

**ADVANCING HEALTH  
EQUITY AND  
RACIAL JUSTICE  
IN CHILDREN'S  
BEHAVIORAL HEALTH**



This toolkit is a product of the CONNECTing with CLAS team of the **CONNECTing Children and Families to Care** initiative, funded by the Substance Abuse and Mental Health Services Administration (SAMHSA), in conjunction with Connecticut's Children's Behavioral Health Plan.

# About This Toolkit

## Advancing Health Equity and Racial Justice in Children's Behavioral Health

In 2014, Connecticut was awarded a four-year Systems of Care Expansion Implementation grant from the Substance Abuse and Mental Health Services Administration (SAMHSA), U.S. Department of Health and Human Services, to fund the Connecticut Network of Care Transformation (CONNECT) initiative. CONNECTing Children and Families to Care builds upon previous efforts in Connecticut to bridge gaps in services for children and youth and their families and to create partnerships between families, state agencies, and service providers at the local, regional, and state levels. These enhanced partnerships support children, youth, and their families in accessing the services and supports they need in a timely and effective manner through an integrated network of care. To ensure an integrated network of care, Connecticut's child and family serving health organizations are engaging partners from each of the following child-serving sectors: behavioral health, child welfare, early childhood, juvenile justice, substance abuse, education, advocacy groups, and families and children served.

This toolkit is a publication of the CONNECTing Children and Families to Care initiative, in conjunction with Connecticut's Children's Behavioral Health Plan (PA 13-178). The toolkit supports child-serving organizations with developing organizational Health Equity Plans, based on the enhanced National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care (The National CLAS Standards), to advance health equity and to reduce racial injustice and health disparities within their organizations, services, and communities in Connecticut.

For additional copies of this toolkit, call 860-679-1519 or visit [www.plan4children.org](http://www.plan4children.org) or [www.chdi.org](http://www.chdi.org). Any portion of this toolkit may be reproduced without prior permission if cited as: Crusto, C. A. 2019. Advancing Health Equity and Racial Justice in Children's Behavioral Health, Farmington, CT: Child Health and Development Institute of Connecticut.

# About the Contributors

On behalf of the CONNECTing with CLAS team, we offer great thanks to our partners for their commitment and innovative strategies and efforts in supporting culturally and linguistically appropriate services and in the elimination of health disparities in the state of Connecticut.

We acknowledge Tim Marshall, Director of Community-Based Mental Health Services, Connecticut Department of Children and Families, for his vision, for being a transformational leader, and for creating models of change that have strengthened the voices of youth, parents, and families in Connecticut. We also acknowledge his work designing and implementing specific recommendations and standards that enhanced the Connecticut Behavioral Health Plan and Public Act 13-178.

We acknowledge Jeana Bracey, PhD, Director of School and Community Initiatives, Child Health and Development Institute, Inc.; Gabrielle Hall, Director of Intensive Care Coordination, Beacon Health Options; Lisa Palazzo, LCSW, Network of Care Manager, North Central Region, Intensive Care Coordination Program, Beacon Health Options; and Beresford Wilson, Executive Director, FAVOR, Inc., for ongoing support of this work. We acknowledge Cecilia Frometa, PhD, consultant to Child Health and Development Institute and Yale Child Study Center, and Catherine Wagner EdD, Marie Spivey, EdD, RN, MPA, and Michele Stewart-Copes, MS, MSW, Health & Equity, LLC, for their contributions to advancing culturally and linguistically appropriate work in Connecticut and nationally, and for developing and refining change models to advance health equity.

We thank the organizations and their service populations who have participated in initiatives aimed at improving culturally and linguistically appropriate services and eliminating health disparities in Connecticut. Finally, we acknowledge Cindy A. Crusto, PhD, The Consultation Center, Department of Psychiatry, Yale University School of Medicine, as the lead author on this toolkit.

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# 6 Executive Summary

The delivery of culturally and linguistically appropriate services (CLAS) is a fundamental value of any good health or mental/behavioral health care organization. This toolkit is designed to support child- and family-serving organizations with developing organizational plans, based on the enhanced National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care (The National CLAS Standards), to advance health equity and to reduce racial injustice and health disparities within their organizations, services, and communities and in Connecticut. We refer to these organizational plans as Health Equity Plans.

This toolkit outlines the steps that will support child- and family-serving organizations to increase organizational capacity to work with the communities they serve and to implement effective culturally responsive, linguistically appropriate, and racially just services in populations that are facing health disparities. The toolkit's primary focus is on how to create policy, systems, and internal agency changes at the organizational level that will reduce health disparities and achieve health equity within a six-month timeframe.

This toolkit is designed so that individuals (particularly executives) or groups from organizations can work independently through a structured process to develop an organizational Health Equity Plan. It can also be used in conjunction with voluntary training and technical support to statewide child- and family-serving organizations in the further development of Health Equity Plans.

# 7 Introduction to the Toolkit

A children's behavioral health system based on the system of care core values and principles will result in improved health outcomes. A system of care is:

A spectrum of effective, community-based services and supports for children and youth with or at risk for mental health or other challenges and their families, that is organized into a coordinated network, builds meaningful partnerships with families and youth, and addresses their cultural and linguistic needs, in order to help them to function better at home, in school, in the community, and throughout life.

**The four core values driving the development of a system of care are:**

- Family driven and youth guided.
- Community based.
- Trauma informed.
- Culturally and linguistically competent.

For systems of care values and philosophy see,  
[https://gucchd.georgetown.edu/products/Toolkit\\_SOC\\_Resource1.pdf](https://gucchd.georgetown.edu/products/Toolkit_SOC_Resource1.pdf)

Systems of care are culturally and linguistically competent, with agencies, programs, and services that reflect the cultural, racial, ethnic, and linguistic differences of the populations they serve to facilitate access to and utilization of appropriate services and supports

The delivery of **culturally and linguistically appropriate services (CLAS)** and culturally competent services is a fundamental value of a strong implementation process. A primary objective is the development, planning, and implementation of a statewide process for incorporating the **enhanced National Culturally and Linguistically Appropriate Services Standards for Health and Healthcare (The National CLAS Standards)** into organizations and their services and communities.

The National CLAS Standards aim to improve health care quality and advance health equity by establishing a framework for organizations to serve the nation's increasingly diverse communities. The National CLAS Standards are a comprehensive series of 15 guidelines that inform, guide, and facilitate practices related to culturally and linguistically appropriate health services. The National CLAS standards incorporate several principles, including:

- Fostering cultural competence.
- Building community partnerships.
- Collecting diversity data.
- Provider planning and evaluation benchmarks.
- Reflection of respect and diversity.
- Ensuring language access to all communities.

See <http://www.ctmhp.org/wp-content/uploads/2011/07/Jacobs-PPT.pdf> for more information about the history of the enhanced National CLAS Standards.

## The National CLAS Standards and Racial Justice

There has been some criticism that the National CLAS Standards do not adequately address racial injustice, defined as disparities in outcomes and experiences in various systems based on race. These racial differences in outcomes and experiences have been well documented in the healthcare, child welfare, juvenile justice, education, early care and education, and criminal justice systems in the United States. Because children and families come into contact with, and are negatively impacted by, racial and ethnic disparities across all of these systems, the need to address these disparities is emphasized in this toolkit and a racial justice perspective has been integrated throughout.

Racial justice is defined as “the systematic fair treatment of people of all races, resulting in equitable opportunities and outcomes for all.” The enhanced National CLAS Standards address racial injustice through their explicit focus on eliminating racial and ethnic health disparities across the United States and on advancing health equity (the attainment of the highest level of health for all people (U.S. Department of Health and Human Services Office of Minority Health, 2011)). More specifically, according to ThinkCultural Health, “Culturally and linguistically appropriate services are increasingly recognized as effective in improving the quality of care and services. By providing a structure to implement culturally and linguistically appropriate services, the enhanced National CLAS Standards will improve an organization’s ability to address health care disparities.”



## Connecticut Behavioral Health Disparity Impact Statement

SAMHSA requires a disparity impact statement for all new grant awards. As a result, the system of care and CLAS work in Connecticut are guided by a behavioral health disparity impact statement developed in November 2014 titled, Connecticut Network of Care Transformation (CONNECT) Statement Regarding Behavioral Health Disparities. This statement indicates the proposed number of individuals to be served by subpopulations in the grant service area, provides a Quality Improvement Plan using the data on the proposed population and subpopulations, and indicates how the proposed quality improvement plan will ensure adherence to the enhanced National Standards. (See Appendix A for the CONNECT Statement Regarding Behavioral Health Disparities.)

## CONNECTing Children and Families to Care

CONNECTing Children and Families to Care is a statewide effort to blend and integrate ALL child-serving systems into a Network of Care that will equally and effectively serve all children and families and provide care so that children and families can access services and supports when they need them. (For more about CONNECTing Children and Families to Care, please see <http://www.plan4children.org/>.)

This work is guided by the vision laid out in the Connecticut 2014 Behavioral Health Plan for Children. This plan was developed to improve children's behavioral health services and systems across the state. Parents, community members, mental health experts, and others offered ideas and shared their experiences related to children's behavioral health

issues, which contributed to the plan. The completed plan is guiding the State's efforts to build a comprehensive and integrated behavioral health system that benefits all of Connecticut's children. (See <http://www.plan4children.org/final-plan/> for the full plan and for a concise summary of the plan.)

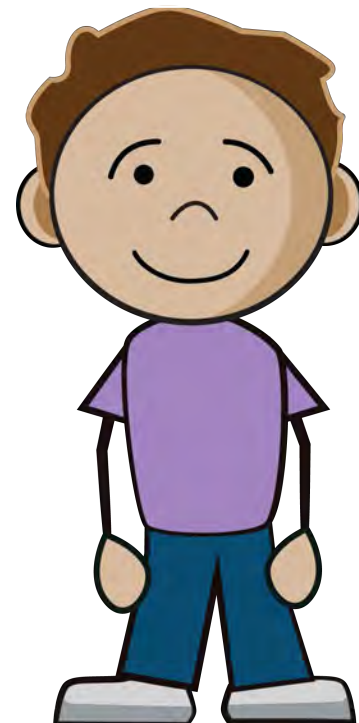
### CONNECTing Children and Families to Care: Vision

For children and their families to be connected to the care they need to grow up healthy and thrive.

### CONNECTing Children and Families to Care: Goal

To connect children and families to care.

A vital component of the CONNECTing Children and Families to Care work is to partner with families and network of care leaders to promote health equity, racial justice, and cultural and linguistic competence across all behavioral health services at the local, regional, and state levels.



# PURPOSE

The purpose of the **CONNECTing Children and Families to Care Toolkit** is to increase organizational capacity to work with the communities they serve to implement effective culturally responsive, linguistically appropriate, and racially just services in populations that are facing health disparities.

This toolkit provides the steps that will support child-serving organizations to increase this organizational capacity within a six-month timeframe.

**The toolkit's primary focus is on how to create policy, systems, and internal agency changes at the organizational level that will reduce health disparities and achieve health equity. For this toolkit, "policy" refers to procedures or practices that apply to large sectors, which can influence complex systems in ways that can improve the health and safety of a population.<sup>vi</sup>**

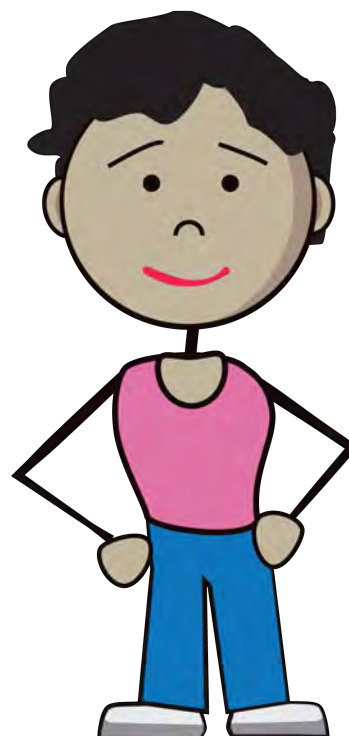
The steps to achieving these organizational level changes are outlined in the Health Equity Plan, which is the primary product that will result from this toolkit. The toolkit uses sample Health Equity Plans to assist organizations with planning and evaluating strategies to promote and to increase health equity conversations.

Connecticut is already conducting activities to address health disparities across populations by working with more than forty agencies serving children and families. This toolkit provides guidance on how to supplement and complement existing efforts and how to begin organizing ideas and engaging staff and family members to be a part of this change process.

## How to Use the Toolkit

This toolkit provides a step-by-step guide for planning, implementing, and evaluating strategies to address health disparities. The toolkit is not prescriptive. It presents a process that can be followed in the order presented or parts of the change process can be referenced, depending on organizational needs.

The toolkit begins with a description of the CONNECTing Children and Families to Care CLAS Four-Phase Change Model to Develop Health Equity Plans and to Address Racial Justice and Health Disparities (Change Model). This is followed by toolkit sections that discuss each of the four steps of the Change Model and ongoing considerations of the change process. Next, the toolkit orients the user to the burden of health disparities in the United States and in Connecticut. A glossary of terms used in the toolkit can be found in Appendix B.





# 11 The CONNECTing Children and Families to Care

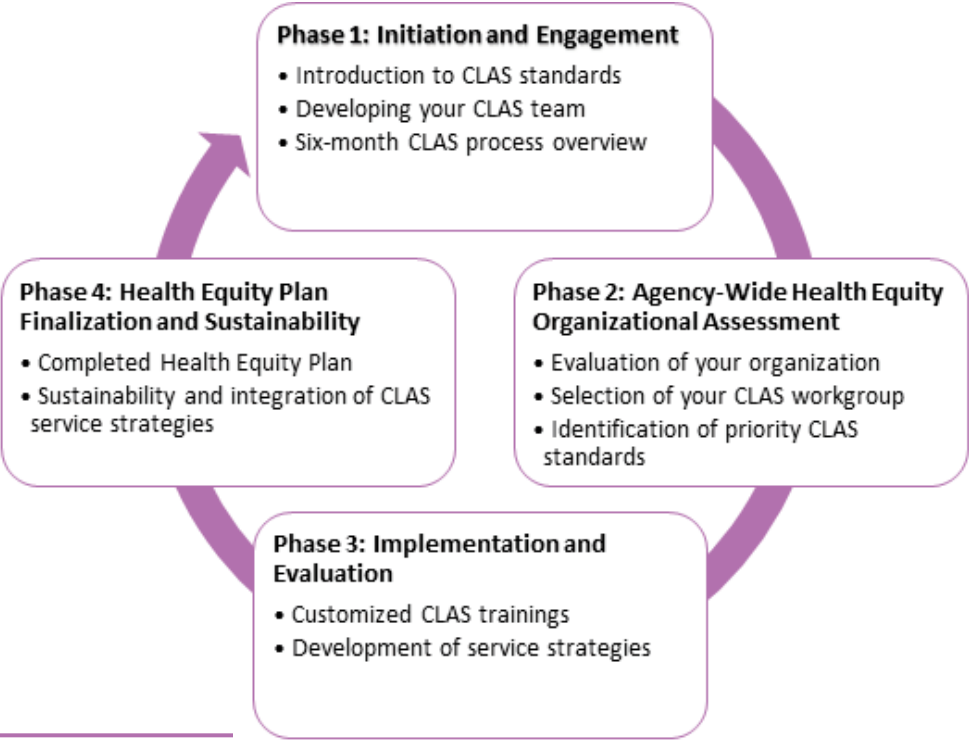
## CLAS Four-Phase Change Model to Develop Health Equity Plans and to Address Racial Justice and Health Disparities

A four-phase developmental strategy assists organizations with developing Health Equity Plans to advance health equity and to reduce racial injustice and health disparities within their organizations, services, and communities and in Connecticut. The Health Equity Plans are based on the National CLAS Standards, and each phase of the model addresses various aspects of the Standards and assists with completing a Health Equity Plan within a six-month period. (See Figure 1.)

**The four phases of the CONNECTing Children and Families to Care CLAS Four-Phase Change Model to Develop Health Equity Plans and to Address Racial Justice and Health Disparities are:**

- Phase I: Initiation and Engagement.
- Phase II: Agency-Wide Health Equity Organizational Assessment.
- Phase III: Implementation and Evaluation.
- Phase IV: Health Equity Plan Finalization and Sustainability.

**Figure 1.** The four phases of the CONNECTing Children and Families to Care CLAS Four-Phase Change Model to Develop Health Equity Plans and to Address Racial Justice and Health Disparities (Change Model)



It is important to note that the change process outlined in this toolkit is not linear. Where you begin the toolkit and the order in which you proceed through the four phases and within the planning, implementation, and evaluation process will depend on the priorities and needs of your organization and program(s). Some organizations may need foundational work and, if so, may start with developing a team within their organization to champion and oversee CLAS work, or create or strengthen partnerships across the community to address health disparities and health equity. Other organizations may augment an existing strategic plan to include CLAS-specific strategies, and other organizations may be ready to plan an evidence-informed intervention to address an already-identified priority health disparity issue.

**Each section of the toolkit contains:**

1. A description of the purpose and goals of the phase of the Change Model.
2. Key steps of the change process.
3. Practical tools for carrying out activities to help reduce health disparities.
4. Reflection questions to assist organizations discuss health disparities more clearly and to outline areas of focus.
5. Frequently asked questions to address questions about the change process.
6. Hyperlinks to additional resources to further support the change process.

