

2016 National Ambulatory Medical Care Survey (NAMCS) Culturally and Linguistically Appropriate Services (CLAS) Supplement

Findings of cognitive interview testing conducted June – July 2015

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I. Introduction

This report summarizes the findings of the cognitive evaluation of questionnaire items on the forthcoming 2016 National Ambulatory Medical Care Survey (NAMCS) Culturally and Linguistically Appropriate Services (CLAS) supplement. The NAMCS CLAS supplement was designed as a self-administered paper questionnaire to assess office-based physicians' training, awareness, and organizational policies related to CLAS. The NAMCS CLAS supplement will be a national survey conducted by the National Center for Health Statistics' (NCHS) Division of Health Care Statistics (DHCS), and is sponsored by the Office of Minority Health (OMH), Department of Health and Human Services (DHHS).

The National Standards for CLAS in Health and Health Care were established in 2000 by OMH to advance health equity and eliminate health care disparities through the provision of culturally and linguistically appropriate services. In 2010, OMH published the Enhanced Standards for CLAS in Health and Health Care in order to revise the National CLAS Standards and reflect advancements made since 2000, expanding its scope and improving its clarity to ensure better understanding and implementation. The NAMCS CLAS supplement will provide important information on the types of cultural and linguistic training received by office-based physicians; their awareness of patients' cultural and linguistic needs; as well as organizational policies related to services and provision of these services in patient care.

The main goals of the cognitive evaluation of the NAMCS CLAS supplement were to: (1) assess respondents' patterns of interpretation of the survey questions, (2) identify any potential question-response problems, which could lead to response error in the survey data, and (3) identify any usability issues with the self-administered paper questionnaire. The following report summarizes the cognitive interview methodology, describes the interviewing procedures and data collection, and how the qualitative data analysis was performed. A summary of key findings is then presented, followed by a question-by-question review.

II. Methodology

A team of research analysts at NCHS' Center for Questionnaire Design and Evaluation Research (CQDER) conducted cognitive interviews with 20 office-based physicians, which is the population the DHCS aims to survey in 2016. Cognitive interviewing took place in June and July of 2015.

Cognitive interview methodology is a qualitative question evaluation method that can be used both to uncover potential question-response problems and to examine the construct validities of survey questions (Tourangeau, Rips, and Rasinski, 2000; Willis, 2005; Miller et al., 2014). The method involves interviewing a small, purposive sample of respondents to understand the cognitive processes that make up their responses to survey questions and identify respondent patterns of interpretation for each question. The intent of cognitive interview methodology is to determine the way in which questions perform when asked of respondents.

¹ Paul Scanlon and Sarah Lessem of CQDER were additional cognitive interviewers for the study.

Sample

A purposive sample of 20 office-based physicians in the Washington, DC and Baltimore, MD metropolitan areas was recruited for the study.² Physicians were recruited by developing a list of physicians from the “Find physicians and other health care professionals” search engine on Medicare.gov (<https://www.medicare.gov/physiciancompare/search.html>), general internet searches about those physicians, word-of-mouth, and by contacting participant physicians from past CQDER projects. An advance invitation letter was sent to physicians followed by an e-mail, telephone call, and/or fax to participate in the study. Physicians were screened to confirm that they were office-based physicians.

The aim of recruitment was to also obtain a sample of office-based physicians diverse in both their practice type and the patient population they serve. Accordingly, the sample included physicians who practiced in primary care, had a surgical specialty, or medical specialty. The sample also included physicians who provided healthcare services to either a racially diverse patient population (no one race category constitutes >65% of the population) or a less racially diverse patient population (>65% of population is one race category).³ In a couple of cases, physicians were also included in the sample who provided healthcare services to a “special population,” such as a family medical facility that specifically reaches out to Hispanic, Jewish, Muslim, or Ethiopian communities.

Respondent demographics for the sample (n=20) are shown in Table 1. During the testing, DHCS survey managers reformatted and revised some questions in the original questionnaire (see Appendix A). The revised questionnaire (see Appendix B) was tested on the final eight of the 20 respondents. The sample was mostly female and non-Hispanic. About half the sample was Asian. There was about an even split among respondents between the ages of 30 to 49 and 50 to 69. Half the sample practiced in primary care.

Table 1: Respondent Demographic Profile

	Original Version	Revised Version	Total (n=20)	
Gender				
	Female	7	6	13
	Male	5	2	7
Age				
	30-39	5	2	7
	40-49	1	1	2
	50-59	5	3	8
	60-69	0	2	2
	70-79	1	0	1
Hispanic/Non-Hispanic				
	Hispanic	1	0	1
	Non-Hispanic	11	8	19
Race/Ethnicity				
	Black	2	0	8
	White	3	4	7
	Asian	7	4	11
Practice Type				
	Primary Care	5	5	10
	Surgical Specialty	1	2	3
	Medical Specialty	6	1	7
Patient Population				
	Diverse	7	5	12
	Less Diverse	4	2	6
	Special Population	1	1	2

² Lauren Creamer of CQDER was the lead recruiter for the study.

³ Once a physician was located, 2014 Census data was used to determine if their respective office was located in a racially diverse or less racially diverse area. During interviews, interviewers asked the physicians about the racial breakdown in their patient population.

Interviewing Procedure & Data Collection

Interviews were conducted off-site (not in NCHS' Questionnaire Design Research Laboratory) at respondents' location of choice (typically their workplace). Prior to beginning the interview, interviewers explained the purpose of the study, the interview procedure, and assured respondents that confidentiality would be upheld. Respondents then had the option to consent to participate in the study and agree to be audio-recorded. Interviews lasted no more than one hour and respondents each received \$100 for their participation in the study.

Interviewers maintained a similar interview protocol throughout the study, which involved a combination of respondent think-aloud and interviewer verbal-probing techniques to collect question-response process data. Since the NAMCS CLAS supplement was designed as a self-administered paper questionnaire, respondents were directed to read and answer each question on their own until completion. Specifically, respondents were asked to think aloud as they interpreted and answered each question. As respondents proceeded through the questionnaire, interviewers used concurrent, intensive verbal probing to further collect question-response process data. Interviewers also developed extensive interview notes, which were later used for data analysis purposes. Interviewers noted any usability issues with question instructions, term definitions, and skip instructions—either reported by the respondents or observed by the interviewers. Similarly, interviewers noted if respondents re-read any questions, changed their answers, or had difficulty in choosing an available answer category. The final two interviews included a timed portion in which each respondent first took the self-administered questionnaire, followed by interviewers administering retrospective probes. One of these respondents took nine minutes to complete the questionnaire while the other took ten minutes to complete it, giving an average burden of nine and a half minutes for the questionnaire.

Throughout the data collection, CQDER staff met regularly to discuss the interviews and interview procedures, as well as preliminary findings. These meetings were especially helpful as salient issues with questionnaire usability and problematic questions were identified early on in the study. These issues were also discussed with the DHCS survey managers, which resulted in the revised questionnaire (Appendix B). Any revisions made during the reformatting of the original questionnaire are discussed in the Question-by-Question Review section of this report.

Data Analysis

Research analysts, who were also the interviewers in this study, relied on a rigorous qualitative data analysis procedure to ensure reliability and transparency in determining how respondents interpreted each question and formulated their answers. Data analysis was informed by Grounded Theory, an inductive reasoning approach (without preconceived notions) that is driven by qualitative data to form conclusions about that data (see Glaser and Strauss 1967). For this project, research analysts generated their qualitative data, or question-response data, through cognitive interviewing, which resulted in summaries that explain how respondents completed the survey questionnaire and formulated their answers to its questionnaire items.

To arrive at these summaries, three levels of analysis were performed, which involved a process of data synthesis, reduction, and comparison (Strauss and Corbin, 1990; Suter, 2012; Miller et al., 2014). The first level of analysis occurred during the cognitive interview, when research analysts began assessing the questionnaire *in situ* for any potential question-response problems. Through asking questions, listening, probing, and extensive note-taking, research analysts assessed how each respondent formulated her or his answer to each questionnaire item. Through this assessment, research analysts determined how that question performed, identifying any discrepancies, or potential problems, with how the respondent answered the question. This level of analysis is illustrated through direct quotes provided in the Question-by-Question Review section of this report.

The second level of analysis occurred post-interview, once all audio-recordings and interview notes were transferred into the Q-Notes software program. Q-Notes is a software program that supports the structured collection and transparent analysis of cognitive interview data and serves as an audit trail tracing each finding to the original source. Research analysts relied on Q-Notes to further assess and compare the question-response data that was generated in this study. At this comparative level of analysis, research analysts identified respondents'

patterns of interpretation and common difficulties in answering the questionnaire items, further alluding to potential question-response problems. This level of analysis is illustrated with a discussion about the general patterns of interpretation that occurred across multiple respondents for each question, also provided in the Question-by-Question Review section of this report.

The third level of analysis was also comparative by which research analysts explored various patterns of interpretation (as well as question-response problems) across certain groups of respondents who shared a particular social characteristic. For this study, respondents were compared across their practice type, years practicing, and patient population they served according to the racial diversity measure of either being racially diverse or less racially diverse.

III. Summary of Key Findings

This summary of key findings is based on the overall question-by-question review that follows this section. Several major themes were identified in the study, which are discussed below.

Training in Cultural Competency

Several questionnaire items addressed respondents' training in cultural competency, particularly Questions 9 through 12. Understanding of the phrase "training in cultural competency" was crucial to the performance of this sub-set of questions, as the intent was to identify whether or not respondents had received such training, as well as which population groups and topics of culture were covered (if they had that training). Various interpretative patterns of "training in cultural competency" emerged (see Question 9 review), affecting how respondents framed and answered subsequent questions. While respondents generally interpreted training in cultural competency according to a particular *training setting* and certain *topics of culture* (summarized below), they also used multiple interpretations in a single question.

Training setting

When comparing across groups of respondents by their years of post-residency practice, training in cultural competency was more salient to those who had recently begun practicing medicine (who were generally the younger respondents below the age of 50 in the cognitive sample). These respondents referred to *training* in cultural competency as training within a curricula-based setting, that is, within medical school or early years of residency. Those respondents practicing medicine much longer (who were, correspondingly, older), more likely thought about training within a practice setting or part of continuing medical education (CME).

Topics of Culture

Respondents also explained that culture is a broad term, leaving some uncertain as to which topics of culture would qualify as part of training in *cultural* competency. Since both groups of respondents thought about training in a particular setting, they subsequently thought about topics of culture that were (or would have been) covered in such a setting. That is, while the group of respondents who had recently begun practicing medicine thought back to topics covered in their medical school lectures, the group of respondents practicing much longer thought about topics addressed in their current practice or CME. Also, respondents who worked in a practice that catered to a special patient population, such as those with predominantly Latino patients, often referred to cultural topics specific to their patients' ethnic backgrounds.

Formal (Official) vs. Informal (Unofficial)

Respondents also expressed concerns in whether or not "training in cultural competency" indicates formal, mandated training or informal, voluntary training. Similarly, respondents had concerns with questionnaire items that asked about the use of policies, organizational resources, and interpreters related to the provision of culturally and linguistically appropriate services (see Questions 13, 17, 32, and 33). For example, respondents were

uncertain if questions about policy were asking about formal or informal policies. To add to the complexity in answering these questions, respondents also thought about policies at the greater organizational level and policies specific to their practice. Also, when asked about the use of interpreters, respondents overwhelmingly described interpreters as unofficial interpreters, such as bilingual staff members (but not officially licensed). Depending on the intent of each of these questions, such as to capture a more narrow response about a formal policy at the organizational level, or licensed interpreters, per se, the divergent interpretive patterns among respondents could lead to response errors.

Universal vs. Situational

Respondents experienced difficulty when having to answer about their patients in a universal way. In the set of Questions 20-27, respondents were asked about how often they considered race/ethnicity and other cultural factors when (1) assessing patients' medical needs, (2) diagnosing patients, (3) treating patients, and (4) conducting health education with patients. Respondents expressed that while they might often consider race/ethnicity for one racial/ethnic group of patients, they might not for another because it is situational and depends on what the patient is being seen for that day. Practice-type also influenced how respondents thought about and answered these questions. For example, one respondent (a dermatologist) explained that she often considers race when specifically treating African-American patients for certain skin conditions. Another respondent (a primary care physician) also explained that he often considers ethnicity when specifically providing healthcare education to Spanish-speaking Latinos. While these respondents often considered these racial/ethnic factors when thinking about these particular racial/ethnic groups, and in regards to their particular health condition, they rarely or never considered racial/ethnic factors for other racial/ethnic groups. As such, respondents had a difficult time answering this set of questions about their patients in a universal way.

