfied were you with the translation services provided?

Answered: 335 Skipped: 456

Answer Choices	Responses	
Very satisfied	8.66%	29
Satisfied	15.82%	53
Neutral	7.16%	24
Unsatisfied	0.90%	3
Very unsatisfied	0.90%	3
Not applicable	66.57%	223
Total		335

Q32 Do you have any suggestions that could improve the translation services?

Answered: 334 Skipped: 457

Answer Choices	Responses	
Yes	9.58%	32
No	56.59%	189
I don't know	33.83%	113
Total		334

Q33 Please list any additional concerns, comments or questions you may have about the cultural diversity work of NMDOH.

Answered: 87 Skipped: 704