# 13 Phase I: Initiation and Engagement

This section of the toolkit describes the first of the four stages of the change process to develop a Health Equity Plan and provides resources to ensure health equity is addressed throughout the change process.

## Purpose and Goals

The purpose of the Initiation and Engagement phase is to establish institutional/organizational commitment and internal capacity to engage in CLAS, health equity, racial justice, and health disparities work within organizations, services, and communities and in Connecticut.

## The goals of this phase are to:

- Obtain the commitment of organizational leadership and governance bodies to participate in the four-phase change process to develop a Health Equity Plan.
- Establish the organizational structures, processes, and procedures to support CLAS-related work and Health Equity Plan development.
- Increase knowledge about CLAS and the National CLAS Standards, beginning with leadership and governance bodies.
- Develop partnerships and coalitions to address racial injustice and health disparities, and to advance health equity.
- Develop a plan for including family members and, when appropriate, engage children and youth, in the change process and in health equity work.

**Obtain the commitment of organizational leadership and governance bodies to participate in the four-phase change process to develop a Health Equity Plan.**

Past efforts of working with and providing organizations with voluntary training and technical support to develop a Health Equity Plan included a packet of introductory information that was sent to the organizations’ leadership to educate about and to ensure commitment to the change process. After organizational commitment was secured, a 90-minute face-to-face training for leadership and governance bodies was conducted to further educate about the change process and the CLAS standards. Relevant introductory documents include:

- the enhanced National CLAS Standards (see Appendix C);
- an outline of activities and associated timeline (see Appendix D); and
- a 90-minute CONNECTing to CLAS orientation training for organizational leadership (PowerPoint slides; see Appendix E).

For organizations that develop their Health Equity Plans independent of voluntary training and support,

It is worthwhile to establish some form of working agreement and training with leadership and governance bodies so that they are more knowledgeable about the process of developing a Health Equity Plan and about the enhanced National CLAS Standards.

Objective(s):

- Develop a document such as a working agreement that outlines the purpose and scope of work from your

organization’s leadership or governance body (e.g., board of directors) to participate in the change process, which results in a Health Equity Plan.

- Engage leadership and representatives from governance body (e.g., board of directors) in training to learn about the change process, including their roles and responsibilities.

**Establish the organizational structures, processes, and procedures to support CLAS-related work and Health Equity Plan development.**

It is recommended that organizations build on existing structures, processes, and procedures to support CLAS and health equity work. For example, explore if your organization has a standing (i.e., permanent and year-round) committee in which CLAS work can easily be aligned and integrated. Also, explore if there is a subcommittee within the board of directors that can focus on CLAS. For example, if your organization has a management committee that is made up of staff at all levels of the organization and meets regularly to review important documents and to update the strategic plan, consider how CLAS and health equity can be integrated into committee work, or how the human resource committee of your board of directors can address diversity in hiring practices and policies.

Organizations also are encouraged to establish a permanent CLAS workgroup/development team. Ideally, this team will comprise three to five individuals from all levels of the organization and with representation of those served by the organization. This team should meet regularly to establish the direction of and to champion the CLAS work. It is recommended that this group address organizational policies and oversee the Health Equity Plan development process. It also is advisable that organizations appoint someone within

the organization to oversee and to champion this work. Also, to create or to clarify a commitment to CLAS, health equity, and racial justice work, organizations should enhance their existing documents outlining services to incorporate more intentional language around the commitment to eliminate health disparities and write health equity goals into critical documents, such as mission and vision statements. Organizations can also consider developing a diversity, health equity, and inclusion statement, policy, or plan. (See Appendix F for sample health equity and inclusion statements and policies.)

These recommendations are designed to ensure institutionalization and sustainability of CLAS and health equity at the organizational level. For more specific guidance on advancing and embedding race equity and inclusion within your organization, please see

[https://www.aecf.org/m/resourcedoc/AECF\\_EmbracingEquity7Steps-2014.pdf](https://www.aecf.org/m/resourcedoc/AECF_EmbracingEquity7Steps-2014.pdf) and <https://bloomerang.co/resources/templates/diversity-inclusion-and-equity-policy-template/>.

#### Objective(s):

- Build on existing organizational structures to support CLAS and health equity work.
- Establish CLAS workgroup/development team consisting of three to five members from the organization, including those served by the organization.
- Write health equity goals into critical documents.
- Develop a diversity, health equity, and inclusion statement or policy.

### **Increase knowledge about CLAS and the National CLAS Standards, beginning with leadership and governance bodies.**

In this initial phase of the change model, it is essential that organizational leadership is knowledgeable about CLAS, the enhanced National CLAS Standards, and the CONNECTing Children and Families to Care CLAS change process described in this toolkit. The 90-minute orientation session for organizational leadership mentioned previously provides an overview of these topics.

#### Objective:

- Leadership trained in CLAS, staff trained in CLAS standards.

### **Develop partnerships and coalitions to address racial injustice, reduce health disparities, and advance health equity.**

Addressing the complexities of inequities is beyond the scope of any one organization; thus developing trusting relationships with multi-sectorial organizations and the communities affected by inequities is essential.

#### Objective(s):

- Identify multi-sectorial partnerships.
- Develop key partnerships (i.e., sign memorandum of agreement or memorandum of understanding).

### **Develop a plan for including family members and, when appropriate, engage children and youth, in the change process and in health equity work.**

It is often difficult to engage families and youth in change efforts because there are few examples of how these practices can be carried out.



Organizations are asked to include family members and, when appropriate, engage children and youth, in the health equity change and Health Equity Plan development processes.

Organizations are asked to assess at what level and when to engage family members and children/youth and to develop a plan for including them in the change process.

There are national, state, and local resources to assist you with family and youth engagement and involvement from the perspective of multiple child-serving systems, including:

- Early childhood care and education.
  - o <https://www.naeyc.org/resources/topics/family-engagement/principles>
  - o <https://cssp.org/wp-content/uploads/2018/11/Race-Equity-and-Parent-Leadership-Manifesto.pdf>
  - o <https://eclkc.ohs.acf.hhs.gov/sites/default/files/pdf/parent-involvement-family-engagement-for-professionals.pdf>
- Education.
  - o <https://www.cde.ca.gov/>
- Child welfare.
  - o <https://www.childwelfare.gov/pubs/f-family-engagement/>
- Pediatric health and medical homes.
  - o [https://www.nichq.org/sites/default/files/resource-file/Family\\_Engagement\\_Guide\\_FINAL.pdf](https://www.nichq.org/sites/default/files/resource-file/Family_Engagement_Guide_FINAL.pdf)
- Juvenile justice.
  - o <https://www.ojjdp.gov/mpg/litreviews/Family-Engagement-in-Juvenile-Justice.pdf>
  - o <https://csgjusticecenter.org/youth/family-engagement-and-involvement/>

- o [https://storage.googleapis.com/vera-web-assets/downloads/Publications/family-engagement-in-the-juvenile-justice-system/legacy\\_downloads/family-engagement-juvenile-justice.pdf](https://storage.googleapis.com/vera-web-assets/downloads/Publications/family-engagement-in-the-juvenile-justice-system/legacy_downloads/family-engagement-juvenile-justice.pdf)
- Behavioral health.
  - o [http://www.excellenceforchildand youth.ca/sites/default/files/resource/EIS\\_Family\\_Engagement\\_EN.pdf](http://www.excellenceforchildand youth.ca/sites/default/files/resource/EIS_Family_Engagement_EN.pdf)
  - o <https://www.samhsa.gov/brss-tacs/recovery-support-tools/parents-families>

The National Federation of Families for Children’s Mental Health is a national family-run organization linking more than 120 chapters and state organizations focused on the issues of children and youth with emotional, behavioral, or mental health needs and their families (<https://www.ffcmh.org/>).

FAVOR, Inc. (<http://www.favor-ct.org/>), is the Connecticut state organization of the Federation for Families for Children’s Mental Health and provides technical assistance on family engagement, including:

- Assessing your organization’s family engagement needs by soliciting feedback.
- Helping to design and administer surveys to the families that you serve to get their feedback.
- Offering professional development opportunities to staff and families on family engagement, advocacy, cultural competency, and related topics.
- Assisting in developing advisory boards within your organization to provide ongoing input from the families you serve.
- Reviewing existing policies and procedures from the family perspective.

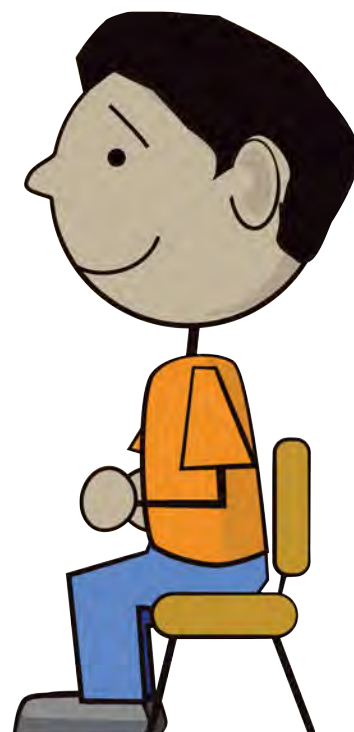


According to FAVOR, Inc.—a statewide, family led, non-profit organization in Connecticut that is committed to empowering families as advocates and partners in improving educational and health outcomes for children—family engagement, from a behavioral health perspective, is an ongoing process by which families, schools, and providers develop and maintain a positive alliance to promote the health, well-being, and academic success of children. This definition suggests that engagement is an ongoing process necessary to develop and keep a positive alliance. It includes efforts to build trust with families and to promote family buy-in for participation in school initiatives.

It is recommended that organizations contact FAVOR as early as possible in their change process for training and technical assistance with meaningful inclusion of and engagement of families and youth in the change process and the Health Equity Plan development.

#### Objective(s):

- Assess at what level and when to engage family members and children/youth.
- Assess and address organizational barriers to meaningful family engagement.
- Assess training and technical assistance needs related to family involvement.
- Select family member and child and youth engagement strategies that are appropriate for your context.
- Contact FAVOR, Inc., for training and technical assistance to become more knowledgeable about existing family engagement activities and initiatives in the state and in your local community.
- Establish a Family Engagement Action Team to oversee family engagement and involvement in the change process and health equity work.
- Develop a plan for family involvement and engagement in health equity work and Health Equity Plan development.



Initiation and Engagement Phase  
Reflection Questions

Obtain the commitment of organizational leadership and governance bodies to participate in the four-phase change process to develop a Health Equity Plan.

□ What is our leadership and governance body’s current level of commitment to advance health equity and racial justice, and to address health inequities?

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□ Does our organization have a stated commitment to health equity and racial justice? If so, is the commitment documented and widely understood by staff and the individuals/families served?

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□ In what ways do our organizational policies, procedures, and practices inhibit or facilitate health equity or racial justice?

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□ What level of introduction to health equity and to racial justice does our organization need initially to support this work (i.e., basic language, buy in, training, support)?

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Establish the organizational structures, processes, and procedures to support CLAS-related work and Health Equity Plan development.

□ How can we create a process to help us review existing documents?

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□ Do important organizational documents include health equity goals?

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□ Do we need to develop or modify our organization’s important documents and statements to reflect a commitment to racial justice and health equity?

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□ Do we have existing structures, processes, and procedures to support CLAS? If so, what are they?

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□ Who should be a part of our CLAS workgroup/development team? How do we ensure representation from all levels of the organization? How often can we realistically meet to advance this work?

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□ What is our capacity to develop a Health Equity Plan within six months, including the identification and implementation of two strategies to implement and to evaluate? What do we need to ensure plan development?

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**Increase knowledge about CLAS and the National CLAS Standards, beginning with leadership and governance bodies.**

□ What do our leadership and governance bodies know about CLAS and the enhanced National CLAS Standards?

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□ What existing mechanisms can we use to further educate about CLAS, the enhanced National CLAS Standards, and CONNECTing Children and Families to Care?

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□ What opportunities are there for ongoing training, technical support, and discussion about CLAS and the enhanced National CLAS Standards? In what ways can ongoing CLAS training and discussions be institutionalized?

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□ Are there existing CLAS-related projects/forms that can help the organization start the process of building a Health Equity Plan?

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**Develop partnerships and coalitions to address racial injustice and health disparities and to advance health equity.**

□ What existing partnerships do we have that can help us address and further our commitment to advance health equity and to racial justice?

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□ How much do we know about racial justice in our geographic/catchment/service area? How does racial injustice manifest in our community and how does it impact the organization, families, community, and staff?

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□ What new partnerships can we form to help us address and further our commitment to advance health equity and racial justice?

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□ How can we build better connections to the populations experiencing health inequities and racial injustices?

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**Develop a plan for including family members and, when appropriate, engage children and youth, in the change process and in health equity work.**

□ What is our current philosophy about engaging families and, where appropriate, children and youth, in all levels of decision making in our organization? Do we understand what meaningful family engagement and participation are and what practices look like to support both?

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□ Do we understand our families’ needs related to our services and supports? What is our organization’s commitment to obtaining formal feedback about our services and supports from families?

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□ What are our organizational barriers and facilitators to meaningful family engagement and involvement?

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□ In what ways can we train leadership, governance bodies, and staff at all levels on meaningful family member (and child and youth) engagement and participation in decision making?

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□ At what level and when should we engage family members and children/youth in the Health Equity Plan development process? Can we develop a plan for including them in the change process?

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□ How can we increase our capacity to engage FAVOR, Inc., in this Initiation and Engagement Phase of the change process?

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## Obtain the commitment of organizational leadership and governance bodies to participate in the four-phase change process to develop a Health Equity Plan.

- ☐ Obtain a signed working agreement with leadership and governance bodies to participate in the change process to develop a Health Equity Plan.
- ☐ Engage leadership and representatives from governance body (e.g., board of directors) in training to learn more about the change process, roles, and responsibilities.

## Establish the organizational structures, processes, and procedures to support CLAS-related work and Health Equity Plan development.

- ☐ Establish a CLAS workgroup/development team with three to five members from the organization, including those served by the organization.
- ☐ Ensure health equity goals are written into critical documents.
- ☐ Develop a diversity, health equity, and inclusion statement or policy.

## Increase knowledge about CLAS and the National CLAS Standards, beginning with leadership and governance bodies.

- ☐ Train leadership and staff at all levels in CLAS and in the enhanced National CLAS Standards.

## Develop partnerships and coalitions to address racial injustice and for addressing health disparities and advancing health equity.

- ☐ Identify multi-sectorial partnerships.
- ☐ Develop key partnerships.

## Develop a plan for including family members and, when appropriate, engage children and youth, in the change process and in health equity work.

- ☐ Assess at what level and when to engage family members and children/youth.
- ☐ Assess and address organizational barriers to meaningful family engagement.
- ☐ Assess training and technical assistance needs related to family involvement and engagement.
- ☐ Select engagement strategies that are appropriate for your context.
- ☐ Contact FAVOR, Inc., for training and technical assistance related to family/child/youth involvement and engagement.
- ☐ Develop a Family Engagement Action Team.
- ☐ Develop a plan for family involvement and engagement in health equity work and in the Health Equity Plan development.

# Initiation and Engagement Phase Frequently Asked Questions

## What is CONNECTing Children and Families to Care?

CONNECTing Children and Families to Care is a statewide effort to blend and integrate ALL child-serving systems into a Network of Care that will equally and effectively serve all children and families and provide care so that children and families can access services and supports when they need them. (For more about CONNECTing Children and Families to Care, please see <http://www.plan4children.org/>)

## What are the enhanced National CLAS Standards?

The National CLAS Standards aim to improve health care quality and advance health equity by establishing a framework for organizations to serve the nation’s increasingly diverse communities. The National CLAS Standards are a set of 15 standards that help organizations advance and sustain culturally and linguistically appropriate services. The National CLAS standards incorporate several principles, including:

- Fostering cultural competence.
- Building community partnerships.
- Collecting diversity data.
- Provider planning and evaluation benchmarks.
- Reflection of respect and diversity.
- Ensuring language access to all communities.

## What if my organization does not use the term “cultural competence”?

Some organizations prefer to use terms like cultural humility, cultural responsiveness, or cultural appropriateness rather than cultural competence. The terminology you use is completely up to your organization and community. The

important aspect of this work is a commitment to addressing racial injustice, health disparities, and health equity. This work is done through the development of a Health Equity Plan or the inclusion of the enhanced National CLAS Standards into existing efforts within your organization.

## What is the actual product that results from the voluntary training and ongoing support from this toolkit?

Your organization will develop a Health Equity Plan within a six-month timeframe as a result of using this toolkit. (See Appendix G for sample Health Equity Plans.)

## What is health equity?

Healthy People 2020 defines health equity as the “attainment of the highest level of health for all people.” The Substance Abuse and Mental Health Services Administration (SAMHSA) indicates that “health equity means that everyone has a fair and just opportunity to be as healthy as possible.”

## What is a Health Equity Plan?

Health Equity Plans are intended to advance principles of health equity, improve quality of care and services, and help eliminate health disparities. Plans developed in collaboration with the CONNECTing Children and Families to Care focus on the federal Office of Minority Health’s Culturally and Linguistically Appropriate Services (CLAS) Standards.

## How long does it take to develop a Health Equity Plan?

It is intended that your organization will develop a Health Equity Plan within a six-month timeframe as a result of using this toolkit and/or training and technical assistance.

### **What if our organization already has a strategic plan?**

You are encouraged to integrate health equity goals and strategies and the enhanced National CLAS Standards into an existing strategic plan.