IV. Question-by-Question Review

Note that throughout this question-by-question review, the questions displayed are from the survey instrument used after revisions were made during the testing by DCHS survey managers (Appendix B). The majority of the questions in the revised survey instrument remained the same as the questions in the original survey instrument (Appendix A). For those questions that were revised, the revisions are noted in their respective question review and explained in detail. Also, for some questions, a definition (or preamble) is displayed with its related question (e.g., the introductory definition about ambulatory care and Question 1) or as a set of related questions (e.g., Questions 10-10d). For these questions, the question-by-question review covers both the definition and the question, or the entire question subset. Finally, respondents were only probed on select questionnaire items (due to the one-hour time limit), therefore there is insufficient data to provide a question-level review on all questionnaire items.

*This survey asks about **ambulatory care**, that is, care for patients receiving health services without admission to a hospital or other facility.*

1. How many years have you been providing direct care for ambulatory care patients? ____

Question 1

The question was asked of all 20 respondents. All but one respondent calculated a total number of years for their answer. The one respondent who did not, simply wrote in the four-digit year that he started providing direct care for ambulatory care patients.

Interpretation of “ambulatory care” and “ambulatory care patients.” While most respondents understood the questionnaire definition of “ambulatory care,” meaning, “they’re walking around and not admitted,” several respondents explained that the term was not commonly used by them. Respondents more commonly used the term “outpatient care,” since outpatients are considered patients who are not hospitalized. Accordingly, they referred to “ambulatory care patients” as “outpatients.” However, some respondents also referred to their patients as “office-based patients,” that is “patients in a clinic-like setting.”

Interpretation of “years providing direct care for ambulatory care patients.” When formulating their response to the question, several respondents were unsure if they should include years in medical school, residency, and fellowship providing direct care for ambulatory care patients, or only include years since they started practicing. For example, one respondent asked: “Is it asking post-residency, or does that include residency?” While this respondent was unsure exactly what the question asked, she included years of residency in her answer. However, another respondent who asked the same question only included post-residency years in her answer. Also, another respondent excluded years in residency, but included years in fellowship. Therefore, respondents varied in their interpretation of years providing direct care for ambulatory care patients.

Respondents were also uncertain if they should think back to when they first directly cared for ambulatory care patients and count all of the years since then (up until the present) or total each year directly caring for ambulatory care patients within that timeframe. For example, one respondent who cared for hospital-based patients in between years of caring for ambulatory care patients included those years in his answer. He explained:

At the beginning, I had a few patients that were in the hospital. And I was taking care of patients in consultation that were admitted to a hospital but not admitted by me, so consultations. They would call me and say, there is a patient in the hospital in bed number, blah, blah, blah, who needs to have their eyes checked and then I’d go in and do it, but that is within the scope of the 40 years.

In another case, the respondent wrote in the four-digit year when he first started practicing, “since 1986,” and did not bother to calculate the number of years.

<p>2. What is your specialty?</p> <p><input type="checkbox"/> General practice/family medicine</p> <p><input type="checkbox"/> Internal medicine</p> <p><input type="checkbox"/> Pediatrics</p> <p><input type="checkbox"/> Obstetrics and gynecology</p> <p><input type="checkbox"/> Geriatrics</p> <p><input type="checkbox"/> Other (Please specify): _____</p>

Question 2

The question was asked of all 20 respondents. Seven respondents answered “Other” and wrote in their answer, including two dermatology, two psychiatry, one neurology, one cardiology, and one ophthalmology. Among the answer categories provided, six respondents answered “Pediatrics,” three respondents answered “Obstetrics and gynecology,” and three respondents answered “General practice/family medicine.” One respondent selected multiple answer categories, including “Internal medicine,” “Pediatrics,” “Geriatrics,” and “Other.”

Interpretation of “specialty.” While all of the respondents understood the types of specialties listed in the answer categories, with each of them choosing at least one answer category without hesitation, some respondents mentioned that other physicians can have multiple specialties (e.g., a double-certified physician). As this applied to one respondent who had multiple certifications, he was uncertain if the question was asking about his current, primary specialty or all of his specialties. He ended up choosing multiple answer categories because he has been

involved with several specialties since he first started practicing, over the last 15 years. Also, a few respondents suggested to include “Surgery” as an additional answer category, as they deemed it a major specialty group.

<p>3. Are you fluent in a language besides English?</p> <p><input type="checkbox"/> Yes</p> <p><input type="checkbox"/> No [SKIP to item 4]</p> <p>3a. How many languages, other than English, do you feel comfortable enough to provide healthcare services?</p> <p><input type="checkbox"/> 1</p> <p><input type="checkbox"/> 2</p> <p><input type="checkbox"/> 3</p> <p><input type="checkbox"/> 4 or more</p>

Question 3

Question 3 was asked of all 20 respondents. Sixteen respondents answered “Yes” and four respondents answered “No.”

Interpretation of “fluent.” Several respondents described themselves as fluent in a language besides English because they were either raised speaking that particular language as part of their ethnic upbringing or learned it by taking language courses. A few respondents explained that they are fluent in a language besides English because they use that particular language within their practice on a daily basis, such as those with predominantly Spanish-speaking patients. However, respondents varied in their interpretation as to what qualifies as being *fluent*, specifically in regards to their level of fluency.

In-Depth Understanding

Most respondents described being fluent as having an in-depth understanding of a particular language, which includes the ability to speak, read, and write in that language. For example, one respondent who answered “Yes” said: “Fluent means you can speak it, understand it, and read material in that language.” However, one respondent who answered “No” emphasized that being fluent goes beyond speaking, understanding, and reading at a basic level, such as learning by taking a language course. While this respondent took German courses in both high school and college, he answered “No” because he had difficulty remembering what he had learned. He said being fluent is “being able to converse and read without difficulty, on at least a high school level.”

Some Fluency, Proficiency, or Working Knowledge

While most respondents who answered “Yes” expressed that being fluent means having an in-depth understanding of a particular language, some respondents questioned whether or not being fluent included having “some fluency,” “some proficiency,” or “some working knowledge” of that language. As explained by one respondent who answered “Yes”:

I have some fluency, it's not great. I have some...I do have some Sri Lankan patients that I converse with, but then when they talk too fast, I have to slow them down. So, I guess I could put it.

Another respondent who answered “Yes” said: “I don’t dream in Spanish and I don’t conduct full conversations in Spanish.” This particular respondent explained that she almost answered “No” to the question, but then read ahead to Question 3a, which influenced her answer choice because she felt that she can provide healthcare

services in Spanish. Reading Question 3a before answering Question 3, may have also occurred among other respondents (as explained in Question 3a review).

Question 3a

Question 3a was asked of all 20 respondents. Nine respondents answered “1,” four respondents answered “2,” two respondents answered “3,” and one respondent answered “4 or more.” Four respondents skipped out of the question.

Interpretation of “feel comfortable enough to provide healthcare services.” Most respondents who answered “Yes” to Question 3 (implying that they are fluent in a language besides English) also answered that they feel comfortable enough to provide healthcare services in that language. According to one respondent in this case, being *comfortable* is “explaining to the patient what they are here for, explaining the treatment to them, and following up with them.” Similarly, another respondent in this case stated:

I can perform a complete exam, eye exam, which is my sub-specialty, in those languages and be able to explain to my patients exactly the problem that they may have or whatever course of action I have to take.

However, one respondent who answered “Yes” to Question 3, and initially answered “1” language in Question 3a, re-read the question and then realized that the question was asking about feeling *comfortable enough* to specifically *provide healthcare services*. She then stated that she only felt “fairly comfortable” in providing healthcare services in a language besides English, because she cannot speak in that language “using medical terms.” She then wanted to change her answer to “0,” but did not have the option to do so among the available answer categories.

Although, in another case, a couple of respondents who answered “Yes” to Question 3 and chose at least “1” in Question 3a, mentioned that they actually are not fluent in a language beside English, but still comfortable enough to provide healthcare services in that language. This case applied to the one respondent (described in Question 3 review) who mentioned that she read ahead to Question 3a before answering Question 3, and stated that although she is not fluent in Spanish, she feels comfortable providing services in that language, particularly “medical Spanish.” Similarly, another respondent who answered “Yes” to Question 3 stated:

Hindi and Spanish I would say I have a working medical knowledge...definitely working, not fluent...That means if you dropped me in a village in Spain that had a population of 300 people I would be fine. No, that's not the case. If you dropped me in a village in South India, I would die (laughs) because I would not be able to communicate with anybody. But if you brought me a patient who was the mother of someone who was born here, and they were Indian and the patient came and said I don't speak very good English, but I know a few words, I would say that's fine, speak in Hindi I can understand you, I may not be able to respond back to you in Hindi, but I will be able to treat you...I would say working knowledge, but not fluent.

These same respondents questioned whether or not Question 3 considers having some proficiency or working knowledge of a language besides English as being fluent.

In one other case, a respondent who answered “Yes” to Question 3 said that she is fluent in Tagalog, and so she chose “1” language in Question 3a because she felt that being fluent in Tagalog allowed her to feel comfortable enough to also provide healthcare services in that language. However, she mentioned that while she speaks medical Spanish “comfortably,” she is not fluent in Spanish. Accordingly, she did not answer “2” languages in Question 3a. Yet, another respondent explained that he is fluent in Farsi, and so he similarly answered “1” language in Question 3, also implying that he is comfortable enough to provide healthcare services in that language. However, he further mentioned that while he is “semi-fluent” in French, he did not choose “2” languages in Question 3a because “it is not good enough to provide healthcare services.”

According to these various interpretation patterns, in some cases, being fluent in a language besides English means also being comfortable enough to provide healthcare services in that language. Although, in other cases, being fluent does not, because respondents might not feel comfortable enough to use medical terminology in that language. However, for a couple of respondents, they expressed that while they are not fluent in a language (yet still answered “Yes” to being fluent in Question 3), they do feel comfortable enough to provide healthcare services in that language. In other words, there seems to be a mix of interpretations, all of which might lead a respondent to answer “Yes” to Question 3 and for different reasons (which includes looking ahead to Question 3a before answering) and then choosing one or more answer categories in Question 3a, also for the different reasons explained above.

(In)Ability to answer the question based on answer categories. While most respondents who were fluent in a language besides English (those who answered “Yes” to Question 3) felt comfortable enough to provide healthcare services in that language, some respondents did not. As in the case with the respondent who felt “fairly comfortable,” she said: “But there is no zero...the question assumes that since you know a language that you can provide healthcare services.” While this respondent initially answered “1” language to Question 3a, she wanted to change it to “0,” but did not have the option to do so according to the available answer categories.

<p>4. What is your sex?</p> <p><input type="checkbox"/> Female</p> <p><input type="checkbox"/> Male</p>
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Question 4

The question was asked of all 20 respondents. Thirteen respondents answered “Female” and seven respondents answered “Male.”

Respondents were not probed on this question because of the one-hour time limit. Therefore, there is insufficient data to provide an explanation of respondents’ interpretation of the question and response categories.

<p>5. What is your ethnicity?</p> <p><input type="checkbox"/> Hispanic or Latino</p> <p><input type="checkbox"/> Not Hispanic or Latino</p>
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Question 5

The question was asked of all 20 respondents. Nineteen respondents answered “Not Hispanic or Latino” and one respondent answered “Hispanic or Latino.”

Respondents were not probed on this question because of the one-hour time limit. Therefore, there is insufficient data to provide an explanation of respondents’ interpretation of the question and response categories.

<p>6. What is your race? (Check all that apply)</p> <p><input type="checkbox"/> White</p> <p><input type="checkbox"/> Black or African American</p> <p><input type="checkbox"/> Asian</p> <p><input type="checkbox"/> Native Hawaiian or other Pacific Islander</p> <p><input type="checkbox"/> American Indian or Alaska Native</p>

Question 6

The question was asked of all 20 respondents. Eleven respondents answered “Asian,” six respondents answered “White,” and two respondents answered “Black or African American.” One respondent did not enter any data.

