The COA360: A Tool for Assessing the Cultural Competency of Healthcare Organizations

Thomas A. LaVeist, PhD, William C. and Nancy F. Richardson Professor in Health Policy, Hopkins Center for Health Disparities Solutions, Johns Hopkins Bloomberg School of Public Health, Baltimore, Maryland; Rachel Relosa, administrative director, Hopkins Center for Health Disparities Solutions, Johns Hopkins Bloomberg School of Public Health; and Nadia Sawaya, codirector, Cultural Competency Program, Johns Hopkins Medicine International, Baltimore, Maryland

EXECUTIVE SUMMARY

The U.S. Census Bureau projects that by 2050, non-Hispanic whites will be in the numerical minority. This rapid diversification requires healthcare organizations to pay closer attention to cross-cultural issues if they are to meet the healthcare needs of the nation and continue to maintain a high standard of care. Although scorecards and benchmarking are widely used to gauge healthcare organizations' performance in various areas, these tools have been underused in relation to cultural preparedness or initiatives. The likely reason for this is the lack of a validated tool specifically designed to examine cultural competency. Existing validated cultural competency instruments evaluate individuals, not organizations.

In this article, we discuss a study to validate the Cultural Competency Organizational Assessment—360 or the COA360, an instrument designed to appraise a healthcare organization's cultural competence. The Office of Minority Health and the Joint Commission have each developed standards for measuring the cultural competency of organizations. The COA360 is designed to assess adherence to both of these sets of standards. For this validation study, we enlisted a panel of national experts. The panel rated each dimension of the COA360, and the combination of items for each of the scale's 14 dimensions was rated above 4.13 (on 5-point scale). Our conclusion points to the validity of the COA360. As such, it is a valuable tool not only for assessing a healthcare organization's cultural readiness but also for benchmarking its progress in addressing cultural and diversity issues.

For more information on the concepts in this article, please contact Dr. LaVeist at tlaveist@jhsph.edu.

In 1950, U.S.-born whites made up about 90 percent of the U.S. population. By 2000, this number declined to about 75 percent, and by 2050 non-Hispanic whites will be in the numerical minority (U.S. Census Bureau 2001, 2002). The United States will one day be "minority-majority," a term for a place wherein the ethnic population outnumbers the racial majority (usually, non-Hispanic whites). Currently, four states—California, Texas, New Mexico, and Hawaii—are minority-majorities, and by 2010, the number of states with this distinction could be as many as eight.

Considerable attention has been devoted to the healthcare management challenges related to the dramatic increases in the number of underserved people (Lewis 2007; Anderson et al. 2003; Hayes-Bautista 2003). These challenges, many of which stem from language barriers and different culturally related patterns of illness behavior, are exacerbated by the complexity of the U.S. healthcare system. The consequences can include lower quality care and poorer patient outcomes. Additionally, a healthcare organization's poor management of its culturally diverse patient population may result in negative financial implications (Dreachslin and Myers 2007) and exposure to clinical and litigation risks (Remus 2004). Cultural competency training has been touted as a strategy to remediate these looming concerns (Anderson et al. 2003; Betancourt et al. 2005; Hayes-Bautista 2003; Kairys et al. 2002; Siegel, Haugland, and Chambers 2003; Siegel et al. 2000; Brach and Fraser 2000, 2002; Reynolds 2004; Zambrana et al. 2004; Weech-Maldonado et al. 2002). According to the Task Force on Community Preventive Services, cultural competency is "a set of congruent behaviors, attitudes, and policies that come together in a system, agency or among professionals and enable effective work in cross-cultural situations" (Anderson et al. 2003).