### **How do I keep a Health Equity Plan a living document?**

It is recommended that Health Equity Plans are reviewed at regular intervals (like strategic plans) to assess goals that need to be re-addressed. The Health Equity Plan also can serve as a tool to assist organizations in developing ideas around possible grant funding needs, training, and hiring/promotional practices to enhance or sustain particular gains.

### **What does family engagement mean and what is “meaningful” family involvement?**

Family engagement begins with the fundamental belief that all families care for their children, have strengths, and can be engaged and empowered. Family engagement is not a single policy or practice; it is a mindset about collaborating with families in ways that respect their knowledge about their children and their communities. When policies and practices are family-driven, families have the primary decision-making role in the care of their own children, such as choosing supports and services, setting goals, designing and implementing programs, monitoring outcomes, and determining the effectiveness of efforts to promote the mental health and well-being of children.

Schools often define family engagement more narrowly as the participation of parents in regular, two-way, meaningful communication about students’ academic learning and other school activities. However, from the behavioral health perspective, family engagement is an ongoing process by

which families, schools, and providers develop and maintain a positive alliance to promote the health, well-being, and academic success of children. This definition suggests that engagement is an ongoing process necessary to develop and keep a positive alliance. It includes efforts to build trust with families and to promote family buy-in for participation in school initiatives.

### **When should we engage family members in this Health Equity Plan development process? Is there assistance to help us engage family members? Can you provide suggestions for how they can be meaningfully engaged?**

Ideally, family members and, where appropriate, children and youth, should be included in the change and health equity planning processes from the beginning. However, each organization needs to assess its capacity to meaningfully engage children, youth, and families. Some organizations may need training and support to build their capacity for involving family members.

A statewide organization, FAVOR, Inc. (<http://www.favor-ct.org/>), provides technical assistance on family engagement, including:

- assessing your organization’s family engagement needs by soliciting feedback;
- helping to design and administer surveys to the families that you serve to get their feedback;
- offering professional development opportunities to staff and families on family engagement, advocacy, cultural competency, and related topics;
- assisting in developing advisory boards within your organization to provide ongoing input from the families you serve; and
- reviewing existing policies and procedures from the family perspective.

**What is FAVOR's typical process for being involved in helping us address family engagement and involvement? How does FAVOR provide data back to our organization that they have helped us collect?**

Favor's family engagement coordinator will work with your team to identify your priorities for assessment, what methods (qualitative or quantitative) you want to use to collect data, your timeline for collecting data, and a plan for how data will be reported back to you. FAVOR can assist with qualitative (e.g., focus groups with family member or youth) or quantitative (e.g., paper-and-pencil surveys) data collection. Some questions that the FAVOR coordinator will ask include:

- What are the key questions you want to answer or gather more information about?
- What is the best method for collecting data to answer the questions you want to answer?
- Who will collect data: staff at your organization or staff from FAVOR?
- Do you have existing family events or gatherings where data can be collected (e.g., family nights that can be used to conduct focus groups)?
- In addition to families, do you have existing youth groups that would be interested in discussing health equity?
- How do you want data presented back to your organization (e.g., verbal report, written report)?

**Should we engage youth that we work with/on behalf of in this work, too?**

Where appropriate, organizations should include children and youth served in this change process and ongoing health equity and CLAS work. FAVOR, Inc., can be of assistance for youth engagement and involvement.

Some organizations have used existing internal youth groups to gather information on health equity. Other ideas include art projects or health equity walls where individuals served by your organization can anonymously share ideas on what health equity means to them (from a language, cultural, gender identity, sexual identity, religious, immigration, community violence, poverty perspective). The projects could be used as a source of continued discussions within the CLAS workgroup/development team of themes that are salient and identified consistently.

**What does sustainability look like? What should I do now to plan for sustainability?**

Sustainability of your change efforts and progress can take many forms, and planning for it from the beginning of the change process is helpful. For instance, it is recommended that you institutionalize your CLAS workgroup/development team. You can align funding decisions with your commitment to health equity.

**What if I am a small agency and I do not have three to five individuals to include in this process?**

Some organizations do not have the capacity to include three to five people in this work and these organizations are encouraged to start where they can. The goal is for you to be as inclusive as possible. Small agencies have successfully completed a Health Equity Plan with only one person participating in the training offered and ongoing support. These agencies often need more support to help others in the organization understand health equity.



# 25

## Phase II: Agency-Wide Health Equity Organizational Assessment

This section of the toolkit describes the second of the four stages of the change process to develop a Health Equity Plan and provides resources to ensure health equity is addressed throughout the change process.

### Purpose and Goals

The purpose of the Agency-Wide Health Equity Organizational Assessment phase is to collect data to understand racial injustice and health disparities within your organization and in your community, and to use that information to move to action through the development of a Health Equity Plan.

### The goals of this phase are to:

- Conduct a health equity assessment to inform a Health Equity Plan.
- Continue to build and develop your CLAS workgroup to oversee the Health Equity Plan development, implementation, evaluation, and sustainability.
- Select priority areas and the National CLAS Standards and strategies that will be documented in the Health Equity Plan.

### Conduct a health equity assessment of your organization and community.

The health equity assessment data will guide the selection of priority areas and the selection of the National CLAS Standards and strategies that will be documented in your Health Equity Plan.

Each organization is unique in its readiness and capacity to conduct a health equity assessment. Organizations are encouraged to start where they can and to build their capacity over time to routinely collect data, to critically reflect on data, to use data to inform the selection and evaluation of National CLAS Standards and strategies, and to monitor health equity. To assist with conducting an assessment and with building capacity over time, organizations are encouraged to take advantage of training, technical assistance, and support offered by organizations in Connecticut, such as:

- Connecticut Data Collaborative (ctdata.org), CTData Academy.
  - o <http://ctdata.org/academy/>
- DataHaven.
  - o <http://www.ctdatahaven.org/ask-mark>
- Connecticut Department of Mental Health and Addiction Services (DMHAS).
  - o The DMHAS Center for Prevention Evaluation and Statistics (CPES) at UConn Health
  - o <https://health.uconn.edu/community-medicine/programs/health-services-research-unit/center-for-prevention-evaluation-and-statistics-cpes/about-cpes/>
- Research and evaluation firms and consultants.
  - o American Evaluation Association listings of researchers and evaluators in Connecticut

- o [http://archive.eval.org/find\\_an\\_evaluator/evaluators\\_found.asp?where=CT](http://archive.eval.org/find_an_evaluator/evaluators_found.asp?where=CT)
- Local institutions of higher education.

While organizations may need to develop capacity over time, ideally, organizations will conduct a multi-level, multi-method, and multi-informant health equity assessment. This means that you would:

- assess different levels of influence on the population(s) of interest (e.g., individual, family, and community level factors that affect health and well-being);
- use both qualitative (e.g., focus groups, interviews) and quantitative (e.g., archival data, surveys) data collection methods; and
- collect data from different viewpoints and perspectives (i.e., different stakeholders).

More specifically, to address inequities in health, organizations are encouraged to look beyond individual determinants of health (e.g., health behaviors and access to health care) to also identify larger structural conditions (e.g., living and working environments, social class, policies, and systems) that affect health. That is, assess factors related to health where people live, work, go to school, and play. For examples of the types of larger structural questions that could be asked, consult the resource below:

- HEDA: Conducting a Health Equity Data Analysis A GUIDE FOR LOCAL HEALTH DEPARTMENTS IN MINNESOTA
  - o <http://www.health.state.mn.us/divs/chs/genstats/heda/healthequitydataguideV2.0-final.pdf>

Organizations also are encouraged to explore and to join existing efforts, such as other organizations, collaborations, or partnerships within their communities that may conduct health-related assessments. For example, according to the Office of Health Care Access, Connecticut State Department of Public Health,

*“Under the Patient Protection and Affordable Care Act (PPACA), non-profit hospitals are now required to conduct a community health needs assessment with input from public health experts and community members, and adopt an implementation strategy to meet needs identified by the assessment.”*

The Office’s website provides several hospital assessment reports, including those focused on children and families (<https://portal.ct.gov/DPH/Office-of-Health-Care-Access/Community-Needs-Assessments/Community-Needs-Assessments>).

To assist you with starting the health equity assessment process, you will first use the Organizational CLAS Standards Assessment provided in Appendix H. This assessment tool was adapted by Health Equity, Inc., from the Culturally Competent Annual Self-Evaluation developed by County of San Diego Behavioral Health Services. Using three response categories (not met, partially met, met), the tool assesses areas such as presence of an organizational health equity plan, language access and availability, CLAS staff training, and data collection among client populations.

The tool can be modified to customize to the needs of your organization. It is recommended that the CLAS workgroup/development team administer the survey either electronically (e.g., SurveyMonkey, Qualtrics) or through a paper-and-pencil survey. The organizational assessment should be administered to a wide array of stakeholders, including:

- *Leadership.*
- *Clinical staff.*
- *Administrative support staff.*
- *Human resource staff.*
- *Clients, consumers, or individuals served.*

There are numerous other self-assessment measures and tools available in the public domain that can be used to assess culturally and linguistically appropriate services and cultural competence within an organization. These measures assess attitudes, practices, policies, and structures of administrators and service providers. Resources for self-assessment tools are:

- The National Center for Cultural Competence at Georgetown University Center for Child & Human Development.
  - o <https://nccc.georgetown.edu/assessments/>
- Culture Care Connection.
  - o <http://www.culturecareconnection.org/navigating/assessment.html>
- Department of Justice, Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons, 67 FR 41464-65 (June 18, 2002).
  - o [https://www.lep.gov/resources/2011\\_Language\\_Access\\_Assessment\\_and\\_Planning\\_Tool.pdf](https://www.lep.gov/resources/2011_Language_Access_Assessment_and_Planning_Tool.pdf)

A good starting point is to use a health equity lens that begins with your own organization by collecting and reflecting on demographic and descriptive data on the children, youth, and families that you serve, on your leadership, and on your staff. This work is consistent with CLAS Standard 11: Collect and maintain accurate and reliable demographic data to monitor and evaluate the impact of CLAS on health equity and outcomes and to inform service delivery.

Some organizations have collected these data and found that while their staff demographic characteristics do not mirror those of their client/consumer populations, their clients/consumers have achieved positive behavioral health outcomes. Important discussions have resulted from these findings, such as the need for provider-service recipient cultural matching versus the need for all staff to demonstrate cultural competence (knowledge, attitudes, skills) in working across cultural boundaries. As can be seen from this example, work in this organizational assessment phase of the change model overlaps with the Implementation and Evaluation phase of the change model. Thus, the phases of the change model often overlap.

For more information and assistance with collecting demographic data, see the HRET Disparities Toolkit: A Toolkit for Collecting Race, Ethnicity, and Primary Language Information from Patients (<http://www.hretdisparities.org/Tool-4205.php>).

Conducting a qualitative assessment of CLAS and health equity related issues is essential. Qualitative assessments can include focus groups or individual interviews with different stakeholder groups. (See Appendix I for sample focus group questions.)

## Community Level Assessment

There are several data sources that you can access to obtain community level data, including:

- Connecticut Data Collaborative.
  - o <http://ctdata.org/>
- DataHaven.
  - o <http://www.ctdatahaven.org/ask-mark>
- Connecticut Department of Mental Health and Addiction Services (DMHAS).
  - o The DMHAS Center for Prevention Evaluation and Statistics (CPES) at UConn Health
  - o <https://health.uconn.edu/community-medicine/programs/health-services-research-unit/center-for-prevention-evaluation-and-statistics-cpes/about-cpes/>
- Connecticut Department of Public Health.
  - o Office of Health Care Access
  - o <https://portal.ct.gov/DPH/Office-of-Health-Care-Access/Community-Needs-Assessments/Community-Needs-Assessments>
- United Way of Connecticut.
  - o Community Results Center
  - o <http://www.ctunitedway.org/crc/>
- Connecticut State Department of Education.
  - o EdSight
  - o <http://edsight.ct.gov/SASPortal/main.do>
- Community Action Agencies.
  - o Community Renewal Team of Greater Hartford, Community Needs Assessment
  - o <http://www.crtct.org/en/about-crt/community-needs-assessment>
- Center for Healthy Schools & Communities.
  - o <http://edadvance.org/schools-districts/community-school-health-assessments>

You can also utilize data from your funder when available.

The organizational assessment also can help to determine how well your agency communicates with limited English proficient individuals and can inform language access program planning. For guidance on conducting a language access assessment, see [https://www.lep.gov/resources/2011\\_Language\\_Access\\_Assessment\\_and\\_Planning\\_Tool.pdf](https://www.lep.gov/resources/2011_Language_Access_Assessment_and_Planning_Tool.pdf).

**Objective(s):**

- Complete a health equity assessment, starting with the collection of demographic data about service recipients, staff, and organizational leadership and governance.
- Assess needs related to conducting a health equity assessment.
- Secure training, technical assistance, and ongoing support to conduct a health equity assessment.

**Continue to build and establish your CLAS workgroup/development team to oversee the health equity plan development and implementation, evaluation, and sustainability of identified strategies.**

This team will be responsible for the final product, which is the Health Equity Plan, within six months, and will be the main contact should your organization engage with a CLAS technical assistance provider. It is encouraged that the team provide the organization with updates on the process as well as join in opportunities and meetings to briefly discuss the importance of the National CLAS Standards.

Ideally, you will establish this workgroup/team from the beginning of this CLAS and Health Equity Plan development process (i.e., in Phase 1: Initiation and Engagement), but ultimately, you should determine the best timing for the formation and development of the workgroup/team.

Also, you should determine whether your team will be an operational or permanent committee as well as an ad hoc committee or a task force.

**Objective(s):**

- Establish CLAS workgroup/development team.
- Build on existing organizational structures to form the workgroup/team and establish a regular meeting schedule.

**Select priority areas and the National CLAS Standards and strategies that will be documented in the Health Equity Plan.**

First, once organizational health equity assessment information is gathered from multiple sources—including focus group themes, strategic plan goals, survey data, and a review of health disparities from data collection both within organization and in the community—organizations are encouraged to select **two** CLAS areas they will commit to and prioritize working on within their Health Equity Plan.

Organizations are encouraged to make certain the CLAS Standards selected are linked to the evidence gathered from the organizational health equity assessment. The data you collect should guide the priority areas and strategies. Second, organizations are encouraged to select priority areas and strategies that are feasible (i.e., doable) and that can be evaluated within the six-month timeframe outlined in this toolkit.

Finally, organizations are encouraged to consider taking a “small wins” approach to the CLAS and health equity work and in the selection of priority areas and strategies given the six-month timeframe outlined in this toolkit. In a small wins approach, organizations focus on one small piece (e.g., facilitating language access by translating important documents distributed to consumers to improve consumer outcomes, such as health literacy, knowledge, or access to health care) of an overwhelming and seemingly intractable problem (i.e., health inequity) and where a success can build momentum and lay the foundation for other larger changes (e.g., more individuals you serve enrolled for insurance coverage).<sup>x</sup>

Objective(s):

- Select CLAS priority areas and complete the Health Equity Plan with associated strategies, performance measures, timelines, and persons responsible.



## Agency-Wide Health Equity Organizational Assessment Phase Reflection Questions

**Conduct a health equity assessment of your organization and community.**

☐ Where and how can you join existing efforts to conduct your organizational assessment?

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☐ What type of technical assistance do you need to conduct the organizational assessment and can you identify technical assistance providers to meet your needs?

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☐ What specific areas related to health disparities or health inequities do you want to assess?

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☐ How will you organize your efforts to conduct the assessment? What is the best way to organize, store, manage, and share organizational assessment information and data with other members of your team?

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☐ Who will be the person responsible for making sure the organizational assessment is conducted?

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☐ What is your timeline for conducting the organizational assessment?

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☐ In what ways might you need to modify the Organizational CLAS Standards Assessment provided in Appendix H?

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☐ What other self-assessment tools might you use to answer assessment questions?

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☐ What types of resources can assist you with gathering data?

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☐ What is your capacity to collect data in different languages? How will you translate data collection tools?

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☐ How will you feed data back to various groups and levels within your organization?

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☐ What types of data portals to assist with your assessment can you easily access?

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☐ Do you have access to previous reports on organizational demographic data? If so, what was ascertained?

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☐ Reporting on data collected will be important: Have you thought about to whom you will present findings (e.g., leadership, staff, families, youth, others in the community)?

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☐ Have you thought of other mechanisms such as newsletters or websites to disseminate results?