Respondents were not probed on this question because of the one-hour time limit. Therefore, there is insufficient data to provide an explanation of respondents’ interpretation of the question and response categories.

7. In what setting do you typically provide care to the most patients? (Check all that apply)

- Solo or group practice
- Freestanding clinic or urgent care center
- Community health center (e.g. Federally Qualified Health Center (FQHC), federally-funded clinics or “look-alike” clinics)
- Mental health center
- Non-federal government clinic (e.g. state, county, city, maternal and child health, etc.)
- Family planning clinic (including Planned Parenthood)
- Health maintenance organization or other prepaid practice (e.g. Kaiser Permanente)
- Faculty practice plan (an organized group of physicians that treat patients referred to an academic medical center)
- Hospital emergency or hospital outpatient department
- None of the above

Question 7

The question was asked of all 20 respondents. Seventeen respondents answered “Solo or group practice” and two respondents answered “Community health center.” One respondent did not enter any data.

The original question excluded the “Check all that apply” instruction directly following the question in parentheses. As a result, some respondents were unsure if they could choose more than one answer category. During the testing, “Check all that apply” was added to the question (as displayed above in this revised question), which provided clarification on whether or not respondents could choose more than one answer category.

Interpretation of setting answer categories. Most respondents were familiar with the setting answer categories, with each of them being able to choose an answer without hesitation and were able to answer accordingly to the setting where they typically provide care to the most patients. However, not all of the answer categories were mutually exclusive to respondents, which they mentioned was problematic when making their answer selection. For example, some respondents explained that the answer category “Solo or group practice” can be interpreted as either a “private practice” or “private office” owned entirely by a solo physician or group of physicians. In

addition, some respondents' private practice was also "affiliated with a hospital." In the case that respondents' practice was affiliated with a hospital, they were unsure if they should check both answer categories, that is, to check both "Solo or group practice" and "Hospital emergency or hospital outpatient department" (this was particularly confusing for respondents who did not have the option to "check all that apply," which was added to the question during the testing).

Respondents also identified the term "practice" in the answer category "Solo or group practice" as different from the term "clinic" in the answer category "Freestanding clinic or urgent care center," such that clinics are not owned by physicians. However, some respondents were uncertain with the meaning of the term "freestanding clinic." As one respondent said, "the word 'freestanding' is a little weird." Another respondent said that she was only familiar with the term "urgent care center," which she described as "more of a walk in type practice for people who can't see their primary physician to be treated for something medically." She then asked: "Non-federal government clinic I assume can be freestanding clinic too?"

8. What is the street name for the location where you typically see the most patients?

Street _____

Question 8

The question was asked of all 20 respondents. All respondents wrote in at least one location except for one respondent who incorrectly skipped the question.

Difficulty in choosing the location. Most respondents were able to identify which location they typically see the most patients. However, some respondents expressed difficulty when writing in one location where they typically see the most patients. If respondents worked at multiple locations, they had to consider all of those locations where they see patients, including hospitals that may or may not be affiliated with their practice. If respondents saw an equal amount of patients at more than one location, they had to determine which one of those locations was their primary location. In this case, one respondent wrote in both locations because he felt that both locations were his primary locations since he sees about an equal amount of patients at each. Another respondent considered both the location where he spends most of his time working and where he actually sees the most patients, when formulating his response. He chose to write in his private practice location (where he spends most of his time working), even though he sees less patients there compared to the hospital where he also works part-time (but has a higher volume of patients). As a result of having to choose among multiple locations, both of these respondents experienced difficulty in choosing just one. Also, for these respondents, they referred to their multiple locations in which they practiced medicine when answering remaining questionnaire items.

For the remaining questions, please provide answers reflecting your experiences at this location.

As observed, several respondents skipped over reading this instruction, which may have affected how they answered the remaining questions. As explained in Question 8, some respondents referred to more than one location (including an unaffiliated hospital) when they answered some of the remaining questionnaire items.

9. Did you receive any training in cultural competency in your clinical training programs including medical school and residency?

- Yes
- No

Question 9

The question was asked of all 20 respondents. Ten respondents answered “Yes” and ten answered “No.”

Interpretation of “training in cultural competency.” Respondents who had recently begun practicing medicine (and tended to be younger than 50 years in the cognitive sample) interpreted training in cultural competency as “curricula-based” and thought specifically about training in medical school or the early years of their residency. They assumed that training in cultural competency entailed “medical school lectures” “seminars,” and “course modules” that covered any possible topic about culture. For example, one of these respondents who answered “Yes” specifically referred to training he had during residency. He said:

First we were trained to work with an interpreter and that wasn't just Spanish, that was with a whole group of languages...and then we learned a little bit about different cultures and how they view doctors and the world of medicine.

Respondents who began practicing medicine much longer were less sure as to what training in cultural competency entailed because, as one respondent who answered “No” explained:

A bit of a trick question because it's been 30+ years since I was in training, though there was some informal discussions and emphasis on multiculturalism in medical school. No formal training. I think that would be different if I was in medical school now. I hope it would be.

These respondents provided hypothetical responses, and only assumed what that training may entail within medical school. For example, one respondent who answered “No” said, “I think it is kind of, maybe, finding out more information of what people think and believe from other cultures besides yours.”

Various interpretative patterns of “training in cultural competency” were identified. These interpretative patterns included: (1) to obtain awareness of their patients’ racial, ethnic, and religious backgrounds, as well as gender and sexual orientation, (2) learn how to communicate with patients of different cultures or who come from countries outside the United States, (3) and understand various cultural customs, norms, and practices among patients, especially in terms of health, such as cupping procedures in Chinese medicine, or having vegetarian eating habits.

Several respondents thought about training specifically in regards to learning how to better communicate with patients of different cultures or who come from countries outside the United States (especially among the Spanish-speaking Latino community). They understood this training as learning to work with interpreters and use translating services. According to one respondent who answered “Yes”: “There were services at Georgetown where we could call a translating service or there were actually physical translators who could come.” However, as another respondent explained, learning how to better communicate also includes “being able to approach people that come from other cultures and countries.”

10. After your clinical training, have you participated in training for cultural competency such as continuing education or continuing medical education?

- Yes
- No [SKIP to item 11]

a. Within the past 12 months, have you participated in any training for cultural competency?

- Yes
- No [SKIP to item 11]

b. Which of these population groups have been addressed in the training(s) for cultural competency in which you have participated? (Check all that apply)

- Racial/ethnic minorities
- Religious groups
- Lesbian, gay, bisexual, transsexual (LGBT) populations
- Persons with limited English proficiency (LEP)
- Inmates/ex-offenders
- Other (please specify): _____

*For the purposes of this survey, **culturally and linguistically appropriate services** are services that are respectful of and responsive to individual cultural health beliefs and practices, preferred languages, health literacy levels, and communication needs.*

c. Which of the following areas have been typically included in training(s) for cultural competency in which you have participated?

(Check all that apply)

- Cultural beliefs, values, and behaviors
- Organizational policies, plans, and protocols regarding culturally and linguistically appropriate services
- Health disparities
- Complementary and alternative healing practices
- Other (please specify): _____

d. Was your participation in training for cultural competency to satisfy a continuing education unit (CEU) requirement or as requirement for credentialing?

- Yes
- No

Question 10

Question 10 was asked of all 20 respondents. Fifteen respondents answered “No” and five answered “Yes.”

The original question excluded “continuing medical education.” During initial testing, some respondents interpreted “continuing education” as “continuing medical education,” which they commonly referred to as “CME.” During mid-testing, “continuing medical education” was added to the question (as displayed above in this revised question), which provided clarification to whether or not the question was also asking respondents to include training for cultural competency during any continuing medical education.

Interpretation of “training for cultural competency such as continuing education or continuing medical education.” Respondents provided various interpretations of training for cultural competency, as some thought about continuing education while others thought about continuing medical education.

Continuing Education

Respondents who thought about training for cultural competency in regards to continuing education, referred to such training as occurring within their workplace. They also provided different interpretations as to what this type of training entailed. For example, one respondent who answered “Yes” referred to a handout, and explained:

Since I work in a government facility [as part of the hospital], every year they give us a handout that we have to study and we have to answer some questions that has to do with cultural competency. It's called “cultural competency at the workplace.” So that is the training, so I would say “yes.”

Another respondent who answered “Yes” referred to orientation, and said:

In our clinic we do an orientation for new employees and for when we work with family medicine residents that do training with us...part of their orientation is part of cultural competency and background of Central America clients, so that is part of our place.

Yet, another respondent who answered “Yes,” referred to a video, and said:

There's a standard video we watch every year, it's the same video....what it entails now is the same 15-20 minute video on cultural competency, focusing on being open to listening to patients, asking questions to understand a patient's culture and cultural practices, how their culture can affect their health.

While these respondents thought specifically about workplace training in cultural competency (although referring to different forms of training), others referred to training for cultural competency in regards to continuing medical education.

Continuing Medical Education

Some respondents clearly indicated that they understood the question to be asking about training for cultural competency as part of their CME coursework. These respondents also answered “No” to the question, since either they had not taken such courses yet or did not choose such CME courses that covered cultural topics. One respondent simply stated: “I haven't taken any CME courses yet.” Another respondent explained that she does not think she has completed any credits for cultural competency specifically for CME. So, she responded: “I'm pretty sure that's a no.”

Formal (Mandated) Training or Informal (Voluntary Training)

Respondents also referred to training for cultural competency as being either formal, mandatory training or informal, voluntary training. Respondents were uncertain as to which type of training the question was asking about and, as such, they differed from one another in their answers to the question. Several respondents considered both workplace training and CME training as formal, mandatory training. Other respondents explained that while CME is mandated, they voluntarily choose among which CME courses to take. In the case of informal training, some respondents were unsure if attending voluntary presentations, engaging in self-taught courses, or reading a journal article, qualified as training in cultural competency. For example, one respondent who answered “No,” asked:

What does training actually mean? Does training mean a lecture series or course, then “no,” but have I picked up an article on my own about this, then “yes.”

However, a respondent who answered “Yes,” asked:

When you say training, is it formal training, or on the job training?...It's kind of given that because you are in this kind of population that you will be dealing with diverse cultures and different people, so I think I will answer that, yes, but it's not a formal training.

As illustrated in these two examples, respondents thought about and answered the question in different ways, specifically in regards to continuing education and continuing medical education.

Skip instruction. All five respondents who answered “Yes” to Question 10 correctly moved on to answer Question 10a, while fourteen respondents who answered “No” correctly skipped to Question 11. One respondent who answered “Yes” to Question 9 and “No” to Question 10 did not SKIP to Question 11. She incorrectly moved on to answer Question 10a because she read ahead and explained that while she did not complete training for cultural competency after her clinical training (as part of continuing education or continuing medical education), she wanted to fill in the other questions (particularly Question 10b and 10c) to provide information on what she did learn in her cultural competency training during clinical training.

Question 10a

Question 10a was answered by six respondents. Three respondents answered “Yes” and three answered “No.”

Respondents understood the timeframe “within the past 12 months.” Their understanding of the timeframe was implied as they referred to training they had within that timeframe, thinking back from the present moment. For example, one respondent said: “Yes I have, through my work, we are required yearly to have cultural competency training.”

Question 10b

Question 10b was answered by four respondents who checked multiple answer categories. Three respondents answered “Racial/ethnic minorities,” three answered “Persons with limited English proficiency (LEP),” two answered “Religious groups,” two answered “Lesbian, gay, bisexual, transsexual (LGBT) populations,” and one answered “Other.”

While most respondents skipped out of Questions 10b (and subsequently Questions 10c and 10d), for those that did answer them, they carried forward their concerns in formulating their answers in Questions 9, 10, and 10a. That is, they were still uncertain as to what would qualify as training in cultural competency. For example, when formulating her response to Question 10b, one respondent considered her clinical training as well as her voluntary reading of a journal article about transgender issues when answering among these population groups. While she explained that her reading of the journal article was “voluntary” and “not formal training,” she decided to answer “Lesbian, gay, bisexual, transsexual (LGBT) populations.”