In response to patient diversification, various efforts have been underway to improve the cultural competency of those involved in healthcare delivery. Professional associations, such as the American College of Healthcare Executives, the American Medical Association, and the Association of American Medical Colleges, have created standards or formed initiatives to inform, train, and guide physicians, other caregivers, and managers when dealing with cultural diversity issues. Some states—New Jersey, Washington, and California—have passed laws that require cultural competency training for healthcare professionals, and similar legislation is under consideration in other states. In their systematic review of the limited empirical research on cultural competency training programs, Beach and colleagues (2005) found that such programs can effectively improve the ability of individuals to work cross-culturally within the healthcare setting. However, some have argued that while training individuals (and assessing their progress) in the principles of cross-cultural communication and interaction is beneficial, it may be more efficient and effective to foster a organization-wide culture that is accepting of, supportive of, and prepared to adjust to the changing demands of the

increasingly diverse patient population (Anderson et al. 2003; Betancourt et al. 2005; Hayes-Bautista 2003).

The Joint Commission (2007) conducted a study of 60 healthcare organizations throughout the United States to determine best practices for addressing issues related to patient diversity (Wilson-Stronks and Galvez 2007). The Joint Commission's study focused on six principal areas: (1) leadership, (2) quality improvement and data use, (3) workforce implications, (4) patient safety and provision of care, (5) language services, and (6) community engagement. These areas are closely aligned with the 14 CLAS (Culturally and Linguistically Appropriate Services) Standards established by the Office of Minority Health (2001). The CLAS Standards (see Table 1) were put together using a combination of Title IV requirements (Standards 4 through 7) and the recommendations of a national expert panel. In addition, the Joint Commission developed cultural competency standards. An extensive guide for linking the CLAS Standards to relevant Joint Commission accreditation standards can be found on the Joint Commission website at www.jointcommission.org.

Conceptually, improving the cultural competency of a healthcare organization increases the likelihood that the staff can relate to the diverse patient population; lessens miscommunication between patients and providers; and heightens provider and staff sensitivity to the values, beliefs, and health-related practices of patients. All of these, in turn, lead to greater acceptance among patients of the organization's health education message, to improved accuracy of diagnoses and interventions, and to better patient adherence to prescribed treatment regimens. The ultimate results are higher patient satisfaction scores, more positive health outcomes, and the narrowing of health disparities (i.e., gaps in patient outcomes, quality, and literacy, among others).

The business case for being culturally competent has been documented in numerous publications and summarized in an article by Dreachslin and Myers (2007). However, efforts to expand the infusion of cultural competence into healthcare organizations may be hampered by the fact that the concept has limited empirical support (Hayes-Bautista 2003). The root of this barrier has been the lack of validated tools to assess competency at the organizational level. Most instruments of this kind are designed for individuals, not organizations, and generally have not been subjected to validation. Lack of validated tools, then, impedes rigorous research and hampers the adoption of cultural competency interventions in healthcare settings. In this article, we discuss a validation study of the Cultural Competency Organizational Assessment—360 or the COA360, a measurement instrument intended for evaluating the cultural competence of a healthcare organization, not an individual.

METHODS

The COA360 is designed for use in hospital subunits, such as clinical departments and inpatient and outpatient services. It is adaptable to the unique configuration of patient diversity