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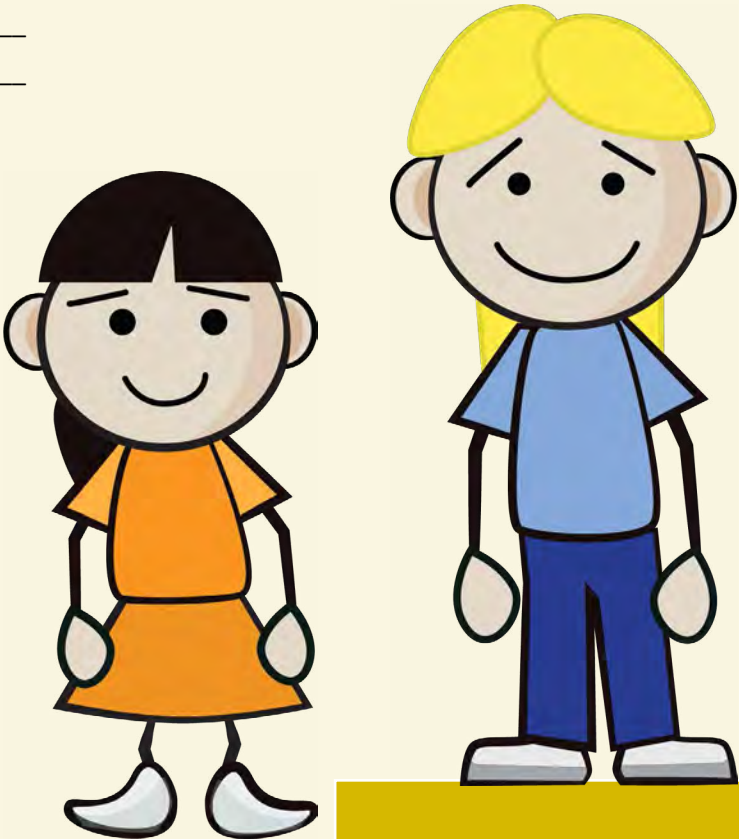
**Continue to build and establish your CLAS workgroup/development team to oversee the health equity plan development and implementation, evaluation, and sustainability of identified strategies.**

☐ Can you build on existing structures, processes, and procedures to develop your CLAS workgroup/development team (i.e., integrate CLAS work into an existing group within your agency)?

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☐ Can you include representatives from all levels of the organization in the workgroup/development team?

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☐ How frequently will your workgroup/development team meet?

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**Select priority areas and the National CLAS Standards and strategies that will be documented in the Health Equity Plan.**

☐ How well are the CLAS priority areas that you selected linked to the evidence gathered from the organizational health equity assessment?

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☐ What strategies can you realistically implement and evaluate within a six-month timeframe?

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☐ What are the pros and cons of taking a small wins approach (modest changes that can set off a chain reaction of more and better changes) during this six-month change process?

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☐ What process will you use to select the priority areas, National CLAS Standards, and strategies?

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☐ Which stakeholder groups will be involved in selecting the priority areas, National CLAS Standards, and strategies?

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## Agency-Wide Health Equity Organizational Assessment Phase Checklist

### Conduct a health equity assessment of your organization and community.

- ☐ Identify your assessment technical assistance and capacity building needs.
- ☐ Identify technical assistance providers who can address your needs.
- ☐ Identify existing efforts to conduct community health assessments.
- ☐ Assess the pros and cons of joining existing community assessment processes, partnerships, or collaborations to gather assessment data.
- ☐ Determine what areas/aspects of health disparities you want to focus on.
- ☐ Review and modify the Organizational CLAS Standards Assessment provided in Appendix H to meet your specific needs.
- ☐ Review other organizational self-assessments to determine if they fit for your organizational assessment priorities and the questions you want to answer.
- ☐ Identify who will be responsible for conducting the organizational assessment.
- ☐ Establish a timeline for completing the organizational assessment.
- ☐ Review sample health equity organizational assessment reports from FAVOR, Inc.
- ☐ Start by collecting demographic data about your service population, staff, and leadership.

### Select your CLAS workgroup/development team to oversee the health equity plan development and implementation, evaluation, and sustainability of identified strategies.

- ☐ CLAS workgroup/development team established with three to five members from the organization, including those served by the organization. **Select priority areas and the National CLAS Standards and strategies that will be documented in the Health Equity Plan.**
- ☐ Link the CLAS priority areas that you selected to the evidence gathered from the organizational health equity assessment.
- ☐ Select strategies you can realistically implement and evaluate within a six-month timeframe.
- ☐ Determine and document the process will you use to select the priority areas, National CLAS Standards, and strategies.
- ☐ Determine which stakeholder groups will be involved in selecting the priority areas, National CLAS Standards, and strategies.

## Agency-Wide Health Equity Organizational Assessment Phase Frequently Asked Questions

How do I begin an organizational assessment, and how do I collect this and other data central to health equity?

The toolkit provides an organizational assessment that we recommend you use and modify where necessary (Appendix H). Also, there is a wealth of CLAS-related assessment tools available that are free of charge. Some of these tools can be found at:

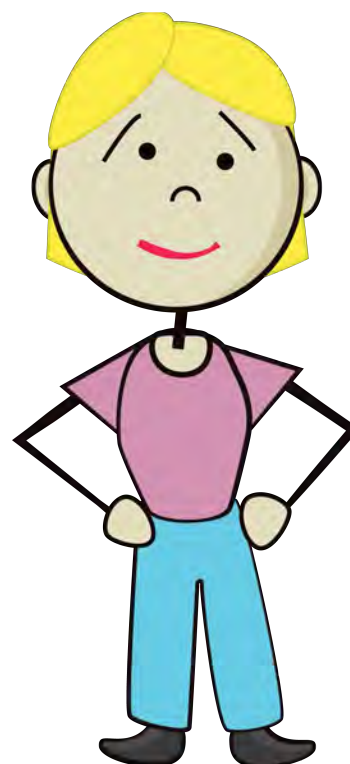
- The National Center for Cultural Competence at Georgetown University Center for Child & Human Development.
  - o <https://nccc.georgetown.edu/assessments/>
- Culture Care Connection.
  - o <http://www.culturecareconnection.org/navigating/assessment.html>
- Department of Justice, Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons, 67 FR 41464-65 (June 18, 2002).
  - o [https://www.lep.gov/resources/2011\\_Language\\_Access\\_Assessment\\_and\\_Planning\\_Tool.pdf](https://www.lep.gov/resources/2011_Language_Access_Assessment_and_Planning_Tool.pdf)


**Where can we obtain assistance for identifying strategies to address our priority areas and the National CLAS Standards that we select?**

There are several resources containing examples of specific strategies and interventions to address the National CLAS Standards, including:

- Connecticut Department of Public Health.

- o Office of Health Equity
- o <https://portal.ct.gov/DPH/Workforce--Professional-Development/Office-of-Health-Equity/Office-of-Health-Equity>
- Think Cultural Health.
  - o A Blueprint for Advancing and Sustaining CLAS Policy and Practice <https://www.thinkculturalhealth.hhs.gov/clas/blueprint>





# 36 Phase III: Implementation and Evaluation

This section of the toolkit describes the third of the four phases of the change process to develop a Health Equity Plan.

## **Purpose and Goals:**

The purpose of the Implementation and Evaluation Phase is to use organizational assessment data to develop a Health Equity Plan and to implement and evaluate strategies documented on the Plan.

## **The goals of this phase are to:**

- Develop a full Health Equity Plan based on organizational health equity assessment data collected in Phase 2 of the change model.
- Implement strategies associated with two or three priority areas within a six-month period.
- Evaluate priority area strategies within a six-month period.

## Develop a full Health Equity Plan based on organizational health equity assessment data.

Typically, organizational assessments identify multiple areas needing attention to improve services with respect to cultural and linguistic appropriateness and to achieve greater health equity. The Health Equity Plan should be comprehensive and address these multiple areas of need. Thus, during this phase, organizations will develop their full Health Equity Plan, but it is not recommended that organizations focus on all areas and strategies initially or simultaneously.

**Organizations are asked to prioritize two or three National CLAS Standards and to implement associated strategies to address those Standards during the six-month change period.**

Organizations may need to consult stakeholders or the CLAS workgroup/development team to prioritize the two or three National CLAS Standards and associated strategies.

**These National CLAS Standards and strategies should be feasible (i.e., doable) within the six-month change process outlined in this toolkit.**

Planning for the identification of National CLAS Standards and strategies necessitates that organizations provide ongoing CLAS and health equity training at all levels (governance, leadership, supervisors, front line staff, children, youth, and family members, and community members) of the organization. Several national and state resources are available to assist with training and with building the CLAS expertise within organizations and in communities.

### National Resources:

- Substance Abuse and Mental Health Services Administration (SAMHSA).
  - o <https://www.samhsa.gov/capt/tools-learning-resources/national-clas-standards-action>
  - o <https://www.integration.samhsa.gov/search?q=cultural+and+linguistic++competence>
- National Network to Eliminate Disparities in Behavioral Health.
  - o <https://nned.net>
- Office of Minority Health.
  - o <https://minorityhealth.hhs.gov/>
- ThinkCulturalHealth.
  - o <https://www.thinkculturalhealth.hhs.gov/pdfs/CLASCompendium.pdf>
- National Center for Cultural Competence, Georgetown University Center for Child & Human Development.
  - o <https://nccc.georgetown.edu/>
- Centers for Medicare & Medicaid Services and Office of Minority Health.
  - o <http://www.emfp.org/Main-Menu-Category/Library/A-Practical-Guide-to-Implementing-the-National-CLAS-Standards-For-Racial-Ethnic-and-Linguistic-Min.pdf>
- Washington State, Governor's Interagency Council on Health Disparities.
  - o <http://healthequity.wa.gov/clastrainingandresources>

### Connecticut State and Local Resources:

- Connecticut Multicultural Health Partnership.
  - o <http://www.ctmhp.org/>
- Connecticut Department of Public Health.
  - o Office of Health Equity
  - o (<https://portal.ct.gov/DPH/Workforce--Professional-Development/Office-of-Health-Equity/Office-of-Health-Equity>)

- o [https://portal.ct.gov/-/media/Departments-and-Agencies/DPH/dph%20%20/hems/health\\_equity/CLASTOOLKITFINAL102816pdf.pdf?la=en](https://portal.ct.gov/-/media/Departments-and-Agencies/DPH/dph%20%20/hems/health_equity/CLASTOOLKITFINAL102816pdf.pdf?la=en)

**Implement strategies associated with two to three priority areas within a six-month period.**

Some organizations may choose to pilot small-scale ideas and strategies that were developed from the organizational assessment phase findings to begin implementation. One example would be a focus on CLAS Standard #5: Offer language assistance to individuals who have limited English proficiency and/or other communication needs, at no cost to them, to facilitate timely access to all health care and services. (See the example Health Equity Plan in Appendix G). The specific strategy to address this Standard is to ensure that the agency has language assistance available for all programs. The major task to address this strategy is to ensure parent forms are fully accessible in secondary languages and the forms are used in the agency. This necessitates working with translators to ensure a translation process that represents service populations. The performance measure (quantifiable indicator to determine if the desired outcome is met) is that the translated forms are made available.

**Evaluate priority area strategies within a six-month period.**

The evaluation component of Phase 3 focuses on collecting data to monitor progress in a six-month period. More specifically, this relates to columns three (Performance Measure) and four (Impact or Result) of the Health Equity Plan template. (See Appendix J.) Many of the National CLAS Standards 9 through 15 (Engagement, Continuous Improvement and Accountability) focus on evaluation.

Evaluation involves assessing the strengths and weaknesses of programs, policies, personnel, products, and organizations to improve their effectiveness.

Thus, this component of Phase 3 is about continuously assessing and improving your CLAS and health equity work and activities.

Assessing the degree to which organizations have achieved their CLAS- and health equity-related goals and desired outcomes is essential, but organizations differ in their readiness and capacity to engage in this work. The American Evaluation Association, an international professional association of evaluators devoted to the application and exploration of program evaluation, personnel evaluation, technology, and many other forms of evaluation, provides a list of evaluators by state who can assist with evaluation training, technical assistance, capacity building, and support: ([http://archive.eval.org/find\\_an\\_evaluator/evaluators\\_found.asp?where=CT](http://archive.eval.org/find_an_evaluator/evaluators_found.asp?where=CT))

Additional resources to assist with building evaluation capacity and with conducting evaluation:

- <http://www.racialequitytools.org/evaluate/designing/evaluation-design>

- Objective(s):
- Develop Health Equity Plan.
  - Implement strategies.
  - Evaluate strategies.

## Implementation and Evaluation Phase Reflection Questions

**Develop a full Health Equity Plan based on organizational health equity assessment data.**

☐ Does your full plan represent the perspectives of multiple stakeholders?

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☐ How will you ensure that stakeholders have input into the plan development?

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☐ How comprehensive is your Health Equity Plan?

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**Implement strategies associated with two or three priority areas within a six-month period.**

☐ What strategies to address priority areas and National CLAS Standards can you realistically implement within a six-month period?

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☐ What are/will be the challenges and barriers to implement the strategies that you have selected?

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☐ What are/will be the factors to facilitate implementation of the strategies that you have selected?

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**Evaluate priority area strategies within a six-month period.**

☐ What strategies can you realistically evaluate within the six-month change period?

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☐ What is your organization's evaluation capacity and readiness?

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☐ What training, technical assistance, and ongoing support does your staff and organization need to build its evaluation capacity and readiness?

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☐ How will you begin to explore the evaluation and capacity building assistance that is available?

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☐ How can you incorporate the routine collection of data and reflection about data into your operating procedures and processes?

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## Implementation and Evaluation Phase Checklist

### Develop a full Health Equity Plan based on organizational health equity assessment data.

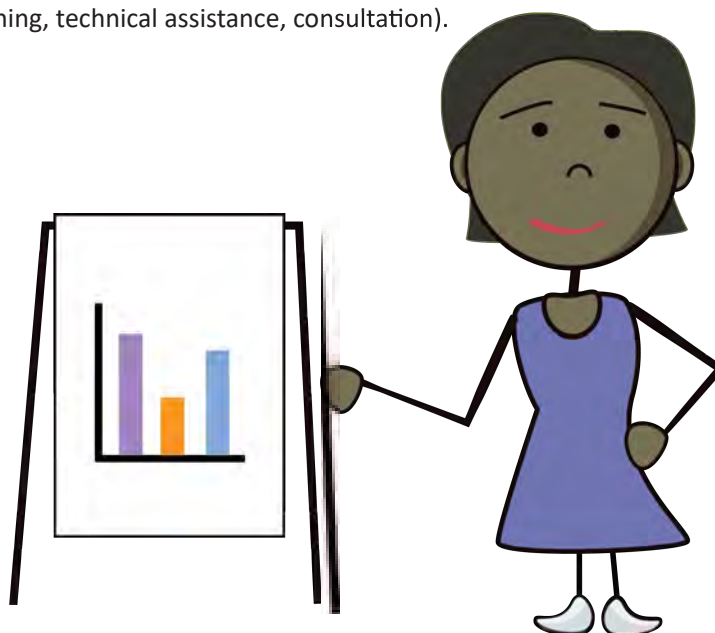
- ☐ Obtain input from multiple stakeholders.
- ☐ Develop full Health Equity Plan.

### Implement strategies associated with two or three priority areas within a six-month period.

- ☐ Select strategies that can realistically be implemented and evaluated within a six-month period.
- ☐ Obtain input from stakeholders to select strategies.
- ☐ Identify barriers and facilitators to implementation and develop plan for addressing/reducing barriers and further supporting facilitators.

### Evaluate priority area strategies within a six-month period.

- ☐ Identify evaluation readiness and capacity training, technical assistance, and consultation needs and consultant.
- ☐ Identify resources for evaluation (staff time, training, technical assistance, consultation).





## Implementation and Evaluation Phase Frequently Asked Questions

### **How do we ensure input into our Health Equity Plan from our various stakeholders?**

There are several ways you can obtain stakeholder input for the development of your Health Equity Plan. First, identify the stakeholder group(s) you want to engage. Then, consider what, if any, support you will need to provide to ensure stakeholders are equipped to provide input. For instance, will the stakeholder group need to increase its knowledge of health disparities, health equity, and the National CLAS Standards to meaningfully participate? With some basic knowledge, perhaps they will be better prepared and engaged in the process of providing their feedback.

Next, think about what organizational assessment data you want to disseminate to the stakeholders and how you want the stakeholder group to reflect on and use the data to rank order its priority areas, National CLAS Standards, and/or strategies.

For governance bodies, you may consider presenting the CLAS work at a board meeting and facilitating large or small group work to obtain feedback.

For staff, you might consider a staff retreat—like those conducted to develop a strategic plan—presentations at staff meetings, or web-based strategies (i.e., website) to present results of the organizational assessment and to allow staff to rank order priority areas, National CLAS Standards, and strategies.

For community members, you may consider holding an open meeting or attending existing meetings where community members typically gather. You may consider specific

organizations in your community where you want to be sure to obtain their input into the plan.

For consumers your organization serves, ideally, they already will be integrated into your organizational structures and processes, such as representation on governance bodies and on your CLAS workgroup/development team. You also could use peer mentors to help obtain consumer input. This may require training for the peer mentor, who then works with the consumers directly. Another option for obtaining family input in the plan development is to hold meetings at convenient times for families and facilitate attendance by providing meals, child care, and/or transportation.

### **Implement strategies associated with two or three priority areas within a six-month period.**

#### **How do we select priority areas when all areas identified on our plan seem to need attention?**

The input of various stakeholder groups can help with setting priorities. Also, organizations are encouraged to start with priority areas and associated strategies that can be implemented and evaluated within the six-month timeframe outlined in this toolkit.

### **Evaluate priority area strategies within a six-month period.**

#### **How can we build our capacity to evaluate the strategies we implement?**

There are several resources both nationally and locally that can assist you in your program evaluation efforts. You can look to the American Evaluation Association, which lists evaluators by state, and/or you can locate evaluators and researchers, including graduate students, at local colleges and universities. In addition, you can build the capacity of your organization and staff by offering specialized training to existing staff or hiring new evaluation staff.



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## Phase IV: Healthy Equity Plan Finalization and Sustainability

This section of the toolkit describes the fourth of the four phases of the change process to develop a Health Equity Plan and provides resources to ensure health equity is addressed throughout the process.