Question 10c

Question 10c was answered by four respondents who checked multiple answer categories. Four respondents answered “Cultural beliefs, values, and behaviors,” three answered “Organizational policies, plans, and protocols regarding culturally and linguistically appropriate services,” and two answered “Health disparities.”

During the testing, the definition on “culturally and linguistically appropriate services” was added to precede Question 10c, which was the first time this term was introduced.

Interpretation of “culturally and linguistically appropriately services.” Prior to adding the definition on “culturally and linguistically appropriate services,” respondents were unsure as to what would qualify as culturally and linguistically appropriate services in the answer category “Organizational policies, plans, and protocols regarding culturally and linguistically appropriate services.” For example, one respondent who chose this answer category said that he had never heard of it, but assumed that it was part of their policy. He explained:

...our intake process when a new person comes in we have a process where someone up front asks how much schooling have you had, what is your literacy, what is your language, do you speak other languages, what language do you want to speak here, do you want an interpreter, and then we figure out how to make that available.

Since respondents were unsure of the CLAS term in the answer category, they specifically answered according to them having some type of *organizational policy*, which included formal and informal policies.

Question 10d

Question 10d was answered by four respondents. Three respondents answered “No” and one answered “Yes.”

Interpretation of “continuing education unit.” The few respondents that answered the question interpreted CEU as continuing medical education (CME). One respondent explained that CEU is more related to social workers while CME is specifically for physicians.

11. Is training in cultural competency required as a condition of employment by your practice?

- Yes
- No

Question 11

The question was asked of all 20 respondents. Sixteen respondents answered “No” and four answered “Yes.”

Interpretation of “required as a condition of employment by your practice.” Most respondents interpreted the phrase “required as a condition of employment by your practice” as a formal requirement. However, some respondents were uncertain if the question was also asking about any informal requirements that may be expected of certain employees other than themselves. That is, several respondents were unsure if the question was asking about a requirement that pertains to them (as the individual physician) or includes other employees. When thinking about themselves, a few respondents thought about a formal orientation that is required upon being hired that addresses topics about culture. When thinking about other employees, several respondents explained that while staff members may not have a formal requirement to speak multiple languages, it was expected to have at least one bilingual employee to work at the front desk.

12. How often does your practice offer or make available training in cultural competency?

- Annually
- Biannually
- Quarterly
- Other (Please specify): _____
- Not applicable: my practice does not offer or make available training in cultural competency.

Question 12

The question was asked of all 20 respondents. Seventeen respondents answered “Not applicable: my practice does not offer or make available training in cultural competency,” two answered “Annually,” and one answered “Quarterly.”

Interpretation of “your practice” and “offer or make available training in cultural competency.” While the majority of respondents stated that their practice does not offer or make available training in cultural competency,

respondents referred to previous questions and interpreted this type of training as something that could be either mandatory, voluntary, formal, or informal training. Respondents were also uncertain if this training would be something that their practice offers within the practice or hires an outside person to come into the practice and train their employees on cultural competency. Respondents provided hypothetical responses to explain what this type of training may entail, including: “seminars,” “orientations,” “web-based trainings,” “handbook guides,” and “meetings,” all of which they mentioned could address cultural issues.

*For the purposes of this survey, **culturally and linguistically appropriate services** are services that are respectful of and responsive to individual cultural health beliefs and practices, preferred languages, health literacy levels, and communication needs.*

While this definition on “culturally and linguistically appropriate services” was added during the testing to precede Question 10c, which was the first time this term was introduced, it also remained in this initial questionnaire location. The following questions, Question 13 and Question 13a specifically refer to the term. About half the respondents read the definition, including some who read it aloud and others who paused and read it in silence. One respondent questioned why the definition was repeated in the questionnaire (making reference to the one located prior to Question 10c) and asked “is there a reason you’re repeating that?...it looks like that’s the same...it’s repeating this statement.”

13. Does your practice have at least one policy in place related to the provision of culturally and linguistically appropriate services?

- Yes
- No [SKIP to item 14]
- I don’t know [SKIP to item 14]

a. How aware are you of your practice’s policy related to culturally and linguistically appropriate services?

- Not at all
- Barely
- Fairly well
- Very well

Question 13

The question was asked of all 20 respondents. Ten respondents answered “No,” six answered “Yes,” and four answered “I don’t know.”

Interpretation of “policy” in regards to “culturally and linguistically appropriate services.” Most respondents interpreted “policy” as either pertaining to a formal policy or an informal policy. They explained that they did not know of any formal policy, which they interpreted as an “organizational policy” within the practice or, for some respondents, the greater organization in which their practice is associated.

Respondents particularly referred to the policy as providing services in languages other than English, which included voice-recorded messages in Spanish or offering translation services to their patients. For example, one respondent who interpreted the policy as a translation service explained:

I’m going with linguistically appropriate services, which I guess I’m kind of leaning towards translation. Like appropriate medical translation...Yeah, I think it’s a policy because e-mails are sent out. Basically, it depends on the language and we have staff members in the office that can translate Spanish or French, but then outside of that if someone comes in they will know that there is a phone that we can use.

Similarly, another respondent referred to his policy of having his employees speak Spanish, as well as know about Spanish-speaking cultures. He explained:

I do have a policy that I would much rather have someone who can give the linguistically appropriate services... It’s not a written policy. It’s something that we strongly prefer...if they are knowledgeable of

certain customs foreign people have, you know, that would be also a plus. But it's not absolutely required.

As illustrated in both examples, respondents were unsure if these policies were formal or informal policies.

Skip instruction. The six respondents who answered “Yes” to this question correctly moved on to answer Question 3a. Four respondents who answered “No,” and who should have skipped according to the instruction, incorrectly moved on to answer Question 13a.

Question 13a

Ten respondents answered this question. Four respondents answered “Fairly well,” three answered “Barely,” two answered “Not at all,” and one answered “Very well.”

As respondents were uncertain in their interpretations of what such a policy would entail and whether it be formal or informal (as in their responses to Question 13), they further explained that they were not very well aware of that policy (as reflected in their answers). In other words, respondents who were unsure as to what type of policy Question 13 asked about, yet answered “Yes” to that question, were subsequently unsure how to answer Question 13a.

14. In what format are printed materials provided to your patients with limited literacy? (Check all that apply)

- Documents created with plain language software or reviewed for literacy level
- Universal symbols (*A sign recognized by most people. Example: a square around a plus sign for first aid.*)
- Infographics (*A visual image such as a chart or diagram used to represent information or data*)
- Other (please specify): _____
- Not applicable: no printed materials are available to my patients with limited literacy.

Question 14

The question was asked of all 20 respondents and some respondents checked multiple answer categories. Eight respondents answered “Not applicable: no printed materials are available to my patients with limited literacy,” eight answered “Other,” five answered “Documents created with plain language software or reviewed for literacy level,” four answered “Infographics,” and one answered “Universal symbols.”

The original question excluded definitions of the response categories “Universal symbols” and “Infographics.” During the testing, definitions (in parentheses) were added to these two answer categories (as displayed above in the revised question).

Interpretation of “limited literacy.” Respondents varied with their interpretations of limited literacy. Some respondents provided one separate, exclusive definition, such as “patients who have limited English proficiency because they speak another language.” For example, one respondent said: “It could be someone who doesn’t speak English.” Another respondent explained:

If someone doesn't speak English and you give them a pamphlet in English, they have limited literacy in that language. It doesn't mean that they are uneducated. It means they can't speak the language.

Other respondents added complexity to this interpretation by also considering how literacy within and across languages fits into this question. As one respondent referred to a patient who had limited literacy in their native language: “It could be someone who doesn’t know how to write or read.” Therefore, respondents were unsure if the question was also asking about patients who have limited literacy within their own language (such as someone with a low level of education and limited reading ability). They thought that this case could pertain to

a native-English speaker or a non-native English speaker. Further, some respondents explained that while their patients may be literate and have at least a high-school education level, they may not have medical or health literacy.

15. Which of these free language-assistance services are available to patients in your practice? (Check all that apply)

- Translated informational documents
- Recorded messages in different languages on telephone lines
- Translated signage and notices at key points of contact throughout the office
- Other (please specify): _____
- Not applicable: free language-assistance is not available to my patients.

Question 15

The question was asked of all 20 respondents and some respondents checked multiple response categories. Ten respondents answered “Translated informational documents,” seven respondents answered “Other,” six respondents answered “Not applicable: free language-assistance is not available to my patients,” three respondents answered “Recorded messages in different languages on telephone lines,” and two respondents answered “Translated signage and notices at key points of contact throughout the office.”

During the testing, the original question was revised considerably. The original question asked: “Which methods are used to inform your patients of free language-assistance services available in your practice?” The question was then revised as displayed above.

Interpretation of original question. The original question asked respondents about “which methods are used to inform” their patients of “free-language assistance services available in your practice.” Most respondents were unsure about the first part of the question, specifically the part that stated: “Which methods are used to inform...” and formulated their responses by thinking about “which of these free-language assistance services are available” to patients. For example, one respondent who answered “Translated informational documents” explained that she thought about the answer categories listed as the free-language assisted services and formulated her response according to whether or not she offers them to her patients. Other respondents used to term “we” to explain whether or not their practice offered such services listed in the answer categories. As such, the revised question reflects these early respondents’ understanding of the question from which the remaining respondents responded well to.

16. Which of these free language-assistance services are available to patients from external sources?

(Check all that apply)

- Translated informational documents
- Recorded messages in different languages on telephone lines
- Translated signage and notices at key points of contact throughout the office
- Other (please specify): _____
- Not applicable: free language-assistance is not available to my patients.

Question 16

The question was asked of all 20 respondents and some respondents checked multiple response categories. Seven respondents answered “Not applicable: free language- assistance is not available to my patients,” six respondents answered “Translated informational documents,” five respondents answered “Other,” two respondents answered “Recorded messages in different languages on telephone lines,” and one respondent answered “Translated signage and notices at key points of contact throughout the office.” Four respondents did not answer any data.

During the testing, the original question was revised considerably. The original question asked: “Which methods are used to inform your patients of free language-assistance services available from external sources?” The question was then revised as displayed above.

Interpretation of original question. As with Question 15, the original Question 16 asked respondents about “which methods are used to inform” their patients of “free-language assistance services.” These respondents overwhelmingly understood the question to be asking about “which of these free-language assistance services are available” to patients. As such, the revised question reflects these early respondents’ understanding of the question.

Interpretation of revised question. While respondents responded well to the revision made in Question 15 (as it appeared to correspond well with the provided answer categories, or services, available in their practice), the revision made in Question 16 was still problematic to most respondents. The major difficulty in answering this question was that respondents first had to determine what constitutes “external sources,” such as one respondent who asked if outside her practice, but within her medical organization would qualify. Then, respondents had to determine which services are (or could be) available from these external sources, which many thought of translating services. Finally, respondents felt uncertain about the answer choices as well as how to answer, with the NA answer category deemed insufficient to some of them. As one respondent said:

It’s hard to say, I think that question needs to be clarified. Within a private practice this would be understandable, but my medical practice is part of a larger organizations, so this seems to be a difficult question to answer.

As a result of this increased burden in understanding the question and answer choices, some respondents simply stated: “I don’t know what the question is asking” and “I don’t know how to answer,” reflected in the answer choice “I don’t know.”

17. Do you use interpreters when working with patients who have limited English proficiency? <input type="checkbox"/> Yes <input type="checkbox"/> No [SKIP to item 18]	a. When you use interpreters how often do you use each type?				
		Often	Sometimes	Rarely	Never
	Trained staff	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Contractor	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Patient's relative or friend	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Question 17

The question was asked of all 20 respondents. Eighteen respondents answered “Yes” and two answered “No.”

Interpretation of “interpreters.” Some respondents were unsure as to what would qualify as an interpreter. For example, one respondent was unsure if using an interpreter meant using an official or unofficial interpreter. She said: “I looked at this as officially, unofficially; we do have an interpreter; we get our Spanish nurse.” Some respondents read ahead to Question 17a, which helped them in formulating their response. For example, one respondent asked: “Do I use my own interpreter or use anybody else? I don’t understand this question. Oh it says in next question.” Yet, another respondent was unsure if the question was asking if she uses interpreters every time when working with patients who have limited English proficiency or if she has ever used one. She explained that since she is fluent in multiple languages, she does not really need to use interpreters, but then she answered “Yes” because she has used one before.