TABLE 1
Culturally and Linguistically Appropriate Services (CLAS) Standards

CLAS Standard	# of COA360 Items Measuring Standard
Standard 1: Promote and support the attitudes, behaviors, knowledge, and skills necessary for staff to work respectfully and effectively with patients and each other in a culturally diverse work environment.	9
Standard 2: Have a comprehensive management strategy to address culturally and linguistically appropriate services, including strategic goals, plans, policies, procedures, and designated staff responsible for implementation.	6
Standard 3: Utilize formal mechanisms for community and consumer involvement in the design and execution of service delivery, including planning, policy making, operations, evaluation, training, and, as appropriate, treatment planning.	7
Standard 4: Develop and implement a strategy to recruit, retain, and promote qualified, diverse, and culturally competent administrative, clinical, and support staff who are trained and qualified to address the needs of the racial and ethnic communities being served.	9
Standard 5: Require and arrange for ongoing education and training for administrative, clinical, and support staff in culturally and linguistically competent service delivery.	3
Standard 6: Provide all clients with Limited English Proficiency (LEP) access to bilingual staff or interpretation services.	8
Standard 7: Provide oral and written notices, including translated signage at key points of contact, to clients in their primary language informing them of their right to receive interpreter services free of charge.	4
Standard 8: Translate and make available signage and commonly used written patient educational material and other materials for members of the predominant language groups in service areas.	3
Standard 9: Ensure that interpreters and bilingual staff can demonstrate bilingual proficiency and receive training that includes the skills and ethics of interpreting, and knowledge in both languages of the terms and concepts relevant to clinical or nonclinical encounters. Family or friends are not considered adequate substitutes because they usually lack these abilities.	4
Standard 10: Ensure that the clients' primary spoken language and self-identified race/ethnicity are included in the healthcare organization's management information system as well as any patient records used by provider staff.	5

TABLE 1 continued

Standard 11: Use a variety of methods to collect and utilize accurate demographic, cultural, epidemiological, and clinical outcome data for racial and ethnic groups in the service area, and become informed about the ethnic/cultural needs, resources, and assets of the surrounding community.	3
Standard 12: Undertake ongoing organizational self-assessments of cultural and linguistic competence, and integrate measures of access, satisfaction, quality, and outcomes for CLAS into other organizational internal audits and performance improvement programs.	6
Standard 13: Develop structures and procedures to address cross-cultural ethical and legal conflicts in healthcare delivery and complaints or grievances by patients and staff about unfair, culturally insensitive or discriminatory treatment, or difficulty in accessing services or denial of services.	9
Standard 14: Prepare an annual progress report documenting the organization's progress with implementing CLAS standards, including information on programs, staffing, and resources.	3

Source: Office of Minority Health (2001)

(e.g., nationality, ethnicity, language, tribal affiliation, religion) within the organization's service area. It provides a multidimensional, 360-degree view of the unit because it seeks input from the unit's various constituencies, including administrators or managers, physicians, nurses, support staff, and patients and their families. It is administered via the Internet (www.COA360.org), which facilitates ease of access and use. The COA360 is currently available only in English; however, it will be available in other languages in the future.

The tool consists of questionnaires intended to be completed by a member or members of a unit's constituency groups. For example, the administrator's questionnaire includes items that only the administrator may respond to, and the same is true for the clinician's, nonclinical staff's, and patient's questionnaires. The questionnaires contain varying numbers of items, with the administrator's containing the greatest number (see Table 2). The other questionnaires are subsets of the administrator's questionnaire. An optional questionnaire is also available for persons who live in the service area but who are not current patients of the organization or unit being assessed. The number of raters for each questionnaire will vary on the basis of the size of the unit being assessed. Table 2 lists the recommended minimum number of raters for each constituency group.

The 14 domains of the COA360 are based on the 14 CLAS Standards established by the Office of Minority Health. In this tool, the unit's performance in each CLAS Standard is evaluated; the

TABLE 2
COA360 Overview

Questionnaire	Number of Questions on Questionnaire	Minimum Number of Raters to Complete Questionnaire
Factuals: Statistic data, to be completed by the healthcare organization administration	113	1
Administrators: Questionnaire, to be completed by a representative of the healthcare organization	79	1
Clinical staff: Questionnaire, to be completed by clinical staff of the healthcare organization (e.g., physicians, nurse, physician's assistant)	73	3*
Nonclinical staff: Questionnaire, to be completed by staff of the healthcare organization who are not involved in direct patient care	73	3
Patients and families: Questionnaire, to be completed by patients of the healthcare organization or their family members	20	25
Community residents: Optional questionnaire, to be completed by residents of the healthcare organization's service area who have not used the facility in the past two years	7	50

Note: More information about the COA360 items is available at www.COA360.org.
*The involvement of all clinical and nonclinical staff is recommended if possible.

number of items for each CLAS Standard ranges from three to nine. For example, for Standard 1, the tool poses nine questions that examine the unit's adherence to that standard, while there are only three items for Standard 14.