### Purpose and Goals:

The purpose of this phase of the change model is to finalize the Health Equity Plan and to sustain (institutionalize) CLAS strategies (interventions, processes, policies, procedures) that are documented in the Health Equity Plan and to ensure that the effects of strategies in service populations are maintained over time.

### The goals of this phase are to:

- Finalize the Health Equity Plan.
- Sustain CLAS and health equity work.

## Finalize the Health Equity Plan.

During this phase, the Health Equity Plan is finalized.

**The Health Equity Plan should be routinely reviewed and modified based on organizational priorities.**

The document should be routinely reviewed and modified based on organizational priorities and development, and based on evaluation findings. Thus, the Health Equity Plan is a living document.

Once the plan is finalized, organizations are encouraged to disseminate all or some components of the Health Equity Plan to various stakeholders in a user-friendly manner. Dissemination could take the form of presentations, newsletters, community-based logic models/theories of change, roundtable discussions, websites, and so forth.

## Sustain CLAS and health equity work.

Sustaining and institutionalizing your CLAS and health equity work should be considered and planned for from the beginning of the health equity change process, rather than primarily at the end of the change process.

**To ensure the sustainability of prevention outcomes, it is important to build stakeholder support for your program, show and share results, and obtain steady funding.**

To better ensure the institutionalization and maintenance of CLAS and health equity work, organizations are encouraged to commit to setting aside a small amount of funding annually to bring in an expert from outside of the organization to review

and to provide technical assistance for ongoing work in these areas.

### Objective(s):

- Build upon existing infrastructure for institutionalizing CLAS and health equity strategies.
- Integrate interventions into the regular practice of the delivery organization.
- Incorporate the CLAS strategies into routine organizational practices, procedures, and policies.
- Sustain the long-term effects of strategies on outcomes of interest after initial implementation.
- Secure funding to continue CLAS and health equity work.



## Health Equity Plan Finalization and Sustainability Phase Reflection Questions

### Finalize the Health Equity Plan.

- ☐ What process will you use to finalize the Health Equity Plan?

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- ☐ How often will you formally review the plan and modify it, where necessary?

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- ☐ How will the Health Equity Plan be shared and disseminated with various stakeholders?

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- ☐ With whom should the Health Equity Plan be shared?

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- ☐ When should the Health Equity Plan be shared?

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- ☐ How should the Health Equity Plan be shared? What is your dissemination strategy?

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### Sustain CLAS and health equity work.

- ☐ How can you incorporate the CLAS strategies into the routine organizational practices, procedures, and policies?

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- ☐ How will you build stakeholder support for your Health Equity Plan and its strategies?

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- ☐ How will you disseminate the results of evaluation data of your efforts?

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- ☐ How will you secure steady funding to support your CLAS and health equity work?

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- ☐ Are there existing resources/funding within your organization? \_\_\_\_\_

- ☐ Can you apply for grant funding? \_\_\_\_\_

- ☐ Where can you leverage partnerships to support sustainability? \_\_\_\_\_

☐ How can you garner resources to sustain the strategy?

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☐ How can the strategy or intervention duties be made part of staff job responsibilities?

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☐ How well are the strategy and its objective(s) matched to the organization's mission statement?

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## Health Equity Plan Finalization and Sustainability Phase Checklist

### Finalize the Health Equity Plan.

- ☐ Develop a plan for finalizing your Health Equity Plan.
- ☐ Determine how often you will formally review the plan and modify it, and determine who will be a part of that process.
- ☐ Develop a plan for sharing and disseminating your Health Equity Plan with various stakeholders.

### Sustain CLAS and health equity work.

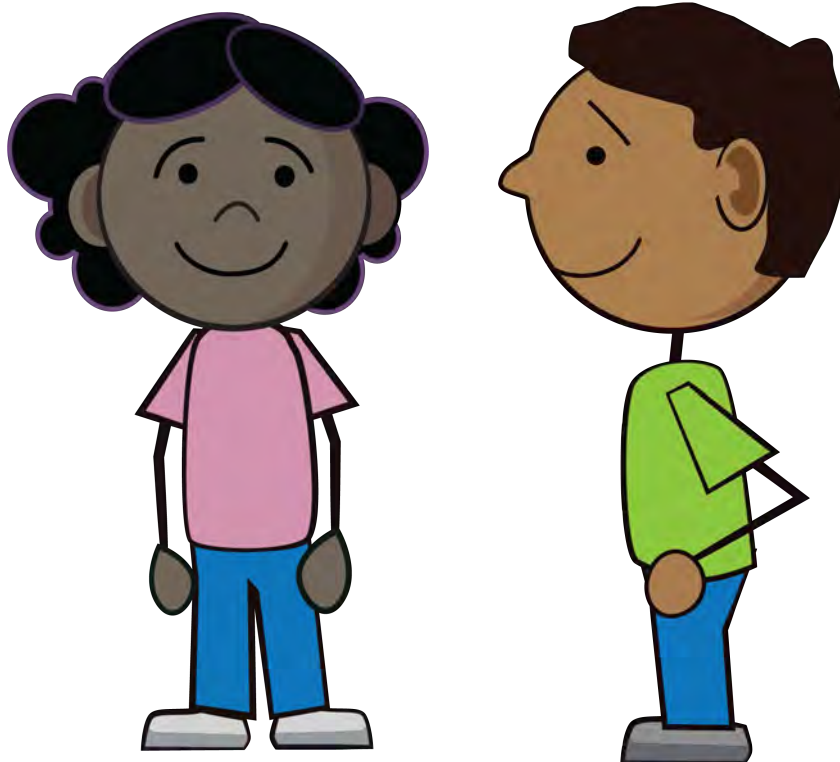
- ☐ Incorporate the CLAS strategies into the routine organizational practices, procedures, and policies.
- ☐ Develop and plan a strategy for building stakeholder support for your Health Equity Plan and its strategies.
- ☐ Develop a plan to disseminate your National CLAS Standards strategy evaluation findings.
- ☐ Develop a plan for securing funding to support your CLAS and health equity work.
  - ☐ Identify existing resources/funding within your organization.
  - ☐ Identify funders and requests for proposals and other sources of funding.
  - ☐ Develop partnerships to support sustainability.
- ☐ Assess how well the strategy and its objective(s) match the organization's mission statement.
- ☐ Build in strategy or intervention duties into staff job responsibilities.

## Health Equity Plan Finalization and Sustainability Phase

### Frequently Asked Questions

**What are some resources that will help us plan for sustainability?**

According to the Center for Public Health Systems Science (CPHSS), a public health research center at the Brown School of Social Work at Washington University in St. Louis, to maintain programming and its benefits over time there are eight organizational and contextual domains that support sustainability: environmental support, funding support, partnerships, organizational capacity, program evaluation, program adaptation, communications, and strategic planning. The Center developed the Sustainability Framework and Assessment Tool (<https://sustaintool.org/assess/>) that can be used by individuals or groups from organizations to assess sustainability and that provide a customized report.



# 47 Endnotes

<sup>i</sup> Stroul, B., Blau, G., & Friedman, R. (2010). Updating the system of care concept and philosophy. Washington, DC: Georgetown University Center for Child and Human Development, National Technical Assistance Center for Children's Mental Health.

<sup>ii</sup> ThinkCultural Health: <https://minorityhealth.hhs.gov/omh/browse.aspx?lvl=2&lvlid=53>

<sup>iii</sup> <https://www.raceforward.org/about>

<sup>iv</sup> U.S. Department of Health and Human Services, Office of Minority Health. 2011. National Partnership for Action to End Health Disparities. Retrieved from <http://minorityhealth.hhs.gov/npa>

<sup>v</sup> <https://www.thinkculturalhealth.hhs.gov/pdfs/EnhancedNationalCLASStandards.pdf>

<sup>vi</sup> Centers for Disease Control and Prevention—Division of Community Health. 2013. A Practitioner's Guide for Advancing Health Equity: Community Strategies for Preventing Chronic Disease. Atlanta, GA: U.S. Department of Health and Human Services

<sup>vii</sup> <https://www.healthypeople.gov/2020/about/foundation-health-measures/Disparities>

<sup>viii</sup> <https://www.samhsa.gov/behavioral-health-equity>



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## **Appendix A**



## Connecticut Network of Care Transformation (CONNECT) Statement Regarding Behavioral Health Disparities Special Terms and Conditions November 28, 2014

1. A behavioral health disparities impact statement that includes all sub-populations and the geographic region. Disparities impact statements must outline the population/s of focus that will be served and the unduplicated number of individuals who are expected to receive services. These statements should be consistent with the information in your application regarding outcomes for the program.

The Connecticut Network of Care Transformation (CONNECT) initiative has the goal of creating a statewide and regionalized infrastructure that integrates efforts across child-serving sectors, including early childhood, child welfare, mental health, juvenile justice, substance abuse, and education, setting the stage for system of care expansion and implementation. Geographically, Connecticut is a small state, ranked 48th in size by area with approximately 5,500 square miles. Connecticut is the 29th most populated state with a total population of just over 3.5 million residents, of whom just over 800,000 (23%) are children and youth under the age of

eighteen. Although prevalence estimates on children with Serious Emotional Disturbance (SED) vary, is estimated that 7.1% or over 56,500 children need mental health services in Connecticut.

The chart below represents the proposed number of individuals to be reached during the grant period and the identified subpopulations within the state. The total number of 824 children represents the priority service population as determined by need and length of stay in behavioral health services.

	FY 1 2014-15	FY 2 2015-16	FY 3 2016-17	FY 4 2017-18	Totals
Number to be reached	175	224	225	200	824
<b>By Race/Ethnicity</b>					
African American	15	24	27	20	86
American Indian/Alaska Native	0	1	1	1	3
Asian	4	10	10	6	30
White (non-Hispanic)	142	168	162	154	626
Hispanic or Latino	12	17	21	16	66
Native Hawaiian/Other Pacific Islander	0	1	0	0	1
Two or More Races	2	3	4	3	12
<b>By Gender</b>					
Female	90	115	110	100	415
Male	85	109	114	100	408
Transgender	0	0	1	0	1
<b>By Sexual Orientation/ Identity Status</b>					
Lesbian	3	4	4	4	15
Gay	3	4	4	4	15
Bisexual	0	1	1	1	3

The target service population reflects the diversity of the state across racial/ethnic, gender, and sexual orientation categories. Eighty-four percent of residents in Connecticut are white, 10.4% are black, 0.4% are American Indian or Native Alaskan, 3.6% Asian, 0.1% Native Hawaiian and other Pacific Islander, and 1.5% of residents report two or more races. Eight percent of the general population is Hispanic (144,500). Connecticut's population of racial/ethnic minorities has grown significantly in the past decade, with largest increases in the Asian (+65%) and Hispanic (+50%) categories. Currently over three-quarters of the population in the state's three largest cities identify as racial/ethnic minorities, with 40% identifying as Hispanic and 31% as non-Hispanic Blacks. With national estimates of 4% of individuals identifying as lesbian, gay, bisexual, or transgender, it is estimated that 2,260 of children in Connecticut, who are in need of mental health services, will identify as a member of a sexual/gender minority group.

The Connecticut Network of Care Transformation (CONNECT) initiative continues to develop a statewide comprehensive system of care for children with severe emotional and behavioral difficulties. For this implementation phase we will work to ensure inclusion of individuals from across all demographic and cultural profiles representative of local and regional communities, in a manner that promotes collaborative partnerships. The CONNECT Initiative has identified strategies to actively engage the following groups:

i. Age: Youth and family voice of children, youth, and transition-age youth from birth through age 21 and their caregivers will be represented as full partners in all aspects of the planning process.

ii. Race, Ethnicity, and Culture: CONNECT will adopt and adhere to the National Standards for Culturally and Linguistically Appropriate Services (CLAS) to guide implementation of the strategic plan and social marketing plan. Particular attention will be paid to racial, ethnic, and cultural groups

currently vulnerable to disparities in the statewide Network of Care, including the growing Hispanic, Black, and Asian subgroups and will be reflected in project leadership positions.

iii. Language and Literacy: Nearly half (45%) of residents in Connecticut's three largest cities speak a language other than English at home. CLAS standards will be adopted and adhered to with respect to linguistic accessibility and will provide the framework for the development and dissemination of the CONNECT social marketing and strategic communications plan to assure accessibility to easily understood materials in the preferred language of the youth and families served in each region.

iv. Disability: The CONNECT Youth and Family Voice Leadership Network is comprised of three family advocacy organizations (FAVOR, AFCAMP, NAMI-CT) with expertise in training, advocacy, and support for youth and families affected by physical and developmental disabilities across all systems. This team will ensure the inclusion of youth and family partners with disabilities and/or special needs throughout the planning and activities process.

v. Gender/Gender Identification and Sexual Orientation: In Connecticut, a total of 8,166 same-sex couples were identified in 2011 by US Census housing data ; however, more work is needed to identify LGBT youth and families served in the local networks of care. This planning process is designed to be inclusive of and respectful to all forms of identification with respect to gender and sexual orientation and will be reflected in project leadership and activities.

vi. Socioeconomic Status: Given the income disparities between the state's richest and poorest residents and high rates of child poverty across urban and rural areas, targeted efforts will be incorporated into the planning process to identify & address needs across geographic areas.

2. Provide a statement documenting how you will address race, ethnicity and disability status, including processes or programmatic adjustments to address identified disparities in the following domains: a) data collection activities; b) program services and activities development and implementation; 3) data reporting, including access, use and outcomes measures.

**Data Collection.** Youth and Family Level Outcomes: Data will be collected for all youth who are transitioning out of or being diverted from congregate care placements through involvement in high level care coordination services. In 2009, Connecticut launched Programs & Services Data Collection & Reporting System (PSDCRS) a web-based data collection program for community providers receiving state funding. PSDCRS collects demographic and descriptive information, risk and protective factors and outcomes specific to each program type. The Care Coordination module of PSDCRS currently includes the Ohio Scales and the Parental Stress Scale. This module will be modified to include the CMHS Child Outcome Measures for Discretionary Programs (NOMS) and the measures proposed by the National Evaluation team (Caregiver Strain Questionnaire, Pediatric Symptom Index, Columbia Impairment Scale and any other required National measures). In addition, starting in 2013, the Department of Children and Families (DCF) began to collect information on the number of natural supports involved in care planning. We will continue to collect this data for families who receive care coordination in order to assess whether training impacts this outcome over time. All measures will be collected by providers at intake, 6-months, 12-months and discharge. The evaluation team will provide quarterly reports at the regional and statewide levels documenting the characteristics of youth (e.g., age, race, ethnicity) who have been enrolled in the statewide Network of Care and how these individuals compare to the population in each region and across the state to assess whether disparities exist in service enrollment and provision. In addition, all analyses will include a comparison of outcomes across these demographic groups to assess if there are disparities in outcomes.

Caregivers who participate in the training such as the Network of Care Systems Impact Agents of

Transformation and those who are members of the CONNECT teams will be asked to complete the Family Empowerment Scale (FES). The FES is a psychometrically sound measure designed to assess empowerment among caregivers of children with significant emotional or behavioral difficulties. We will administer the FES immediately before their participation in the curriculum or joining a committee and then at a three month follow-up. We will conduct a similar evaluation for youth who participate in trainings and/or are members of a CONNECT team who will be asked to complete a modified version of the Youth Empowerment –Mental Health scale (YE-MHS). The YE-MHS is a psychometrically sound measure designed to assess empowerment in youth who have experienced emotional or behavioral difficulties. Results of these assessments will increase our understanding of family member/youth perceptions regarding their capacity for engaging in actions to effect system change and will inform the development of additional strategies that may be needed to facilitate their involvement and to feel more empowered to engage in system level change efforts. We will examine these data to determine if there are any differences in empowerment based on key characteristics (e.g., age, race, ethnicity) and whether specific strategies need to be implemented to enhance empowerment where differences are found.

In addition, the CONNECT Statewide Data Team will develop a process where individuals involved in project planning and development can, if they choose to, provide demographic information based on the HHS Data Collection Standards for Race, Ethnicity, Sex, Primary Language and Disability Status which will be modified to also include sexual minority status and the individuals zip code. This information will be analyzed on a regular basis to determine if representatives of all groups to be impacted by

services are involved in the planning and implementation process. This information will be shared with the Project Director who will develop plans to reach out to groups not involved to identify ways for them to be at the table or to solicit their input regarding plan implementation. In addition, data indicators on all relevant demographic factors will be represented reliably and respectfully throughout the CQI process in a manner consistent with CLAS standards and culturally competent, evidence-informed research and evaluation practices.

System-level Outcomes: We will also evaluate system level outcomes including: 1) assessment of readiness to change; 2) interagency collaboration; and 3) collaborative functioning at the local, regional, and statewide levels.

*Assessment of Readiness to Change.* To assess CONNECT's readiness to make the policy, fiscal and structural changes needed to implement SOC expansion we will employ 2 measures: 1) The System of Care Readiness and Implementation Measurement Scale 2) a modified version of the Tri-Ethnic Center for Prevention Research's Community Readiness Model .

The System of Care Readiness and Implementation Measurement Scale (SOC-RIMS) was developed at the request of the CMHS Child and Family Branch to assist communities in understanding their level of readiness to enact the changes needed to fully implement a system of care for children and families. The SOC-RIMS was administered to the CONNECT SOC Expansion and Steering Teams in the first quarter of our planning year and the SOC-RIMS will be administered again at the end of the planning year and at the end of each implementation year. Results of the survey are provided by the measure developers and are examined to determine if there are differences by race or ethnic groups.