Question 17a

Interpretation of original question. During the testing, the question was revised as well as the formatting of the answer categories. The original question asked: “How often do you use each type of interpreter?” while the revised question (as displayed above) also asks about how often, but specifically in the case “when” respondents use interpreters. The question was revised because as several respondents explained it is situational for them when using interpreters. For example, one respondent explained: “

I’m going to assume that, how often I use it, the answer means how often in these particular cases do I use it, so I would say in those cases, I often use a trained staff or contractor and rarely use a patient’s relative or friend....But on whole, how often do I see patients where I need to use an interpreter is pretty rare.

Interpretation of answer categories. However, when respondents did use interpreters, they might often use staff (which they were thinking of as front-desk staff or nurses) and not a contractor or rely on the patient’s relative or friend. Accordingly, the answer categories were reformatted to provide separate answer categories for “trained staff” and “contractors,” as in the original question they were combined into one answer category and respondents explained that they had never used contractors.

Trained Staff or Contractor

The question was asked of all 20 respondents. All respondents answered in regards to “trained staff” as none of them had used a “contractor.” Seven respondents answered “Often,” four respondents answered “Sometimes,” four respondents answered “Rarely,” four respondents answered “Never” and one respondent did not enter any data.

Interpretation of “Trained Staff.” All respondents explained that among their bilingual staff, they were not “trained” as “official” or “licensed” interpreters. Their staff only tends to know the language because of their own Spanish-speaking background. Most respondents interpreted “trained staff” as staff who is “trained in their medical field.”

Interpretation of “Contractor.” Respondents understood contractor as someone outside of their practice who was paid as an interpreter. As one respondent described: “someone who makes a living being a translator...paid by insurance, third party.”

Patient’s Relative or Friend

The question was asked of all 20 respondents. Nine respondents answered “Sometimes,” six respondents answered “Often,” two respondents answered “Rarely,” one respondent answered “Never,” and two respondents did not enter any data.

Interpretation of “Patient’s Relative or Friend.” Several respondents were thinking more so about a patient who brings in a relative than a friend. They thought of: “patients who come in with family members, the first generation, like they might have their son,” but also sometimes an extended relative, such as a cousin.

<p>18. What types of materials, in language(s) other than English, are available to your patients? (Check all that apply)</p> <ul style="list-style-type: none"><input type="checkbox"/> Wellness/Illness related education<input type="checkbox"/> Patient rights/ Informed consent documents<input type="checkbox"/> Advanced directives<input type="checkbox"/> Payment<input type="checkbox"/> Care plan<input type="checkbox"/> Other (Please specify): _____<input type="checkbox"/> Not applicable: no translated materials are available to my patients
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Question 18

The question was asked of all 20 respondents. Some respondents checked more than one answer category. Fourteen respondents answered “Wellness/Illness related education,” seven respondents answered “Patient rights/ Informed consent documents,” six respondents answered “Care plan,” five respondents answered “Payment,” five respondents answered “Other,” and four respondents answered “Not applicable: no translated materials are available to my patients.”

Interpretation of the answer categories. Respondents first had to think about whether or not they offered these materials (the answer categories) in English and then determine if they also offered them in Spanish. Respondents generally understood the definition of each material, or answer category. However some respondents were unsure what “Advanced directives” were as one respondent simply stated “I don’t know what this is.” Some respondents were also unsure what “Care Plan” meant, such as one respondent who was unsure if it included “operation consents.” While respondents had an easier time stating whether or not they offered such materials in English, some respondents could not recall if they also offered them in Spanish.

*For the purposes of this survey, **culture** is defined as the integrated patterns of thoughts, communications, actions, customs, beliefs, values, and institutions associated with, wholly or partially, with racial, ethnic, or linguistic groups, as well as with religious, spiritual, biological, geographical, or sociological characteristics.*

About half the respondents read the definition of the term “culture,” including some who read it aloud and others who paused and read it in silence. Most respondents understood the definition of culture provided in this preamble. As one respondent paraphrased, culture includes “individuals’ customs and beliefs that are often times related to ethnicity...it’s a broad based term...” So while respondents understood the definition provided, they expressed that it was broad, as well as long. As one respondent explained: “It’s long, but I get it, it’s very broad...it’s comprehensive.” Another respondent said: “I guess if someone looked up culture in the dictionary it

would probably be something like that; it’s a mouthful.” Although, while respondents understood the definition provided, at various moments in the survey respondents expressed that culture could mean anything. For some respondents, (as in their understanding of “cultural competency”), they needed some direction as to what culture might entail, as it relates to the questionnaire items.

19. What information does your practice record on your patients’ culture and language characteristics?
 (Check all that apply)

- Race/Ethnicity
- Nationality/Nativity
- Patient’s primary language
- Sexual orientation/gender identity
- History of criminal justice system involvement
- Other (please specify): _____
- Not applicable: we do not collect information related to culture and language.

Question 19

The question was asked of all 20 respondents. Some respondents checked more than one answer category. Twenty respondents answered “Race/Ethnicity,” eleven answered “Patient’s primary language,” eleven answered “Sexual orientation/gender identity,” seven answered “Nationality/Nativity,” three answered “History of criminal justice system involvement,” and one answered “Other.”

During the testing, the original question was revised so that the word “collect” was replaced with the word “record.” In the original question, two divergent patterns of interpretation emerged, while in the revised format, respondents largely interpreted the question in a uniform way.

With the original question, respondents explained that collection of this information could occur (1) during registration (with the front-desk staff) and (2) during consultation (with the physician). When physicians collected this information, respondents also interpreted “collect” as occurring both “formally” and “informally,” meaning that the information might be formally asked of the patient when the respondent enters it into the Electronic Medical Record (EMR) system or informally asked when only speaking with their patient about this information. Also, respondents explained that sometimes the information is never formally asked, but assumed, such as when understanding the patient’s primary language.

When the term “record” was used in the revised question, it reduced respondents’ interpretations to either formal recording on paper during registration or formal recording by the physician into the EMR system. However, most respondents were thinking about recording information during registration with notable exception of sexual orientation, which was sometimes informally discussed during the consultation.

When assessing your patients’ medical needs, how often do you consider:	Often	Sometimes	Rarely	Never
20. Race/ethnicity?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
21. Other cultural factors?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
When diagnosing your patients, how often do you consider:				
22. Race/ethnicity?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
23. Other cultural factors?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
When treating your patients, how often do you consider:				
24. Race/ethnicity?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
25. Other cultural factors?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
When conducting health education with your patients, how often do you consider:				
26. Race/ethnicity?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
27. Other cultural factors?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Questions 20 - 27

Question 20 was asked of all 20 respondents. Eight respondents answered “Often,” six answered “Sometimes,” four answered “Rarely,” and two did not enter any data. Question 21 was asked of all 20 respondents. Twelve respondents answered “Sometimes,” six answered “Often,” one answered “rarely,” and one did not enter any data. Question 22 was asked of all 20 respondents. Seven respondents answered “Often,” six answered “Sometimes,” four answered “Never,” and three answered “Rarely.” Question 23 was asked of all 20 respondents. Seven respondents answered “Sometimes,” five answered “Often,” five answered “Never,” two answered “Rarely,” and one did not enter any data. Question 24 was asked of all 20 respondents. Eight respondents answered “Often,” six answered “Sometimes,” four answered “Rarely,” and two answered “Never.” Question 25 was asked of all 20 respondents. Seven respondents answered “Often,” seven answered “Sometimes,” three answered “Rarely,” two answered “Never,” and one did not enter any data. Question 26 was asked of all 20 respondents. Eight respondents answered “Sometimes,” seven answered “Often,” and five answered “Rarely.” Question 27 was asked of all 20 respondents. Eight respondents answered “Often,” eight answered “Sometimes,” three answered “Rarely,” and one did not enter any data.

Interpretation of “assessing,” “diagnosing,” “treating” and “conducting health information.” While most respondents were consistent in their understanding of the terms “assessing,” “diagnosing,” “treating,” and “conducting health education,” several respondents found it difficult to separate each process when formulating their answers for each question. For example, some respondents thought of assessing as including the entire process of diagnosing, treating, and conducting health education. In addition, some respondents thought of conducting health information as part-and-parcel to treatment. Also, some respondents experienced difficulty in providing a universal answer about their patients, as they explained that each of these processes can be situational for a patient.

Assessing

Respondents described *assessing* as the initial examination of their patients patient before diagnosing or treating them. For example, a pediatrician, who answered “Often” to both questions about *race/ethnicity* and *other cultural factors*, described assessing in terms of the context of the patient visit and whether or not there is an acute illness or developmental issue that the respondent may have. On the other hand, one respondent mentioned that due to her specialty, she “Often” considered *race/ethnicity* when assessing patients. She stated:

This is difficult in dermatology because so much is based on skin color. This is the only specialty where it actually matters that you see every skin color... so I would say often, because it determines what kind of products we use.

However, for *other cultural factors* she answered “Sometimes,” and further stated:

I would say sometimes because people often will...here’s a great example...African Americans sometimes grease their hair. That’s a cultural thing I think. So, if you have a lot of dandruff and you’re greasing your hair a lot, that can contribute [to acne].

Diagnosing

Respondents referred to *diagnosing* as determining what is wrong with their patient, such as some sort of illness or disease. One OB/GYN, who answered “Sometimes” for *race/ethnicity* but “Never” for *other cultural factors*, simply said: “Diagnosing them with specific diseases.” Similarly, a pediatrician, who answered “Rarely” for *race/ethnicity* and “Sometimes” for *other cultural factors* explained: “Diagnosing...I am thinking it’s basically coming up with your assessment, so you are telling them what they have.” In addition, a pediatrician who answered “Rarely” to both questions, explained that she looks at her patients objectively, that is:

When I a diagnosing I try to look at them objectively and not in cultural terms. Assessing medical needs might be a little different but diagnosing my patients for a condition, I'm looking at that very objectively and not taking into consideration ethnicity and cultural factors...there I'm going to say rarely or never...I'll say rarely not never.

Similarly, a dermatologist who answered “Rarely” to both questions explained:

I mean anybody can get lupus. Is it more common in females? Yes. Is it more common in minority females? Yes. Does that mean a white man can't have it? No.

Lastly, unlike the previous question about assessing, five respondents answered that they “Never” considered these factors when diagnosing patients. They gave similar explanations as respondents above who answered “Rarely.” For example, a dermatologist who answered “Rarely” to both questions stated:

Diagnosing is deciding what they have. And usually, from a dermatological standpoint, there are not many conditions that just occur in Hispanic people or just occur in Black people. They may be more common in black people, but there are very few things that just occur, that is why I say I really don't think about when diagnosing. Some things there are, but overall, skin is skin.

Treating

Respondents' referred to *treating* as simply deciding how to treat an illness or condition, whether it is through medication, behavior change, or a combination that makes up a treatment plan. An internist, who responded “Often” for *race/ethnicity* and “Sometimes” for *other cultural factors* explained: “Treating is providing some sort of treatment plan, whether its medicines or a referral for whatever diagnosis you gave them.” This respondent then mentioned that treatments may be the same across race/ethnicity, but a physician's approach may need to be different. Other respondents had similar comments. A general practitioner who answered “Often” for *race/ethnicity*, but left *other cultural factors* blank (because of lack of her understanding of the term, explained:

The treatment doesn't really vary, much, but to see if they follow what I recommend, and if it is practical for them to follow what I am recommending will depend a lot on their race and ethnicity. And also with ethnicity, some people are vegetarian and if I tell them to follow a high protein diet when they don't eat meat is going to be really difficult for them. Or if I tell them to follow a low carb diet when they are vegetarian, well there aren't a whole lot of choices there. Or I have people who are from Mexico and I tell them to change their diet habits and eat more meat but they will still eat the beans and tortillas. And this is for a lot of diabetics, this comes up. I ask them, what is your normal meal, and they say 'well I don't eat a lot of sugar' but they eat a lot of rice and beans. And same thing with Indian population, so with them I have to think about these issues.