We will replicate our use of the Tri-Ethnic Center for Prevention Research's Community Readiness

Model (see [www.triethniccenter.colostate.edu/communityReadiness\\_home.htm](http://www.triethniccenter.colostate.edu/communityReadiness_home.htm) for a description of the model) to augment the Community Readiness Assessment. The Tri-Ethnic tool helps to identify resources and obstacles, and provides an assessment of community readiness in accepting that the system implementation is needed and in identifying the types of activities or structures that are needed to get to full implementation. During the planning year, our evaluator trained a group of family members and is in the process of training a group of youth on all aspects of focus group evaluation. The family members conducted a series of 28 community conversations regarding strengths, areas of growth, and suggestions for our network of care. The information gathered provided the framework for our network of care implementation plan. We will continue to hold these community conversations and youth will lead focus groups to continue to gain input from our community regarding the network of care. We have found that qualitative data collected by family members provides a more valid representation of the perceptions and beliefs of those who receive services from and work within systems of care. This qualitative data augments the information collected through SOC-RIMS and will provide a more complete picture of the strengths and areas for continued growth in fully implementing the Connecticut Network of Care.

*Interagency Collaboration.* To assess collaboration, we will conduct a web-based interagency collaboration survey—a technique that the evaluation team has employed in similar assessments of SOC collaboration . We will use the Levels of Collaboration Survey; combined with the Interagency Collaboration Scale (IACS). The collaboration survey assesses uni- and bi-directional collaboration within the network of care and the degree of this collaboration specific to information sharing, advocacy, referrals, and resources. We will assess collaboration via web-based survey within the first quarter of the implementation grant and then annually. Data analysis will be conducted to determine network density, strength of

collaborations, and how diffuse the network is. The CONNECT Coordinating Center will send an email explaining the purpose of the survey and inviting participation. This survey will be sent to all community agencies in the Network of Care, including but not limited to, agencies that serve individuals whose primary language may not be English and agencies that focus on serving individuals from under-resourced communities. Participants will provide informed consent, via the web-based survey and will develop a unique identifier which will be used to track participants over time.

**Program Services and Activities Development and Implementation.** The CONNECT Initiative seeks to ensure inclusion across all demographic and cultural profiles, representative of local and regional communities, in a manner that promotes collaborative partnerships. Identification, recruitment, and retention of those youth and families standing to benefit most from systems of care expansion statewide will be facilitated through a collaborative partnership model. A total of \$40,000 will be made available for youth and family stipends to compensate for participation in CONNECT meetings and will cover costs such as child care, gas, mileage, and other meeting expenses. As the extensive network of local-level strengths and community-based resources are pooled at the regional level, cross-sector communication and information-sharing will be enhanced as a mechanism for supporting progress towards improvements in the Networks of Care and will directly impact youth and families. As partners, key family advocacy organizations will provide outreach, leadership, and technical assistance to directly engage youth and families through peer support and meaningful involvement as drivers and leaders in the implementation process. Key individuals such as the CONNECT Youth and Family Engagement Coordinators and Family Systems Managers will play a critical role in the accountability and oversight of recruitment and retention throughout the strategic planning process. Development and implementation

of the culturally competent social marketing plan and data systems to clearly articulate and monitor SOC goals and values reinforcing the CONNECT Initiative will be critical to maintaining successful identification, recruitment, and engagement.



3. Plan for the development and implementation of policies and procedures in line with the Enhanced Culturally and Linguistically Appropriate Services (CLAS) Standards for effective care and services that are responsible to:
- a) diverse cultural health beliefs and practices; b) preferred languages, and c) health literacy and other communication needs of all sub-populations in the proposed geographic region.

A Cultural and Linguistic Competency Plan is in development to guide the implementation of the CONNECT Statewide SOC Strategic Plan in a manner that ensures adherence to CLAS standards with respect to diverse cultural beliefs and practices, preferred languages, and health literacy and communication needs of the identified sub-populations across the state. Three primary strategies will be employed to monitor Connecticut's commitment to and progress towards adherence to the CLAS standards.

**Beliefs and Practices.** First, the CONNECT Youth and Family Voice Leadership Network will collaborate with system leaders to provide oversight regarding attention to cultural and linguistic competence across all CONNECT personnel, activities, and products at the local, regional, and state levels. The CONNECT Youth and Family Engagement Coordinators will play a key role in partnering with Family System Managers to identify, recruit, and retain team members representative of cultural and linguistic subpopulations of focus from each region. This will help ensure genuine youth and family engagement in leadership and decision-making through ongoing partnerships with family advocacy organizations and graduates of the Network of Care Systems Impact Agents of Transformation training across regions.

**Preferred languages.** Second, the CONNECT Youth and Family Voice Team will implement a comprehensive culturally and linguistically competent social marketing and strategic communications plan using strategies and content that documents and promotes infrastructure development and systems transformation. Key documents will be available in both English and Spanish, and translation services will be available for youth and families to participate in services and infrastructure development activities in their preferred languages.

**Health literacy.** Third, the CONNECT Statewide Data Team will be responsible for monitoring CLAS standards as an integral component of the CQI and data management processes. The Self-Assessment of Readiness, Statewide Strategic Plan Logic Model and performance measures/dashboard indicators were developed through a culturally competent process, driven by youth and families, and designed to identify data indicators to track progress towards culturally competent care, language accessibility, and improved organizational supports to meet the needs of the local/regional cultural and linguistic subpopulations of focus currently vulnerable to disparities in service access, utilization, and outcomes. Data dashboards and communication tools will be used to inform and educate youth and families served, as well as providers and community-based stakeholders, to improve health literacy and informed participation.

These three processes will help to ensure that the diverse cultural beliefs, linguistic and health literacy needs of the individuals who utilize the services of our system of care are considered in the ongoing development of the infrastructure for the delivery of services. This will be operationalized through the development of policies that will be the cornerstone of our Statewide Strategic Plan that will insure that materials developed for the system of care are: reflective of the communities that will be served; are provided in the preferred language of the individuals who will receive services and their families; and, are presented in language that is jargon free and provides an easy understanding of the constructs and ideas being presented.



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## Appendix B

# CONNECTing with CLAS

Ensuring Culturally and Linguistically Appropriate Services

**CULTURAL AND LINGUISTIC COMPETENCE**- the ability to interact effectively with people of different cultures, helps ensure the needs of all community members are addressed (SAMHSA).

**CULTURALLY AND LINGUISTICALLY APPROPRIATE SERVICES (CLAS)** - are a set of 15 action steps intended to advance health equity, improve quality and help eliminate health care disparities by providing a blueprint for individuals and health care organizations to implement culturally and linguistically appropriate services ([ThinkCulturalHealth](#)).

**CONNECT**-The Connecticut Network of Care Transformation (CONNECT) is statewide initiative to create a partnership between families, state agencies, and service providers at the local, regional and state levels. This enhanced partnership supports children, youth, and families in accessing the services they need in a timely and effective manner through an integrated network of care ([CHDI](#)).

**SYSTEM OF CARE/NETWORK OF CARE** - a System of Care is an organized spectrum of effective community-based services and supports for children and youth with or at risk for mental health or other challenges and their families that builds meaningful partnerships with families and youth and addresses their cultural and linguistic needs, in order to help them to function better at home, in school, in the community, and throughout life ([Toolkit for Expanding System of Care Approach](#)). In Connecticut, we refer to the Network of Care as an organized collaboration among across multiple child-serving systems, which expands beyond mental health to include early childhood, child welfare, primary care, education, juvenile justice, and substance abuse.

## PA 13-178-AN ACT CONCERNING THE MENTAL, EMOTIONAL AND BEHAVIORAL HEALTH OF YOUTH

-requires the Department of Children and Families (DCF) and the Office of Early Childhood (OEC), in consultation and collaboration with various individuals and agencies, to take several steps to address Connecticut children's mental, emotional, and behavioral health needs through development of a comprehensive statewide Children's Behavioral Health Plan. This law requires training for school resource officers, mental health care providers, pediatricians, and child care providers. It also requires the Birth-to-Three program to provide mental health services to children eligible for early intervention services under federal law. The new law also establishes a 14-member task force to study the effects of nutrition, genetics, complementary and alternative treatments, and psychotropic drugs on children's mental, emotional, and behavioral health (Department of Children and Families (DCF)).

**RACE**- a group of people identified as distinct from other groups because of supposed physical or genetic traits shared by the group ([Oxford Dictionary](#)).

**ETHNICITY**- is a term that describes shared culture—the practices, values, and beliefs of a group. This might include shared language, religion, and traditions, among other commonalities ([American Sociological Association](#)).

**CULTURE**- is defined as the integrated pattern of thoughts, communications, actions, customs, beliefs, values, and institutions associated, wholly or partially, with racial, ethnic, or linguistic groups, as well as with religious, spiritual, biological, geographical, or sociological characteristics. Culture is dynamic in nature, and individuals may identify with multiple cultures over the course of their lifetimes ([ThinkCulturalHealth](#)).

**HEALTH DISPARITY**- particular type of health difference that is closely linked with social, economic, and/or environmental



disadvantage. Health disparities adversely affect groups of people who have systematically experienced greater obstacles to health based on their racial or ethnic group; religion; socioeconomic status; gender; age; mental health; cognitive, sensory, or physical disability; sexual orientation or gender identity; geographic location; or other characteristics historically linked to discrimination or exclusion ([SAMHSA](#)).

**HEALTH EQUITY**-refers to how uniformly services, opportunities and access are distributed across groups and places, according to the population group. Equity in health implies that ideally everyone can attain full health potential, and that no one should be disadvantaged from achieving this potential because of social position or other socially determined circumstance. Efforts to promote equity in health are therefore aimed at creating opportunities and removing barriers to achieving the health potential of all people. It involves the fair distribution of resources needed for health, fair access to the opportunities available, and fairness in the support offered to people when ill ([Connecticut Department of Public Health](#)).

**HEALTH INEQUITY**-An unfair and avoidable difference in health status seen within and between communities ([Connecticut Department of Public Health](#)).

**SOCIAL DETERMINANTS OF HEALTH**-the conditions in which people are born, grow, live, work and age that can contribute to or detract from the health of individuals and communities ([CDC](#)).

**SEXUAL ORIENTATION**- an inherent or immutable enduring emotional, romantic or sexual attraction to other people ([Human Rights Campaign](#)).

**GENDER IDENTITY**- one's innermost concept of self as male, female, a blend of both or neither – how individuals perceive themselves and what they call themselves. One's gender identity can be the same or different from their sex assigned at birth ([Human Rights Campaign](#)).

**GENDER EXPRESSION**- external appearance of one's gender identity, usually expressed through behavior, clothing, haircut or voice, and which may or may not conform to socially defined behaviors and characteristics typically associated with being either masculine or feminine ([Human Rights Campaign](#)).

**CISGENDER**- the sex assigned at birth matches both how the child sees him or herself (gender identity) and how the world sees them (gender expression) (DCF PIE Dictionary).

**TRANSGENDER**- an umbrella term for people whose gender identity and/or expression is different from cultural expectations based on the sex they were assigned at birth. Being transgender does not imply any specific sexual orientation. Therefore, transgender people may identify as straight, gay, lesbian, bisexual, etc ([Human Rights Campaign](#)).



# 58 Appendix C

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

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

## Principal Standard:

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

## Governance, Leadership, and Workforce:

2. Advance and sustain organizational governance and leadership that promotes CLAS and health equity through policy, practices, and allocated resources.
3. Recruit, promote, and support a culturally and linguistically diverse governance, leadership, and workforce that are responsive to the population in the service area.
4. Educate and train governance, leadership, and workforce in culturally and linguistically appropriate policies and practices on an ongoing basis.

## Communication and Language Assistance:

5. Offer language assistance to individuals who have limited English proficiency and/or other communication needs, at no cost to them, to facilitate timely access to all health care and services.
6. Inform all individuals of the availability of language assistance services clearly and in their preferred language, verbally and in writing.
7. Ensure the competence of individuals providing language assistance, recognizing that the use of untrained individuals and/or minors as interpreters should be avoided.
8. Provide easy-to-understand print and multimedia materials and signage in the languages commonly used by the populations in the service area.

## Engagement, Continuous Improvement, and Accountability:

9. Establish culturally and linguistically appropriate goals, policies, and management accountability, and infuse them throughout the organization's planning and operations.
10. Conduct ongoing assessments of the organization's CLAS-related activities and integrate CLAS-related measures into measurement and continuous quality improvement activities.
11. Collect and maintain accurate and reliable demographic data to monitor and evaluate the impact of CLAS on health equity and outcomes and to inform service delivery.
12. Conduct regular assessments of community health assets and needs and use the results to plan and implement services that respond to the cultural and linguistic diversity of populations in the service area.
13. Partner with the community to design, implement, and evaluate policies, practices, and services to ensure cultural and linguistic appropriateness.
14. Create conflict and grievance resolution processes that are culturally and linguistically appropriate to identify, prevent, and resolve conflicts or complaints.
15. Communicate the organization's progress in implementing and sustaining CLAS to all stakeholders, constituents, and the general public.



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<https://www.thinkculturalhealth.hhs.gov/>  
[contact@thinkculturalhealth.hhs.gov](mailto:contact@thinkculturalhealth.hhs.gov)

# The Case for the National CLAS Standards

Health equity is the attainment of the highest level of health for all people.<sup>1</sup> Currently, individuals across the United States from various cultural backgrounds are unable to attain their highest level of health for several reasons, including the social determinants of health, or those conditions in which individuals are born, grow, live, work, and age,<sup>2</sup> such as socioeconomic status, education level, and the availability of health services.<sup>3</sup>

Though health inequities are directly related to the existence of historical and current discrimination and social injustice, one of the most modifiable factors is the lack of culturally and linguistically appropriate services, broadly defined as care and services that are respectful of and responsive to the cultural and linguistic needs of all individuals.

Health inequities result in disparities that directly affect the quality of life for all individuals. Health disparities adversely affect neighborhoods, communities, and the broader society, thus making the issue not only an individual concern but also a public health concern. In the United States, it has been estimated that the combined cost of health disparities and subsequent deaths due to inadequate and/or inequitable care is \$1.24 trillion.<sup>4</sup>

Culturally and linguistically appropriate services are increasingly recognized as effective in improving the quality of care and services.<sup>5-6</sup> By providing a structure to implement culturally and linguistically appropriate services, the National CLAS Standards will improve an organization's ability to address health care disparities.

The National CLAS Standards align with the HHS Action Plan to Reduce Racial and Ethnic Health Disparities<sup>7</sup> and the National Stakeholder Strategy for Achieving Health Equity,<sup>8</sup> which aim to promote health equity through providing clear plans and strategies to guide collaborative efforts that address racial and ethnic health disparities across the country.

Similar to these initiatives, the National CLAS Standards are intended to advance health equity, improve quality, and help eliminate health care disparities by providing a blueprint for individuals and health and health care organizations to implement culturally and linguistically appropriate services. Adoption of these Standards will help advance better health and health care in the United States.

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



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## Appendix D

# CONNECT *ing with CLAS*

Ensuring Culturally and Linguistically Appropriate Services

Location: To be determined

Time: To be Determined

## 1. **Commitment to CONNECT with CLAS!**

July 2017

- Sign Working Agreement
- Organize Workgroup that reflects all levels of the organization
- ✓ Individual agency technical assistance (email, calls)

## 2. **Large Group Meeting: Organizational CLAS Assessment**

August 2017

- Example - Equity, Diversity, & Inclusion Policy
- Orientation to the CLAS Standards
- Instructions on completing Baseline Organizational CLAS Standards Assessment
- Service Delivery Strengths, Vulnerabilities, Needs
- ✓ Bi-weekly large group conference call
- ✓ Individual agency technical assistance (email, calls)

## 3. **Large Group Meeting: Data Review**

October 2017

- Present Baseline Organizational CLAS Standards Assessment
- Selecting Priorities & Performance Measures
- Family & Other Stakeholder Focus Groups and Surveys
- ✓ Bi-weekly large group conference call
- ✓ Individual agency technical assistance (email, calls)

## 4. **Large Group Meeting: Selection of Two CLAS Priority Areas**

### **Health Equity Plan Development**

December 2017

- Present Family findings
- Instructions on developing the Health Equity Plan
- Practice Results Based Accountability exercise
- ✓ Bi-weekly large group conference call
- ✓ Individual agency technical assistance (email, calls)

## 5. **Large Group Meeting: Health Equity Plan Presentation Kick-Off**

February 2018

- Representation from all stakeholders, including clients and families
- Board of Directors participation required

## 6. **Post Connect with CLAS**

- Join Learning Community with Cohorts 1 & 2



# 63 Appendix E

## CONNECTing with the Enhanced Culturally and Linguistically Appropriate Standards in Health and Health Care (CLAS)



### Agenda

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Introductions and CONNECT Overview

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CONNECTing with CLAS Initiative and Important Concepts

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CONNECTing with CLAS Four Phase Change Process

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Enhanced National CLAS Standards

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Closing

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Questions and Answers

2



## Project Background

- ▶ CT Public Act 13-178
- ▶ CONNECT Systems of Care Grant funded by SAMHSA
- ▶ Priority Areas:
  - ▶ Family and Youth Involvement
  - ▶ CLAS standards and Racial Justice Activities
  - ▶ Workforce Development
  - ▶ Data Integration and Network of Care Analysis
  - ▶ Social Marketing and Communication
- ▶ Partnerships:
  - ▶ Child Health & Development Institute
  - ▶ Yale University
  - ▶ FAVOR, Statewide Family Organization
  - ▶ Beacon Health Options
  - ▶ Health & Equity
  - ▶ Consultants
- ▶ National Culturally & Linguistically Appropriate Services (CLAS) Standards

## CT Plan's Theory of Change

A children's behavioral health system based on the system of care core values and principles will result in improved health outcomes.

Four core values drive the development of a system:

- ▶ **Family-driven and youth guided**
- ▶ **Culturally and linguistically appropriate**
- ▶ **Community-based**
- ▶ **Trauma informed**

## ► CONNECTing Children and Families to Care Video

## 24 Participating Organizations

### Cohort I

- The Child and Family Guidance Center
- Children's Center of Hamden
- Family Centered Services of CT, Inc.
- Child and Family Agency of SE CT
- Catholic Charities Archdiocese of Hartford
- Wheeler Clinic
- Family and Children's Aid
- Wellmore Behavioral Health
- Community Mental Health Affiliates
- Klingberg Family Services
- Beacon Health Options
- FAVOR

### Cohort II

- Child Guidance Center of Mid-Fairfield County
- Child Guidance Center of Southern CT
- Domus Kids, Inc.
- Boys and Girls Village
- Justice Resource Institute
- United Community and Family Services
- Community Child Guidance Clinic, Inc.
- The Village for Families and Children
- Marrakech, Inc.
- Child Guidance Clinic for Central CT, Inc.
- Community Health Resources (CHR)
- Office of Early Childhood

## Cohort III

### Region 1 Southwest

- ▶ Southwest Regional Mental Health Board, Inc.
- ▶ Dr. Robert E Appleby School Based Health Centers/Briggs HD
- ▶ Town of Stratford Community Services
- ▶ Boys & Girls Club
- ▶ Child and Family Guidance Center of Bridgeport
- ▶ The Exchange Club Center for the Prevention of Child Abuse of Southern CT
- ▶ St., Vincent's Medical Center
- ▶ Life Bridge Community Services
- ▶ Family & Children's Agency
- ▶ Child First Greater Bridgeport, Bridgeport Hospital

### Region 2 South Central

- ▶ Alternative Therapy LLC
- ▶ South Central Rehabilitation Center, SCRC
- ▶ Clifford Beers Clinic
- ▶ My Father, My Son Counseling and Mentoring Center: Quinnipiac Valley Health District
- ▶ Lower Naugatuck Valley Parent Child Resource Center
- ▶ Youth Continuum Bridges of Milford
- ▶ New Haven Family Alliance

### Region 3 Eastern

- ▶ JRI, NE Behavioral Health Services
- ▶ Community Health Center, Inc.
- ▶ Natchaug Hospital
- ▶ Rushford
- ▶ Madonna Place
- ▶ United Services

### Region 4 North Central

- ▶ Institute of Living/Hartford Hospital
- ▶ Hartford Behavioral Health
- ▶ ECHN Medical Building
- ▶ Trinity Health NE, St. Francis

### Region 5 Western

- ▶ Waterbury Youth Services
- ▶ Community Mental Health Affiliates

### Region 6 Central

- ▶ LISA, Inc.
- ▶ New Opportunities, Inc.
- ▶ CT Coalition Against Organization Services

## CONNECTing with CLAS TEAM

### Child Health and Development Institute (CHDI)



Jeana Bracey, PhD  
Director of School and Community Initiatives  
CONNECT Project Director



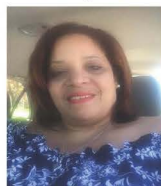
Cecilia Singh, PhD  
Assistant Clinical Professor Yale University School of Medicine  
CONNECT Consultant

### Beacon Health Options



Jillian Taylor, MSW  
CONNECT Network of Care Manager

### FAVOR, Inc.



Daisy Olivo  
CONNECT Family Engagement Coordinator

## CONNECTing with CLAS TEAM

### Crusto Consulting



Cindy Crusto, PhD  
CONNECT Technical  
Assistance Consultant

### Health & Equity, LLC



Michele Stewart-Copes, MS, MSW  
Co-Principal Health & Equity LLC

### Health & Equity, LLC



Marie Spivey, EDD,  
RN, MPA  
Consultant



Catherine Wagner, EdD  
Health & Equity, LLC, Managing  
Partner  
CT State Medical Society, Vice  
President of Education

## FAVOR, INC. TECHNICAL ASSISTANCE ON FAMILY ENGAGEMENT

*To Improve Services and Health Disparities by Building Connections with Families*

*We can help your organization in the following ways:*

- ▶ Conduct an assessment of your organization's family engagement needs by soliciting feedback.
- ▶ Help design and administer surveys to the families that you serve to get their feedback.
- ▶ Offer professional development opportunities to staff and families on family engagement, advocacy, cultural competency and related topics.
- ▶ Assist in developing advisory boards within your organization to provide ongoing input from the families you serve.
- ▶ Review existing policies and procedures from the family perspective.

**For more information, please contact:**

Daisy Olivo, CONNECT Family Engagement Coordinator

Email: [dolivo@favor-ct.org](mailto:dolivo@favor-ct.org)

Phone: 860.837.1436 Website:

[www.favor-ct.org](http://www.favor-ct.org)



## Connecticut Demographics

- ▶ 3.5 million residents about 800,000 children
  - ▶ 80,000 SED (10%)
  - ▶ 160,000 In need with a BH issues (20%)
  - ▶ 84% of CT residents are white,
  - ▶ 10.4% black,
  - ▶ 3.6% Asian,
  - ▶ 0.4% American Indian or Native Alaskan,
  - ▶ 0.1% Native Hawaiian/Pacific Islander, and 1.5% report two or more races
  - ▶ 8% of CT residents are Hispanic
  - ▶ 12.9% (452,358 persons) of CT residents were born outside of the US
- ▶ CT has the 11th highest percentage of foreign-born residents in the country and the largest proportion of residents born in Puerto Rico
- ▶ Among CT's 3 largest cities, over 75% identify as racial/ethnic minorities (40% Hispanic, 31% non-Hispanic black) and 45% speak a language other than English at home

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## CONNECTing with CLAS Vision and Goal

### Vision:

To develop, plan and implement a statewide process for incorporating enhanced Culturally and Linguistically Appropriate Services (CLAS) standards within the children's Network of Care of Connecticut.

### Goal:

To partner with families and network of care leaders in order to promote health equity, racial justice and cultural and linguistic competence across all behavioral health services at the local, regional and state levels.

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## Why CLAS?

### **Hiring/Promotion Practices:**

- ▶ Regular assessments of hiring and retention data to reflect cultural and language needs of the catchment area.
- ▶ Strategic plan to recruit, retain and promote at all levels of the organization.

### **Culturally and Linguistically Responsive Care:**

- ▶ Utilization of multi-lingual and multi-cultural support staff to assist clinicians and managers with culturally competent treatment/service plans and programmatic strategies.

### **Training:**

- ▶ Mandate training requirements related to the national CLAS standards for staff.

### **Policies/Procedures:**

- ▶ Standardized procedures for communication of workplace policies that influence daily operations.

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## Lessons Learned: Cohort I and II

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Normalized difficult conversations

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Intentional focus on cultural and linguistic competence

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Families as partners

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Outside technical assistance

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Learning Collaborative Approach

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## Key Concepts and Terminology

Health  
Equity

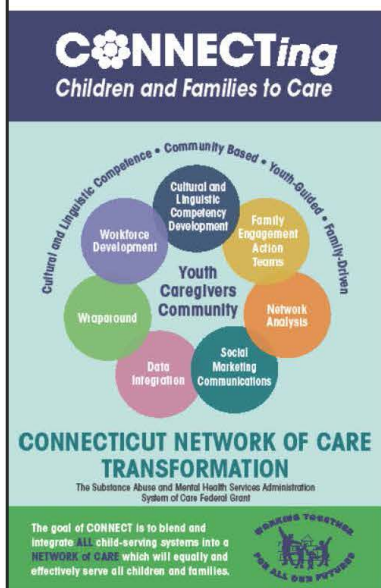
Health  
Disparity

Health  
Equity Plan

Cultural and  
Linguistic  
Competence

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## Welcome Packet



- ▶ Introduction letter
- ▶ Cohort III Process/Activities
- ▶ Working Agreement

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## CONNECTing with CLAS Four Phase Change Process

- ▶ To develop health equity plans and to eliminate health disparities
- ▶ 4 Phases:
  - ❖ Phase 1: Initiation and Engagement
  - ❖ Phase 2: Assessment
  - ❖ Phase 3: Implementation
  - ❖ Phase 4: Sustainability

## CONNECTing with CLAS Four Phase Change Model





## CONNECTing with CLAS Supports and Timeline

### SUPPORTS

- ▶ Convene at least 4 regional meetings to assist in the change process
- ▶ Convene bi-weekly (2 times per month) technical assistance conference calls
- ▶ Provide individual agency technical assistance (emails, calls as needed)
  - ▶ Family engagement technical assistance
- ▶ Conduct at least one site visit per agency

### TIMELINE

- ▶ Initiation and Engagement to *CONNECTing with CLAS!* (Oct 2017)
- ▶ Large Group Meeting: Organizational CLAS Assessment (Oct/Nov 2017)
- ▶ Large Group Meeting: Data Review (Dec/Jan 2017)
- ▶ Large Group Meeting: Selection of Two CLAS Priority Areas/ Health Equity Plan Development (Feb/Mar 2018)
- ▶ Large Group Meeting: Health Equity Plan Presentation Kick-Off (Apr/May 2018)
- ▶ Post *CONNECTing with CLAS* (Apr/May 2018)

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## Benefits of CLAS

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Completed Health Equity Plan, specific to your organization.

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Healthier and more satisfied consumers.

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Increased communications between providers and consumers.

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Improved consumer understanding and consent

---

Higher competency and satisfaction levels of staff

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## National Standards for Culturally and Linguistically Appropriate Services (CLAS)

- Purpose
  - To provide a blueprint for individuals and health and health care organizations to implement **culturally and linguistically appropriate services** that will advance **health equity**, improve **quality**, and help eliminate **health care disparities**.
- First published by the HHS Office of Minority Health in 2000
- Modification and enhancement process from 2010 to 2013, released 2013
- Why the need for enhancement?

## History of CLAS/Enhanced CLAS

- ▶ New England Minority Health Coalition
- ▶ National Partners in Action (NPA)
- ▶ National Culturally and Linguistically Appropriate Services of Health Standards
- ▶ National Stakeholder Strategy
- ▶ New England Regional Health Equity Council
- ▶ ENHANCED National Standards for Culturally and Linguistically Appropriate Services in Health and Healthcare Services and Blueprint

## National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care (2012)

Principal Standard

Governance, Leadership and Workforce  
(Standards 2-4)

Communication and Language Assistance  
(Standards 5-8)

Engagement, Continuous Improvement and  
Accountability (Standards 9-15)

Closing Remarks  
Questions & Answers  
Panel

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## **Appendix F**

This document is designed to help you with creating an inclusion statement for your organization. While the specific content area, type of organization, or population served may not mirror your organization's focus this document is a helpful guide.



## Creating an Inclusion Statement

The goal for each program, chapter or league should be to become an organization where diversity and inclusion are a fundamental part of the values and culture of the program. Bringing together varied life experiences and perspectives adds significant value to your community and reinforces the concept of inclusivity. Nearly all successful organizations have an inclusion statement or philosophy that establishes the platform for their values and identity. This guide will help you develop your inclusion statement, as it provides general information and steps to writing an impactful statement that is both impactful and practical. If you already have an inclusion statement, you can use this guide to review and revise it, if necessary.

### Creating and inclusion statement allows you to:

- Create a public mechanism to share best practices throughout your league or program
- Ensure parents and staff are aware of the inclusion statement and the goals of the organization
- Send a welcoming message to families of all backgrounds
- Create an accountability standard for all coaches and league participants
- Make parents aware of inclusion as an important public policy in your community
- Create a forum for better understanding and appreciation of individual differences

### What you should include in your mission statement?

Inclusion statements can and should serve a real purpose. There are three key elements found in effective statements: Value, plausibility, and accountability. In a couple of short sentences, you should publically share your league's promise and commitment to inclusion and the commitment to live up to those promises. It is important that your inclusion statement be short and as specific and relevant as possible so that everyone can quickly commit it to memory and repeat it to others.

A clear inclusion statement is a great way for coaches and volunteers to measure the quality of their work as leaders and hold themselves accountable. "Is what I'm doing inclusive of every participant and every family despite race, orientation, ability or talent level?" If yes-- keep going, but if not—it might be time to change course. This is a very simple decision to make when you are engaged and on board with a resourceful inclusion statement.

Here is the US Lacrosse Inclusion Statement, plus some additional examples of statements that drive recognized national organizations:

» "US Lacrosse seeks to foster a national lacrosse community that encourages understanding, appreciation and acceptance of all within its membership, volunteer base, and staff. Further, US Lacrosse believes that broad representation and participation add significant value to the lacrosse experience of each of us, and that these valued experiences are enhanced by embracing underrepresented and underserved communities."- Official US Lacrosse Inclusion Statement

» "We respect, value and celebrate the unique attributes, characteristics and perspectives that make each person who they are. We also believe that bringing diverse individuals together allows us to collectively and more effectively address the issues that face our communities. It is our aim, therefore, that our partners, strategies and investments reflect

these core values.” – The United Way Inclusion Statement

» “PGA REACH seeks to create a culture of inclusiveness by communicating and demonstrating that golf is an affordable and accessible game for all abilities, ages, and backgrounds.” –Professional Golfers Association Reach Program Inclusion Statement

» As a core value, the NCAA believes in and is committed to diversity, inclusion and gender equity among its student-athletes, coaches and administrators. We seek to establish and maintain an inclusive culture that fosters equitable participation for student-athletes and career opportunities for coaches and administrators from diverse backgrounds. Diversity and inclusion improve the learning environment for all student-athletes and enhance excellence within the Association. -*NCAA Inclusion Statement*

## **Other Tips:**

### **Keep It Short and Sweet**

Remember, this is a statement, not an essay. Try to sum up your statement in two or three sentences. A concise inclusion statement is more memorable and effective, so less is more.

### **Test It**

Distribute the inclusion statement to your program leaders prior to the season and ask them for their feedback. Create and stick to a timeline to measure your effectiveness and create policies and procedures to enforce your strategies. You must follow up your inclusion statement with action, not just words. By doing this your coaches and volunteers will be more invested in it because they helped form and uphold your league’s policy.

### **Revisit It Often**

All too often an inclusion statement is written and then forgotten about. Your statement ought to be an important representation of your league’s culture. Continuously placing focus on inclusion is not always an easy process. It will take time and effort, but it’s a significant component of any successful organization and should be woven into the fabric of the daily operations of your league. Your league should create and fully embrace an inclusive philosophy for your organization. Make sure to publicize your inclusion statement and communicate your philosophy to all staff, parents and players.



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## Appendix G

## CONNECTing with CLAS Cohort 3: X Agency Health Equity Implementation Plan

**Mission Statement:** To enhance the quality of life of Xtown's diverse community by providing clinical and social services, linking residents to resources, and planning and coordinating partnerships and initiatives.

**Core Services:** Youth and family counseling, juvenile review board, after school and summer programs, substance abuse prevention, and advocacy. Xprogram and Xprogram.

### CLAS Standard 3: Recruit, promote and support a culturally and linguistically diverse governance, leadership and workforce that are responsive to the population in the service area

Strategy	Major Tasks	Performance Measure	Impact or Result	Accountability	Timeline
3.1 Develop recruitment procedures to attract diverse interns and applicants (race, ethnicity, sexual orientation, gender identification, religious affiliation, abilities, etc.) who mirror the Xtown's community	Identify specific demographic profile of the Xtown community including race, income, languages spoken, educational status, etc.	List of demographics and predominant languages spoken by Xtown and residents developed and updated every July	A more diverse workforce that is more aware of the needs of the population served	Community Services Administrator	July--September 2018 Update every January
	Revise job postings and descriptions to include commitment to diversity, equity and inclusion	Revised job postings and descriptions that note more inclusive language & post positions more globally with Spanish--linked advertisers	A positive, inclusive image of Community Services that attracts diverse applicants	Community Services Administrator Human Resources Director	September-December 2018
	Develop community--based activities, such as a focus group to inform department of parent--family needs	Quarterly schedule of community--based activities	Targeted recruitment of under--represented populations	Community Services Clinical Coordinator	July--September 2018
	Develop financial incentives for grant and at--will employees who are bilingual	Revised Grant and At--Will Personnel Policies	Staff who more accurately reflect the diversity of the Stratford community	Community Services Admin. Health Director Human Resources Director	October-December 2018-
3.2 Develop more comprehensive hiring procedures to select candidates and interns who are culturally responsive and express knowledge and skills related to working with diverse populations	Select interview panel committed to equity, inclusion and diversity (EID)	Signature of panel members acknowledging their commitment to EID	An interview process that integrates diversity as part of determinants of fit with department	Community Services Administrator Health Director	July--October 2018
	Educate hiring panel about implicit bias and how to assess a candidate in terms of EID	Signature of panel members acknowledging completion of training	An interview panel who understand implicit bias and have ability to assess candidates in terms of EID	Human Resources Director	October--December 2018
	Revise interview questions to include those that are diversity--related and specific scenario--based	Revised Interview Question --Rating Form to focus on working with diverse populations	Staff who culturally responsive and aware of department's openness to discuss diversity issues	Community Services Administrator Human Resources Director	August--October 2018



**CLAS Standard 3: Recruit, promote and support a culturally and linguistically diverse governance, leadership and workforce that are responsive to the population in the service area**

Strategy	Major Tasks	Performance Measure	Impact or Result	Accountability	Timeline
3.3 Provide opportunities for professional development and growth	Revise organizational chart to include more levels based on experience and merit (i.e. Counselor 1, Counselor 2, Assistant Clinical Coordinator).	Organizational Chart	A more diverse workforce that is more aware of the needs of the population served	Community Services Admin. Clinical Coordinator Health Director Human Resources Director	January-- March 2019
	Integrate EID into supervision and during staff meetings	Supervision Notes Staff Meeting Agenda	Increased diversity through-out department - clerical, direct, service, management	Health Director Community Services Administrator Clinical Coordinator	Weekly and Quarterly beginning in July 2018
	Support individual professional development goals that include EID and department priorities	Professional Development Goals in employee files	Increased advancement opportunities	Community Services Administrator Clinical Coordinator	Annually in July beginning in July 2018
4.1 Conduct ongoing training for all staff and interns in culturally and linguistically appropriate service delivery	Convene a team of diverse residents and staff members to develop training plan	List of Team Members Team Meeting Schedule Team Meeting Agenda	Intentional staff development	Community Services Administrator Clinical Coordinator	January 2019
	Assess training needs	Prioritized training topics	Relevant training	Training team	October-- December 2018
	Conduct quarterly training	Attendance List Training Curriculum Training Evaluation	Staff trained in providing culturally and linguistically appropriate services	Training team	Quarterly beginning in January 2019

## Governance, Leadership, and Workforce:

#2--- Advance and sustain organizational governance and leadership that promotes CLAS and health equity through policy, practices, and allocated resources.