On the other hand, some respondents explained that people of different races or cultures respond to treatment or medications differently and therefore these factors need to be taken into consideration. For example, an OB/GYN who answered “Sometimes” to both stated, “For treating, it is how they respond to something, so we know that African Americans don't respond well to beta blockers as they do to calcium channel blockers for high blood pressure.” In addition, a cardiologist who answered “Sometimes” for both questions said, “When treating, yes. Some medications work better on some populations than others.”

Conducting health education

Respondents referred to *conducting health education* as typically talking to and educating their patients about their condition, how to care for themselves and commonly discussed nutrition. A psychiatrist who responded “Sometimes” to both questions described health education as, “Going through – talking about ways to prevent illness and maintain functioning, nutrition, medication, diet...life coaching and lifestyle.” Similarly, a general

practitioner, who answered “Sometimes” to *race/ethnicity*, but left *other cultural factors* blank (because she did not understand the meaning), described health education as teaching his patients how to change their diet, such as adding more protein but also what to eat and where they can find it.

On the other hand, an OB/GYN’s description of health education focused on information regarding a patients’ condition. She responded to the *race/ethnicity* question with “Rarely” and *other cultural factors* with “Sometimes” and explained health education as informing her patients about all the information related to their specific issue or disease, their treatment options and potential outcomes. She explained that this process actually comes before treating patients and includes giving patients all of their options. Her response contrasted to other physicians who described health education as coming after treatment and diagnosing, and focused on maintaining health based on their condition.

Interpretation of considering “Race/ethnicity.” While most respondents defined “race/ethnicity” according to dominant racial groups in the United States, such as “Caucasian,” “African- American,” or “Hispanic,” some respondents also thought about their patient’s national origin.

Interpretation of considering “Other cultural factors.” Several respondents were unsure what “other cultural factors” entailed, which made it difficult for them to answer these questions. They were unsure if other cultural factors included religious beliefs, income level, education level, food preparation and diet, bodily maintenance, healing practices, language, or all of the above. They also found it a burden to answer in a universal way about all of their patients. They felt that considering other cultural factors was situational for each patient. For example, some respondents discussed how they may treat patients with certain religious beliefs different than others, but in this case they feel that they are only considering the cultural factors of the certain religious people. As a result, some respondents left the answer categories blank.

How knowledgeable are you of your patients’:	Not at all	Barely	Fairly Well	Very Well
28. Health beliefs, customs, and values?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
29. Help-seeking practices? (<i>Process of actively seeking help from others whether it be informally through friends/family or professionally</i>)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Some respondents had a difficult time providing a universal answer about their patients for these two questions. They explained that having knowledge about their patients’ “health beliefs, customs, and values,” (asked in Question 28) as well as “help-seeking practices” (asked in Question 29) is situational depending on the reason for a particular patient visit, which affects the frequency of future visits they would see that particular patient. So while respondents might be knowledgeable of one patient, they might not be for others.

Question 28

The question was asked of all 20 respondents. Twelve respondents answered “Fairly well,” five answered “Barely,” and three answered “Very well.”

Interpretation of “Health beliefs, customs, and values.” Respondents referred to health beliefs, customs, and values as pertaining to how a patient’s culture affects how she or he understands and addresses their health. For example, one respondent who answered “Very Well” explained health beliefs as:

Their beliefs on what causes illness, how illness may be treated, how they distinguish American or modern treatments... and how they distinguish that from their own cultural practices.

Specific examples about certain groups of people included racial differences in their beliefs as well as religious groups. One respondent described how African Americans choose certain foods to eat, or are limited in their food

choices, and how it is prepared can impact their health. Another respondent explained that Jehovah's Witnesses have health beliefs that are specific to their religious beliefs.

Respondents who answered "Very Well" typically said that they have these types of discussions with their patients, whereas respondents who answered otherwise did not. These discussions included how they view disease or treatment, and what they are willing, and not willing to do. Typically, this varied depending on specialty. Respondents with specialties that included longer appointments and in depth conversations with patients, such as psychiatry and obstetrics, were more likely to feel that they knew their patient's health beliefs customs and values answered at least "Fairly Well." Those who felt they did not know their patients' health beliefs customs and values explained that they typically spent 15-20 minutes with patients, once or twice a year. As such, they tended to answer "Barely" or "Not at all." This included specialties such as dermatology, ophthalmology, and cardiology.

However, OB/GYN, pediatricians and general practitioners varied in their responses. One OB/GYN, who answered "Fairly Well" mentioned:

In a way those are vague terms. Because I see my pregnant patients all the time, it is important to me to know about my patients and their health beliefs, but I'm imagining for a primary care doctor who does not see their patients that often it would be difficult.

In addition, the Psychiatry respondents said they have long conversations about all aspects of their patients' lives in 45 minute appointments and therefore ask questions regarding customs and beliefs, specifically regarding treatment options. For example, one Psychiatrist who answered "Fairly well" explained:

I ask patients questions about their lifestyle, what does health mean to them and how they try to maintain their health. I have the luxury of spending more time with patients, I know about alcohol use, drug use, I understand family background what's important to them and how they maintain their health over time.

Question 29

The question was asked of all 20 respondents. Nine respondents answered "Fairly well," eight answered "Barely," one answered "Very well," and one did not enter any data.

Interpretation of "Help-seeking practices." Several respondents had to reread the question and were unsure of what "help-seeking practices" entails, even with the provided definition in parentheses. They particularly had a difficult time determining what the "help" actually entails. Some respondents were unsure if this meant telling other health professionals about their health issues or telling family or friends. Since respondents were uncertain as to what the question was asking, they struggled with finding an answer. Several of them chose the answer category "barely," primarily because they were unsure and not that it actually reflected their knowledge about their patients' "help seeking practices." One respondent who chose "very well" expressed that he assumed that if a patient is there at his office, then the patient is seeking the help.

One respondent who answered "Fairly Well" described help seeking practices as "who the patients are seeking help from, if they would call a family member, a physician, or 911... which is what most Americans would do, or they would just wait to see if it gets worse."

Also, in comparison to the previous question regarding *health beliefs customs and values*, respondents felt they were less likely to know what *help seeking practices* involve. Again, this was also dependent on specialty and length of time physicians spend with patients. Some physicians (such as psychiatrists) spend more time with patients and may ask specific questions about help seeking practices, but the majority of physicians did not ask these questions specifically, and others just did not have the time. For example, a neurologist who answered "Barely" said, "I don't know that about a lot of my patients because I just don't have that kind of ability to know them that well."

On the other hand, some respondents felt that they understand *help seeking practices* because they ask specific questions. A respondent who answered “Fairly well” explained:

This I also ask because there are people who don't want to complain. There are the people that are harder to treat. So I ask about this.

She expressed that due to training and experience in various cultures, she asks these kinds of questions. She gave an example regarding some of her Asian American patients and said, “The macho image has really taken over and they don't want to tell anyone that they're feeling bad.” A few other respondents also mentioned that patients do not always want to tell their doctor that they are seeking help elsewhere, whether from other professionals, advice from family, or receiving information from elsewhere.

<p>30. How often are your services to patients formally evaluated for their cultural and linguistic appropriateness?</p> <p><input type="checkbox"/> Less than once a year</p> <p><input type="checkbox"/> About once a year</p> <p><input type="checkbox"/> About 2 to 4 times a year</p> <p><input type="checkbox"/> More than 4 times a year</p> <p><input type="checkbox"/> My services are not formally evaluated for their cultural and linguistic appropriateness.</p>
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Question 30

The question was asked of all 20 respondents. Seventeen respondents answered “My services are not formally evaluated for their cultural and linguistic appropriateness,” two answered “Less than once a year,” and one answered “About 2 to 4 times a year.”

Interpretation of “formally evaluated.” Several respondents had difficulty understanding the meaning of a formal evaluation of their services to patients for their cultural and linguistic appropriateness. Some respondents answered according to their understanding of formal evaluation occurring at the “organizational level,” such as “an outside organization” or “management in the practice auditing their practice services.” Other respondents answered according to their understanding of formal evaluation as occurring at the “individual level,” such as “an outside organization” or “management within the practice auditing their individual services.”

31. What outcome(s) do you expect by providing culturally and linguistically appropriate services to your patients? (Check all that apply)

- Satisfaction with services
- Comprehension of treatment and lifestyle recommendations
- Health status/outcomes
- Adherence to treatment and lifestyle recommendations
- Improved patient trust
- Improved quality of patient care (e.g. diagnostics, communication, treatment)
- Decreased likelihood of liability/malpractice claims
- Other(s) (Please specify):

- I do not expect any outcomes in providing culturally and linguistically appropriate services to my patients.

Question 31

The question was asked of all 20 respondents. Several respondents answered more than one answer category. Eighteen respondents answered “Satisfaction with services,” eighteen answered “Comprehension of treatment and lifestyle recommendations,” eighteen answered “Health status/outcomes,” eighteen answered “Adherence to treatment and lifestyle recommendations,” eighteen answered “Improved patient trust,” eighteen answered “Improved quality of patient care (e.g., diagnostics, communication, treatment),” seventeen answered “Decreased likelihood of liability/malpractice claims,” three answered “Other,” and one did not enter any data.

Interpretation of the answer categories and presence of social desirability in answering. Due to the one hour time limit, respondents were not probed to describe how they interpret each of the answer categories, however respondents expressed that they had a general understanding of each of them. All, but one respondent selected all of the first seven answer categories. The one respondent could not answer this question because he did not know. This pattern of response indicates either a lack of differentiation or the presence of a strong social desirability bias to answer all the questions in the affirmative.

How has each of the following factors affected you in providing culturally and linguistically appropriate services to your patients?	Helped	No Effect	Prevented	Not Applicable
32. Policy (formal or informal)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
33. Organizational resources	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
34. Training in cultural competency	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
35. Personal knowledge about the prevailing beliefs, customs, norms, and values of the diverse groups in your patient load	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
36. Other, (please specify): _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

For the entire question set (Questions 32-36), some respondents were unsure if each question was asking about how each of the following factors in each question affect them personally (as the individual physician) or the entire practice.

Difficulty with understanding answer categories. The original answer categories included the term “Hindered” instead of the term “Prevented.” One respondent was unsure what the term “Hindered” meant while other respondents thought the response categories were scaled from positive to negative. During the testing, the original question term “Hindered” was replaced with the revised question term “Prevented” (as displayed in the revised response categories above).

Question 32

The question was asked of all 20 respondents. Ten respondents answered “Not applicable,” eight respondents answered “Helped,” and two respondents answered “No effect.”

The original question stated redundant information about “culturally and linguistically appropriate services” already provided in the main question. During the testing, this redundant information was excluded from the question.

Interpretation of “policy.” When formulating their response, some respondents thought back to how they answered Question 13, since that question also asked about policy. Respondents had to determine whether or not they had any “policy” about culturally and linguistically appropriate services. Respondents experienced difficulty in formulating their response as they specifically thought about what constitutes a “policy.”

The original question excluded the terms “formal or informal” displayed in parentheses in the revised question above. As in previous questions, such as Question 13, respondents considered whether or not the question asked about “formal” or “informal” policies, such as a formal policy put into place by “law or their practice” or an informal policy of “having a staff member who speaks Spanish.” During the testing, the question was revised to include both “formal” and “informal” policies.

Question 33

The question was asked of all 20 respondents. Eight respondents answered “Not applicable,” eight respondents answered “Helped,” two respondents answered “No effect,” and one respondent answered “Prevented.”

The original question stated redundant information about “culturally and linguistically appropriate services” already provided in the main question. During the testing, this redundant information was excluded from the question.

Interpretation of “organizational resources.” When formulating their response, some respondents had to determine whether or not they had any “organizational resources” about culturally and linguistically appropriate services. Respondents experienced difficulty in formulating their response as they specifically thought about what constitutes *organizational resources*, whether that include internal or external resources.

Some respondents thought of organizational resources as “internal resources,” such as documents they can print from the EMR. One respondent who answered “Helped” stated: “The fact that our electronic records has some handouts in Spanish is helpful...so I can give my Spanish speaking patients information in a language that they understand.” On the other hand, some respondents thought of organizational resources as “external resources,” such as outside interpreters or contractors, as well as pamphlets and education materials they receive from outside organizations. One respondent who answered “Helped” also mentioned that the ACOG (American College of Gynecology) sends educational materials and pamphlets in a variety of languages. In addition, some respondents mentioned interpreters as a resource. For example, one respondent who answered “Helped” stated, “I think that definitely has helped...having the language line or sign language interpreters...” Another respondent who answered “Helped” referred to external organizational resources as: “I’m thinking more about referring them to the community to get more services, I would say ‘helped.’”

Question 34

The question was asked of all 20 respondents. Eleven respondents answered “Not applicable” and nine answered “helped.”

Interpretation of “training in cultural competency.” Respondents that questioned the meaning of *training in cultural competency* in previous questions carried over their interpretation concerns to this question as well. They answered accordingly to how they understood the training as being formal or informal training, as well as mandated or voluntary. Also, some respondents were uncertain regarding whether or not this question was referring to cultural competency in the past (during medical training) or during their current practice.

For example, one respondent initially answered “Not Applicable” because her current practice does not offer training. She then changed her answer to “Helped” because she has received training in the past. Another respondent expressed that the current training she receives at her practice “helps,” although she said it was very brief. She said: “It’s nice to have that reminder even though it’s only 20 minutes a year.” Other respondents discussed training they received during their medical training. One respondent who answered “Helped” mentioned, “I had training which made me more aware, but that was in Medical School.”

Generally, respondents thought training helped as it reminded them about how they should be aware of patients with different cultures or backgrounds, perceive illness, and interact with patients. As one respondent explained, “At the time, you’re not always aware of different cultures, how they perceive illness.” Another respondent, who also answered “Helped,” explained: “Being able to work through how you may deal with a patient from a different background in a non-patient setting so you can think through what you’re going to do has helped so you are more prepared in the moment.”

Question 35

The question was asked of all 20 respondents. “Eighteen respondents answered helped” and two answered “No effect.”

Interpretation of “personal knowledge about the prevailing beliefs, customs, norms, and values of the diverse groups in your patient load.” Among the answer categories, respondents expressed that this answer category was the most clear as they could formulate a response according to their own *personal knowledge*.

Respondents referred to personal knowledge in one of two ways. First, they referred to their personal knowledge as gained through conversations they had with their patients. Specifically, respondents said that they typically learned from their patients about their distinct cultural beliefs and customs during appointment conversations. By learning from their patients, they were able to then use that personal knowledge to then better understand and care for their patients. For example, one respondent said:

I was thinking like if you know they are Jehovah Witness then you would present different things. So if we know they have a belief or custom then we take that into consideration and [are] sensitive.

On the other hand, respondents referred to personal knowledge as preexisting knowledge that they had about diverse groups of people and their cultures. When they learned of these familiar cultural beliefs and customs, they also provided better care to their patients. For example, one respondent who answered “Helped” suggested:

I think it’s been helpful. I’m aware of people of different nationalities and cultures. It’s helped me in me providing care.

Another respondent who also answered “Helped” explained that knowing different religious beliefs, “such as Orthodox Jews,” and knowing what they can and cannot do, helps her in providing healthcare services.

In addition, respondents discussed how personal knowledge in general has helped them in practicing medicine. Many said personal knowledge provides them with an understanding of their patient’s beliefs and customs, brings awareness and sensitivity and builds trust. For example, one respondent who answered “Helped” explained that her personal knowledge of her patients allows her to understand them better and gain trust among her patients.

Question 36

The question was asked of all 20 respondents. One respondent answered “Helped” and nineteen did not enter any data. Other than the one respondent who answered “Helped,” all other respondents could not think of an “Other” response or did not have any other reason.

<p>37. How familiar are you with the National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care (the National CLAS Standards)?</p> <ul style="list-style-type: none"> <input type="checkbox"/> Never heard of it [SKIP to item 38] <input type="checkbox"/> Heard of it but do not know much about it <input type="checkbox"/> Know something about it <input type="checkbox"/> Very familiar with it 	<p>a. How have you gained knowledge about the National CLAS Standards? (Check all that apply)</p> <ul style="list-style-type: none"> <input type="checkbox"/> Through initial employment orientation in my current organization <input type="checkbox"/> Through other trainings such as in-service, continuing education, or professional development activities in my current organization <input type="checkbox"/> Through attending a training/meeting/webinar outside of my current organization <input type="checkbox"/> Through reading a report, publication, newsletter, or other materials publicly available – (Please list the title of the material you read) _____ <input type="checkbox"/> Other (Please specify): _____
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Question 37

The question was asked of all 20 respondents. Thirteen respondents answered “Never heard of it,” six answered “Heard of it but do not know much about it,” and one respondent answered “Know something about it.”

Interpretation of “National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care.” While the majority of respondents had never heard of the National CLAS Standards, some of them were able to provide some interpretation of what these standards might entail. Respondents’ interpretations varied, but they thought of the standards as a formal set of standards as either part of “an institute;” or “a requirement of expectations and guidelines;” or “organizational governance;” or “national standards that may include training, evaluation, signage, and forms;” all of which are to “provide culturally and linguistically appropriate” healthcare services.

Skip instruction. Thirteen respondents followed the skip instruction correctly when they answered “Never heard of it” and skipped answer Question 37a to then answer Question 38. The seven remaining respondents all correctly moved on to answer Question 37a prior to answering Question 38.

Question 37a

Seven respondents answered the question, each choosing one of the available response categories except for one respondent who checked two response categories. Three respondents answered “Through other trainings such as in-service, continuing education, or professional development activities in my current organization,” two

answered “Through reading a report, publication, newsletter, or other materials publicly available,” two answered “Other,” and one answered “Through attending a training/meeting/webinar outside of my current organization.”

Ability to recall the CLAS standards when formulating a response. While respondents chose an available response category, they had difficulty in recalling what the CLAS standards were when formulating their response. One respondent stated: “So, it comes up in some of those presentations, but I don’t remember what the actual standards are.” As such, some respondents simply guessed where they might have heard about the CLAS standards.

<p>38. Has your practice adopted the National CLAS Standards?</p> <p><input type="checkbox"/> Yes</p> <p><input type="checkbox"/> No</p> <p><input type="checkbox"/> I don’t know</p>
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Question 38

The question was asked of all 20 respondents. Ten respondents answered “No,” eight answered “I don’t know,” and one answered “Yes.” One respondent did not enter any data.

Due to the time limit of one hour set for the interview, several respondents were not probed on this question. Therefore, there is insufficient data to provide an explanation of respondents’ interpretation of the question and response categories. However, one respondent felt this question could only be asked of respondents who in Question 37 answered a response category other than “never heard of it.” He suggested: “If you have never heard of it or heard about it, then how can you answer 38? They should have you finish at 37.”

**National Ambulatory Medical Care Survey
2015 PANEL**

**Cultural and Linguistic Competency in Health Care
Self-Administered Mail Survey for
Office-Based Physicians**

Cultural and Linguistic Competency in Health Care

OMB No. 0920-0222; Exp. Date: 06/30/2015

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*This survey asks about **ambulatory care**, that is, care for patients receiving health services without admission to a hospital or other facility.*

1. How many years have you been providing direct care for ambulatory care patients? _____

2. What is your specialty?

- General practice/family medicine
- Internal medicine
- Pediatrics
- Obstetrics and gynecology
- Geriatrics
- Other (Please specify): _____

3. Are you fluent in a language besides English?

- Yes
- No [SKIP to item 4]

3a. How many languages, other than English, do you feel comfortable enough to provide healthcare services?

- 1
- 2
- 3
- 4 or more

4. What is your sex?

- Female
- Male

5. What is your ethnicity?

- Hispanic or Latino
- Not Hispanic or Latino

6. What is your race? (Check all that apply)

- White
- Black or African American
- Asian
- Native Hawaiian or other Pacific Islander
- American Indian or Alaska Native

7. In what setting do you typically provide care to the most patients?

- Solo or group practice
- Freestanding clinic or urgent care center
- Community health center (e.g. Federally Qualified Health Center (FQHC), federally-funded clinics or “look-alike” clinics)
- Mental health center
- Non-federal government clinic (e.g. state, county, city, maternal and child health, etc.)
- Family planning clinic (including Planned Parenthood)
- Health maintenance organization or other prepaid practice (e.g. Kaiser Permanente)
- Faculty practice plan (an organized group of physicians that treat patients referred to an academic medical center)
- Hospital emergency or hospital outpatient department
- None of the above

8. What is the street name for the location where you typically see the most patients?

Street _____

For the remaining questions, please provide answers reflecting your experiences at this location.

9. Did you receive any training in cultural competency in your clinical training programs including medical school and residency?

- Yes
- No

10. After your clinical training, have you participated in training for cultural competency such as continuing education?

- Yes
- No [SKIP to item 11]

a. Within the past 12 months, have you participated in any training for cultural competency?

- Yes
- No [SKIP to item 11]

b. Which of these population groups have been addressed in the training(s) for cultural competency in which you have participated?

(Check all that apply)

- Racial/ethnic minorities
- Religious groups
- Lesbian, gay, bisexual, transsexual (LGBT) populations
- Persons with limited English proficiency (LEP)
- Inmates/ex-offenders
- Other (please specify): _____

c. Which of the following areas have been typically included in training(s) for cultural competency in which you have participated?

(Check all that apply)

- Cultural beliefs, values, and behaviors
- Organizational policies, plans, and protocols regarding culturally and linguistically appropriate services
- Health disparities
- Complementary and alternative healing practices
- Other (please specify): _____

d. Was your participation in training for cultural competency to satisfy a continuing education unit (CEU) requirement or as requirement for credentialing?

- Yes
- No

11. Is training in cultural competency required as a condition of employment by your practice?

- Yes
- No

12. How often does your practice offer or make available training in cultural competency?

- Annually
- Biannually
- Quarterly
- Other (Please specify): _____
- Not applicable: my practice does not offer or make available training in cultural competency.

For the purposes of this survey, **culturally and linguistically appropriate services** are services that are respectful of and responsive to individual cultural health beliefs and practices, preferred languages, health literacy levels, and communication needs.

- 13. Does your practice have at least one policy in place related to the provision of culturally and linguistically appropriate services?**
- Yes
 - No [SKIP to item 14]
 - I don't know [SKIP to item 14] }

- a. How aware are you of your practice's culturally and linguistically appropriate services-related policy?**
- Not at all
 - Barely
 - Fairly well
 - Very well

- 14. In what format are printed materials provided to your patients with limited literacy?** (Check all that apply)
- Documents created with plain language software or reviewed for literacy level
 - Universal symbols
 - Infographics
 - Other (please specify): _____
 - Not applicable: no printed materials are available to my patients with limited literacy.

- 15. Which methods are used to inform your patients of free language-assistance services available in your practice?** (Check all that apply)
- Translated informational documents
 - Recorded messages in different languages on telephone lines
 - Translated signage and notices at key points of contact throughout the office
 - Other (please specify): _____
 - Not applicable: free language-assistance is not available to my patients.

- 16. Which methods are used to inform your patients of free language-assistance services available from external sources?** (Check all that apply)
- Translated informational documents
 - Recorded messages in different languages on telephone lines
 - Translated signage and notices at key points of contact throughout the office
 - Other (please specify): _____
 - Not applicable: free language-assistance is not available to my patients.

- 17. Do you use interpreters when working with patients who have limited English proficiency?**
- Yes
 - No [SKIP to item 18]

a. How often do you use each type of interpreter?

	Often	Sometimes	Rarely	Never
Trained staff or contractor	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Patient's relative or friend	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

- 18. What types of materials, in language(s) other than English, are available to your patients?** (Check all that apply)
- Wellness/Illness related education
 - Patient rights/ Informed consent documents
 - Advanced directives
 - Payment
 - Care plan
 - Other (Please specify): _____
 - Not applicable: no translated materials are available to my patients

For the purposes of this survey, **culture** is defined as the integrated patterns of thoughts, communications, actions, customs, beliefs, values, and institutions associated with, wholly or partially, with racial, ethnic, or linguistic groups, as well as with religious, spiritual, biological, geographical, or sociological characteristics.

19. What information does your practice collect on your patients' culture and language characteristics?

(Check all that apply)

- Race/Ethnicity
- Nationality/Nativity
- Patient's primary language
- Sexual orientation/gender identity
- History of criminal justice system involvement
- Other (please specify): _____
- Not applicable: we do not collect information related to culture and language.