Strategy	Major Tasks	Performance Measure	Impact or Result	Accountability	Timeline
<i>Identify staff and Grant Resources.</i>	-- Socialize policy developed on cultural humility by having staff complete on-line training	-100% completion rate on cultural humility on-line training	-Shared language and understanding across staff. -Greater sensitivity to the culture of the populations we	--Office of Talent Management (OTM)	-Ongoing
	-- Identify additional training resources/ opportunities with NCCJ	-Care group staff will attend a training once a year	-Xagency will have a core group of staff trained and able to disseminate information throughout the organization	-CARE advisory committee	-Ongoing
	-- Implement and train the trainer approach	-The care workgroup will identify a core training team	-The core training team will be responsible for on-going staff development training	-Members of core training team- Reports to CEO	-Initiate next fiscal year
	-- Seeking funding to support implementation and sustainability of culturally appropriate events for families and youth	-- Grants development and agency leadership will identify at least three grant opportunities a year	-- Xagency will have allocated resources to support cultural and linguistic events	-- Grant development department  -- Agency leadership	- On-going

### Communication and Language Assistance:

#5 --- Offer language assistance to individuals who have limited English proficiency and/or other communication needs, at no cost to them, to facilitate timely access to all health care and services.

Strategy	Major Tasks	Performance Measure	Impact or Result	Accountability	Timeline
<i>Ensure that Xagency has language assistance available for all programs.</i>	-- Identify vendor for language support not spoken in-house	-- Vendor secured	-- Language support available	-- Clinical leadership	-- Achieved
	-- Identify in-house language capacity and qualify current in-house bilingual staff to determine language proficiency	-- Report generated on language capacity in-house	-- Language assistance available in-house	-- Clinical leadership	-- Spring 2018
	-- Based on language proficiency, qualified staff will participate in interpreting training	-- Qualified bilingual staff are trained	-- Staff providing interpretation will be trained and certified	-- Clinical leadership	-- Fall 2018
	-- Staff will be trained on the utilization of interpreters	-- Staff trainings completed	- Staff will be trained	-- OTM	-- Ongoing
	-- Develop procedures on how to access qualified bilingual in-house resources	-- Procedure will be completed	-- Xagency will have a systematic approach to accessing services for non-English speaking families	-- OTM	-- Summer 2018
	- Ensure parent forms are fully accessible in secondary language use in Xagency	- Forms will be available	- Families will have equal access to all forms	- Staff name	- Ongoing

## Engagement, Continuous Improvement, and Accountability:

#11 --- Collect and maintain accurate and reliable demographic data to monitor and evaluate the impact of CLAS on health equity and outcomes and to inform services delivery.

Strategy	Major Tasks	Performance Measure	Impact or Result	Accountability	Timeline
<i>Xagency reports will utilize health equity data to inform service delivery</i>	-The research and evaluation department (RED) will identify and track health equity data points	-Data points will be identified and tracked	-Service delivery modifications as needed	-RED and Xagency clinical practice committee	Summer 2018
	-RED will present outcomes by race to Xagency's clinical practice committee	-RED will present data findings to committee	-Service delivery modifications as needed	-RED and Xagency clinical practice committee	-Fall 2018
	- Xagency's practice committee will utilize data to inform/modify service delivery to populations served	- Clinical practice committee will implement changes in service delivery	- Service delivery modifications as needed	- Agency leadership	- Fall 2018 and ongoing

## Sample 3

## PRIORITY AREA: Community Engagement

CLAS STANDARD OBJECTIVES: STANDARD #13. Partner with the community to design, implement, and evaluate policies, practices, and services to ensure cultural and linguistic appropriateness.

### Identified Challenges:

- There is a need to develop relationships and trust in some communities.
- Mostly women
- Need more Spanish speaking staff and staff who speak other languages
- Lack LGBTQ representation and collaborations
- HR staff consists of one person
- Difficulty in recruiting non-English speakers
- Staff who are caregivers of children with behavioral health issues often cannot work fulltime or have outside issues that affect productivity

Strategies and Major Activities	Measureable Indicators	Accountability	Timeline
<i>The following are some implementation strategies for partnering with the community:</i>	<p>The emphasis is on concrete outcomes rather than on the completion of activities requires that program implementers monitor key outcome variables and make midstream corrections as necessary.</p> <p>By including specific indicators of outcomes and impacts and identifying baselines and targets, the plan will help answer the question: How will we know that the intervention has succeeded?</p>	Identify the position (not the person) and department responsible for the overall accountability of meeting the activities of the CLAS Standard on the Health Equity Work Plan: Position, Department. Reports To	When do you anticipate the completion?
<ul style="list-style-type: none"> <li>• Partner with community organizations that work specifically with limited English speaking people and LGBTQ to reach more people, to share information and learn, and to improve services.</li> <li>• Work with partners to advertise job openings, identify interpreting resources, and organize health promotion activities.</li> <li>• Develop a “Promotores de salud/community health workers Initiative. (“Promotores” are volunteer community members and paid front-line public health workers who are trusted members of the community served or have an unusually close understanding of that community. They generally share the ethnicity, language, socio-economic status, and life experiences of the community members. These social attributes and trusting relationships enable community health workers to serve as liaisons, links, or intermediaries between health and social services and the community to facilitate access to and enrollments in services and improve the quality and cultural competency of services (HHS OMH, 2011).</li> </ul>	<ul style="list-style-type: none"> <li>• A minimum of 2 new partnerships are developed in each of the largest towns (Bridgeport, Hartford, New Haven, etc.)</li> <li>• Job openings and volunteer openings are advertised through at least 6 new partner networks.</li> <li>• Bilingual capacity and LGBTQ staff and volunteers double as a result of new partnerships</li> <li>• Customer satisfaction surveys show a 25% improvement in customer satisfaction surveys with quality of services, cultural understanding and trust in agency</li> </ul>	<ul style="list-style-type: none"> <li>• Executive Director</li> <li>• HR Director</li> <li>• HR Director</li> <li>• Program Director</li> </ul>	<p>7/2016--- 1/2016</p> <p>9/2016--- 6/2017</p> <p>9/2016--- 6/2017</p> <p>9/2016--- 6/2017</p>



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# Appendix H

**Instructions:** Please complete one assessment per organization. Each organization can determine a specific process for completing the survey but the CLAS team should come together to complete one survey.

Please complete the organizational assessment for the Regional TA call on December 6, 2017.

Organization Name: \_\_\_\_\_

Date Assessment Completed (MM/DD/YYYY): \_\_\_\_/\_\_\_\_/\_\_\_\_

Number of people participating in organizational assessment process: \_\_\_\_\_

### **ORGANIZATIONAL CLAS STANDARDS ASSESSMENT**

The first time you take this assessment it will serve as the organization's baseline. It will help you to make decisions and set priorities while developing your Health Equity Plan. For an accurate assessment, please complete the survey with critical reflection and encourage your colleagues and staff members to do so as well. If you are not sure how to answer a question, select not met.

The last five questions are optional and asked for the purpose to see if there are differences in perceptions by demographic characteristics.

This tool was adapted from the Culturally Competent Annual Self-Evaluation. County of San Diego- Behavioral Health Services. For more information contact the Quality Improvement, Performance Improvement Team at [BHSQIPOG@sdcounty.ca.gov](mailto:BHSQIPOG@sdcounty.ca.gov).

\*1. Name of the organization

\*2. Name of department or program

\*3. Type of position you hold

- ☐ Administrative
- ☐ Clinical
- ☐ Support services (outreach, case management) Management
- ☐ Other (please specify)

4. Does the department or program you work with receive funding from the Department of Children and Families (DCF)?

- ☐ Yes
- ☐ No
- ☐ Not Sure

\*5. The organization has a Health Equity Plan (i.e. cultural competency plan, etc)

- ☐ Not Met
- ☐ Partially Met
- ☐ Met

\*6. Employees at all levels of the organization reflect the diversity within the community.

- ☐ Not Met
- ☐ Partially Met
- ☐ Met

\*7. A process is in place for ensuring language competence of employees who identify themselves as bi- or multilingual and provide interpretation and/or translations services on behalf of the organization.

- ☐ Not Met
- ☐ Partially Met
- ☐ Met

\*8. The program has a process in place to access (internally and externally) spoken and sign language interpretation (spoken and sign) and translations (written) services

- ☐ Not Met
- ☐ Partially Met
- ☐ Met

\*9. The program supports/provides employees training on how to work with sign and spoken language interpreters.

- ☐ Not Met
- ☐ Partially Met
- ☐ Met

\* 10. The program has a process in place for assessing the cultural competencies of employees and a mechanism to support and monitor continuous professional development.

- ☐ Not Met
- ☐ Partially Met
- ☐ Met

\* 11. The program has conducted a survey among its clients to determine if the program and its employees are perceived as being inclusive of diverse populations.

- ☐ Not Met
- ☐ Partially Met
- ☐ Met

\*12. The program has a process to ensure informational and educational materials are culturally appealing and easy to understand by the populations served.

- ☐ Not Met
- ☐ Partially Met
- ☐ Met



\* 13. Program services are designed and evaluated with direct input from client populations and representatives in their support systems

- ☐ Not Met  
☐ Partially Met  
☐ Met

\*14. The organization has implemented the use of evidence-based practices or best practice guidelines appropriate for the populations served (and you can identify the source of the guidelines).

- ☐ Not Met  
☐ Partially Met  
☐ Met

\*15. The organization collects client outcome data and monitors outcomes by demographics characteristics to ensure equitable access to, and delivery of services (e.g. completion rates by race, met treatment plan goals by sex).

- ☐ Not Met  
☐ Partially Met  
☐ Met

\*16. Organizational programs conduct outreach efforts appropriate for the populations in the service area and engages diverse populations for meaningful participation in services offered (e.g. advisory board, peer support program).

- ☐ Not Met  
☐ Partially Met  
☐ Met

\*17. The organization is responsive (removes barriers) to the variety of social, educational, economic, and other stressors that populations may experience as barriers to achieving desired program outcomes.

- ☐ Not Met  
☐ Partially Met  
☐ Met

\*18. The organization reflects its commitment to cultural and linguistic competence in all policy and practice documents including its mission statement, strategic plan, and budgeting practices.

- ☐ Not Met  
☐ Partially Met  
☐ Met

19. The organization communicates its progress in implementing and sustaining cultural and linguistic competencies to all stakeholders, constituents, and the general public.

- ☐ Not Met  
☐ Partially Met  
☐ Met

20. RACE (optional)  
American Indian or Alaska Native  
African Origin or Black  
European Origin or White  
Asian or Asian American
21. ETHNICITY (optional)  
Yes, Hispanic, Latino/a, or of Spanish origin  
No, not Hispanic, Latino/a, or of Spanish origin
22. SEX (optional)  
Male   Female
23. Do you identify with the LBGT community? (optional)  
Yes   No

Do you have any special needs? (optional)



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# Appendix I

## Family FOCUS GROUP

Introduction: (Engagement – getting to know the participants)

**What is your connection to the school?**

Student / age / how long

**What is the Best thing about using this service/organization?**

Why did you choose this service?

Have you used any other similar services?

**Facilitators:**

**What is working-well?**

**Barriers:**

**What could be improved?**

**Recommendations:**

**What suggestions/recommendations would you suggest?**

**Probes for each area:**

1. **Operations:** (e.g. meeting times / appointment notices, telephone messages, greetings, giving instructions, etc.)
  - a. **Is the agency respectful and understandable (e.g. appointment notices, telephone messages, greetings, giving instructions, etc.)?**
2. **Cultural traditions** (e.g. faith) and values talked about in discussion groups, therapy sessions, and during other types of services
  - a. **Are cultural traditions (e.g. faith) and values talked about in discussion groups, therapy sessions, and during other types of services?**
  - b. **What recommendations do you have for the agency to show their respect for culture and for who you are as a person?**

3. **Family Partnerships / Accountability:** (where/how are families integrated into the decision-making structure – program planning/implementation/evaluation - satisfaction survey, feedback, family suggestions))

- a. **When and how do staff ask input from families?**

- b. **What kinds of experiences have you had building trust with staff?**

**How often, if ever, have you taken a satisfaction survey for your opinion on how to make services better?**

## **STAFF FOCUS GROUP PROTOCOL**

### **Introduction:**

What is your role?

What is the Best thing about working here?

### **Facilitators:**

What are the success (working-well) you have experienced engaging families in decision-making for their child/organization?

### **Barriers:**

What gets in the way of engaging families in decision-making for their child/organization?

### **Recommendations:**

What suggestions/recommendations would you make to improve family engagement in decision-making for their child/organization?

### **Probes for each area:**

4. Operations: (e.g. meeting times / appointment notices, telephone messages, greetings, giving instructions, etc.)
5. Cultural traditions (e.g. faith) and values talked about in discussion groups, therapy sessions, and during other types of services
6. Family Partnerships (where/how are families integrated into the decision-making structure – program planning/implementation/evaluation – accountability - satisfaction survey, feedback, family suggestions)



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## Appendix J

CONNECTing Children and Families to Care					
DIVERSITY/EQUITY/INCLUSION PLAN					
AGENCY:					
CLAS STANDARD:					
SELECTED GOAL	MEASURABLE OBJECTIVES	PERFORMANCE MEASURE	IMPACT OR RESULT	RESPONSIBLE DEPARTMENT/ COMMITTEE/PERSON(S)	PLANNED DATE OF COMPLETION

# Acknowledgements

CONNECTing Children and Families to Care is a statewide initiative to create partnerships among families, state agencies, and service providers at the local, regional and state levels to develop a single-point-of-access or “No Wrong Door” approach to the delivery of children’s services within Connecticut.

We would like to acknowledge the collaboration and contributions of the partnering organizations working on the CONNECTing initiative, as well as, the extraordinary number of local and regional providers and families working on behalf of children with special health and behavioral health care needs.

Our partnering organizations, alphabetically listed, include:



The mission of AFCAMP is to educate, empower and engage parents and community to improve quality of life for children with special needs and others at risk of education inequity or system involvement.



Beacon Health Options serves as the Administrative Service Organization for Medicaid and HUSKY in Connecticut with a mission to help people live their lives to the fullest potential.



The Child Health and Development Institute is a catalyst for improving the health, mental health and early care systems for children in Connecticut with a mission to ensure healthy outcomes for all children in Connecticut by advancing effective policies, stronger systems, and innovative practices.



The mission of the Injury Prevention Center (IPC) at Connecticut Children's is to reduce unintentional injury and violence among Connecticut residents. The IPC translates research into injury prevention programs and policy. Connecticut Children's Medical Center is dedicated to improving the physical and emotional health of children through fami-





Working together with families and communities to improve child safety, ensure that more children have permanent families, and advance the overall well-being of children is the central focus of the Department of Children and Families (DCF).



FAVOR INC. is a non-profit statewide, multicultural family-led organization that serves families who have children and youth with mental and behavioral health challenges by providing training, technical assistance, and direct family peer support services.



The State of Connecticut General Assembly Public Acts 13-178 and 15-27 and the PA 13-178 Children's Behavioral Health Plan Implementation Advisory Board for their planning and implementation role in the behavioral health plan for children.



The Consultation Center at Yale is a university-based organization that offers a range of services, training and research to individuals, organizations, businesses and governmental agencies throughout Connecticut, the U.S. and internationally. The Center's mission is to promote health and wellness, prevent mental health and substance abuse problems, and enhance equity and social justice.

Additionally, we would like to thank the Substance Abuse and Mental Health Services Administration (SAMHSA) under the U.S. Department of Health and Human Services for grant funding, technical assistance and project oversight.