When <u>assessing your patients' medical needs</u> , how often do you consider:	Often	Sometimes	Rarely	Never
20. Race/ethnicity?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
21. Other cultural factors?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
When <u>diagnosing your patients</u> , how often do you consider:				
22. Race/ethnicity?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
23. Other cultural factors?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
When <u>treating your patients</u> , how often do you consider:				
24. Race/ethnicity?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
25. Other cultural factors?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
When <u>conducting health education with your patients</u> , how often do you consider:				
26. Race/ethnicity?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
27. Other cultural factors?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

How knowledgeable are you of your patients':	Not at all	Barely	Fairly Well	Very Well
28. Health beliefs, customs, and values?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
29. Help-seeking practices? (<i>Help-seeking practices: process of actively seeking help from others whether it be informally through friends/family or professionally</i>)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

30. How often are your services to patients formally evaluated for their cultural and linguistic appropriateness?

- Less than once a year
- About once a year
- About 2 to 4 times a year
- More than 4 times a year
- My services are not formally evaluated for their cultural and linguistic appropriateness.

31. What outcome(s) do you expect by providing culturally and linguistically appropriate services to your patients? (Check all that apply)

- Satisfaction with services
- Comprehension of treatment and lifestyle recommendations
- Health status/outcomes
- Adherence to treatment and lifestyle recommendations
- Improved patient trust
- Improved quality of patient care (e.g. diagnostics, communication, treatment)
- Decreased likelihood of liability/malpractice claims
- Other(s) (Please specify): _____
- I do not expect any outcomes in providing culturally and linguistically appropriate services to my patients.
- I do not provide culturally and linguistically appropriate services.

How has each of the following factors affected you in providing culturally and linguistically appropriate services to your patients?

- 32. Policy (formal or informal) related to the provision of culturally and linguistically appropriate services**
- 33. Organizational resources to provide culturally and linguistically appropriate services**
- 34. Training in cultural competency**
- 35. Personal knowledge about the prevailing beliefs, customs, norms, and values of the diverse groups in your patient load**
- 36. Other, (please specify):** _____

	Helped	No Effect	Hindered	Not Applicable
32. Policy (formal or informal) related to the provision of culturally and linguistically appropriate services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
33. Organizational resources to provide culturally and linguistically appropriate services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
34. Training in cultural competency	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
35. Personal knowledge about the prevailing beliefs, customs, norms, and values of the diverse groups in your patient load	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
36. Other, (please specify):	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

37. How familiar are you with the National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care (the National CLAS Standards)?

- Never heard of it [SKIP to item 38]
- Heard of it but do not know much about it
- Know something about it
- Very familiar with it

a. How have you learned knowledge about the National CLAS Standards? (Check all that apply)

- Through initial employment orientation in my current organization
- Through other trainings such as in-service, continuing education, or professional development activities in my current organization
- Through attending a training/meeting/webinar outside of my current organization
- Through reading a report, publication, newsletter, or other materials publicly available – (Please list the title of the material you read) _____
- Other (Please specify): _____

38. Has your practice adopted the National CLAS Standards?

- Yes
- No
- I don't know

**National Ambulatory Medical Care Survey
2015 PANEL**

**Cultural and Linguistic Competency in Health Care
Self-Administered Mail Survey for
Office-Based Physicians**

Cultural and Linguistic Competency in Health Care

OMB No. 0920-0222; Exp. Date: 06/30/2015

Notice – Public reporting burden for this collection of information is estimated to average 90 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a current valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing burden to: CDC/ATSDR Information Collection Review Office, 1600 Clifton Road, MS D-74, Atlanta, GA 30333, ATTN: PRA (0920-0222).

Assurance of confidentiality – All information which would permit identification of an individual, a practice, or an establishment will be held confidential, will be used for statistical purposes only by NCHS staff, contractors, and agents only when required and with necessary controls, and will not be disclosed or released to other persons without the consent of the individual or establishment in accordance with section 308(d) of the Public Health Service Act (42 USC 242m) and the Confidential Information Protection and Statistical Efficiency Act (PL-107-347).

*This survey asks about **ambulatory care**, that is, care for patients receiving health services without admission to a hospital or other facility.*

1. How many years have you been providing direct care for ambulatory care patients? ____

2. What is your specialty?

- General practice/family medicine
- Internal medicine
- Pediatrics
- Obstetrics and gynecology
- Geriatrics
- Other (Please specify): _____

3. Are you fluent in a language besides English?

- Yes
- No [SKIP to item 4]

3a. How many languages, other than English, do you feel comfortable enough to provide healthcare services?

- 1
- 2
- 3
- 4 or more

4. What is your sex?

- Female
- Male

5. What is your ethnicity?

- Hispanic or Latino
- Not Hispanic or Latino

6. What is your race? (Check all that apply)

- White
- Black or African American
- Asian
- Native Hawaiian or other Pacific Islander
- American Indian or Alaska Native

7. In what setting do you typically provide care to the most patients? (Check all that apply)

- Solo or group practice
- Freestanding clinic or urgent care center
- Community health center (e.g. Federally Qualified Health Center (FQHC), federally-funded clinics or “look-alike” clinics)
- Mental health center
- Non-federal government clinic (e.g. state, county, city, maternal and child health, etc.)
- Family planning clinic (including Planned Parenthood)
- Health maintenance organization or other prepaid practice (e.g. Kaiser Permanente)
- Faculty practice plan (an organized group of physicians that treat patients referred to an academic medical center)
- Hospital emergency or hospital outpatient department
- None of the above

8. What is the street name for the location where you typically see the most patients?

Street _____

For the remaining questions, please provide answers reflecting your experiences at this location.

9. Did you receive any training in cultural competency in your clinical training programs including medical school and residency?

- Yes
- No

10. After your clinical training, have you participated in training for cultural competency such as continuing education or continuing medical education?

- Yes
- No [SKIP to item 11]

a. Within the past 12 months, have you participated in any training for cultural competency?

- Yes
- No [SKIP to item 11]

b. Which of these population groups have been addressed in the training(s) for cultural competency in which you have participated? (Check all that apply)

- Racial/ethnic minorities
- Religious groups
- Lesbian, gay, bisexual, transsexual (LGBT) populations
- Persons with limited English proficiency (LEP)
- Inmates/ex-offenders
- Other (please specify): _____

For the purposes of this survey, **culturally and linguistically appropriate services** are services that are respectful of and responsive to individual cultural health beliefs and practices, preferred languages, health literacy levels, and communication needs.

c. Which of the following areas have been typically included in training(s) for cultural competency in which you have participated?

(Check all that apply)

- Cultural beliefs, values, and behaviors
- Organizational policies, plans, and protocols regarding culturally and linguistically appropriate services
- Health disparities
- Complementary and alternative healing practices
- Other (please specify): _____

d. Was your participation in training for cultural competency to satisfy a continuing education unit (CEU) requirement or as requirement for credentialing?

- Yes
- No

11. Is training in cultural competency required as a condition of employment by your practice?

- Yes
- No

12. How often does your practice offer or make available training in cultural competency?

- Annually
- Biannually
- Quarterly
- Other (Please specify): _____
- Not applicable: my practice does not offer or make available training in cultural competency.

For the purposes of this survey, culturally and linguistically appropriate services are services that are respectful of and responsive to individual cultural health beliefs and practices, preferred languages, health literacy levels, and communication needs.

13. Does your practice have at least one policy in place related to the provision of culturally and linguistically appropriate services?

- Yes
- No [SKIP to item 14]
- I don't know [SKIP to item 14]

a. How aware are you of your practice's policy related to culturally and linguistically appropriate services?

- Not at all
- Barely
- Fairly well
- Very well

14. In what format are printed materials provided to your patients with limited literacy? (Check all that apply)

- Documents created with plain language software or reviewed for literacy level
- Universal symbols (A sign recognized by most people. Example: a square around a plus sign for first aid.)
- Infographics (A visual image such as a chart or diagram used to represent information or data)
- Other (please specify): _____
- Not applicable: no printed materials are available to my patients with limited literacy.

15. Which of these free language-assistance services are available to patients in your practice? (Check all that apply)

- Translated informational documents
- Recorded messages in different languages on telephone lines
- Translated signage and notices at key points of contact throughout the office
- Other (please specify): _____
- Not applicable: free language-assistance is not available to my patients.

16. Which of these free language-assistance services are available to patients from external sources? (Check all that apply)

- Translated informational documents
- Recorded messages in different languages on telephone lines
- Translated signage and notices at key points of contact throughout the office
- Other (please specify): _____
- Not applicable: free language-assistance is not available to my patients.

17. Do you use interpreters when working with patients who have limited English proficiency?

- Yes
- No [SKIP to item 18]

a. When you use interpreters how often do you use each type?

	Often	Sometimes	Rarely	Never
Trained staff	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Contractor	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Patient's relative or friend	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

18. What types of materials, in language(s) other than English, are available to your patients? (Check all that apply)

- Wellness/illness related education
- Patient rights/ Informed consent documents
- Advanced directives
- Payment
- Care plan
- Other (Please specify): _____
- Not applicable: no translated materials are available to my patients

*For the purposes of this survey, **culture** is defined as the integrated patterns of thoughts, communications, actions, customs, beliefs, values, and institutions associated with, wholly or partially, with racial, ethnic, or linguistic groups, as well as with religious, spiritual, biological, geographical, or sociological characteristics.*

19. What information does your practice record on your patients' culture and language characteristics?

(Check all that apply)

- Race/Ethnicity
- Nationality/Nativity
- Patient's primary language
- Sexual orientation/gender identity
- History of criminal justice system involvement
- Other (please specify): _____
- Not applicable: we do not collect information related to culture and language.

When assessing your patients' medical needs , how often do you consider:	Often	Sometimes	Rarely	Never
20. Race/ethnicity?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
21. Other cultural factors?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
When diagnosing your patients , how often do you consider:				
22. Race/ethnicity?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
23. Other cultural factors?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
When treating your patients , how often do you consider:				
24. Race/ethnicity?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
25. Other cultural factors?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
When conducting health education with your patients , how often do you consider:				
26. Race/ethnicity?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
27. Other cultural factors?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

How knowledgeable are you of your patients':	Not at all	Barely	Fairly Well	Very Well
28. Health beliefs, customs, and values?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
29. Help-seeking practices? (Process of actively seeking help from others whether it be informally through friends/family or professionally)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

30. How often are your services to patients formally evaluated for their cultural and linguistic appropriateness?

- Less than once a year
- About once a year
- About 2 to 4 times a year
- More than 4 times a year
- My services are not formally evaluated for their cultural and linguistic appropriateness.

31. What outcome(s) do you expect by providing culturally and linguistically appropriate services to your patients? (Check all that apply)

- Satisfaction with services
- Comprehension of treatment and lifestyle recommendations
- Health status/outcomes
- Adherence to treatment and lifestyle recommendations
- Improved patient trust
- Improved quality of patient care (e.g. diagnostics, communication, treatment)
- Decreased likelihood of liability/malpractice claims
- Other(s) (Please specify): _____
- I do not expect any outcomes in providing culturally and linguistically appropriate services to my patients.

How has each of the following factors affected you in providing culturally and linguistically appropriate services to your patients?

	Helped	No Effect	Prevented	Not Applicable
32. Policy (formal or informal)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
33. Organizational resources	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
34. Training in cultural competency	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
35. Personal knowledge about the prevailing beliefs, customs, norms, and values of the diverse groups in your patient load	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
36. Other, (please specify): _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

37. How familiar are you with the National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care (the National CLAS Standards)?

- Never heard of it [SKIP to item 38]
- Heard of it but do not know much about it
- Know something about it
- Very familiar with it

a. How have you gained knowledge about the National CLAS Standards? (Check all that apply)

- Through initial employment orientation in my current organization
- Through other trainings such as in-service, continuing education, or professional development activities in my current organization
- Through attending a training/meeting/webinar outside of my current organization
- Through reading a report, publication, newsletter, or other materials publicly available – (Please list the title of the material you read) _____
- Other (Please specify): _____

38. Has your practice adopted the National CLAS Standards?

- Yes
- No
- I don't know

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