Ratings from all questionnaires are compiled and then summarized. Doing so allows for a comparison of the scores of each constituency group for each of the tool's domains. This comparison then demonstrates the areas of strength and weakness as perceived by the various groups. The overall result yields an assessment that can be used to improve or evaluate leadership/management and organizational operations. The report provides feedback for each of the 14 CLAS Standards as well as relevant Joint Commission standards. For more information about the COA360, go to www.COA360.org.

Validation Study

We conducted a search of the National Library of Medicine's PubMed article database for the time period from January 2002 through September 2005, using

the keywords "cultural competence" or "cultural competency" to identify authors or coauthors of cultural competency studies who could serve on our expert panel.

From our initial search, we identified 212 potential experts. Twenty of these potential experts were excluded for one or more of the following reasons: (1) we could not locate them, (2) they declined our invitation, or (3) they returned an inadequately completed questionnaire. Six more were immediately disqualified because of their affiliation with the research institution conducting the validation study. The remaining 186 experts were each sent a copy of four (out of the 14) CLAS Standards randomly selected, along with the COA360 question items that measure those specific standards. Each expert was asked to determine how well each COA360 question item measured each of the four CLAS Standards by rating the items on a five-point Likert-type scale (1 = not at all; 5 = very well). The panel was also asked to rate how well the items, as a whole, measured each standard.

The evaluation packets were sent either via e-mail or through the U.S. Postal Service. Follow-up mailings were sent three weeks after the initial mailing, and a second follow-up was sent three weeks later to the remaining nonresponders. We aimed to obtain at least ten evaluations per CLAS Standard. We received between 10 and 16 evaluations for each standard.

RESULTS

The mean score for each item and the overall score for each CLAS Standard were calculated as the mean of the items' scores within that section. Table 3 displays the results of these analyses, showing that the mean score for each individual item was rated ≥ 4.00 on a 5-point scale. The one exception was that Item 7 of Standard 1 had a mean of 3.93, which is 0.07 points below our goal of 4.00.

Based on feedback from the expert evaluators, we modified Item 7, after which all subsequent ratings for this item were ≥ 4.00. However, means presented in Table 3 include the lower ratings recorded before Item 7 was revised. Of the remaining 78 items, 43 percent had a mean rating between 4.00 and 4.49, and 57.7 percent had a mean rating between 4.50 and 5.00. These ratings indicate that each item contributed to the measurement of its related standard "well" or "very well." Additionally, each CLAS Standard received a mean score of ≥ 4.13 on a 5-point scale. Of the 14 standards, six (42.9 percent) had a mean score between 4.00 and 4.49, and eight (57.1 percent) obtained mean scores between 4.50 and 5.00.

DISCUSSION AND CONCLUSION

Clearly, cultural competency of healthcare organizations is tied to social justice and equity, but it is also motivated by business and quality considerations. The COA360, for example, is based on the CLAS Standards, which are linked to the Joint Commission's 2007 Standards for Hospitals, Ambulatory, Behavioral Health, Long Term Care, and Home Care.

Nearly 18 percent of the U.S. population speaks a language other than English at home. Additionally, the

TABLE 3
Mean Validity Rating Summary for Each Standard Item and Overall Validity Rating

CLAS Standard	COA360 Item 1	COA360 Item 2	COA360 Item 3	COA360 Item 4	COA360 Item 5	COA360 Item 6	COA360 Item 7	COA360 Item 8	COA360 Item 9	Overall
1	4.07	4.21	4.21	4.29	4.21	4.07	3.93	4.21	4.00	4.13
2	4.36	4.36	4.14	4.43	4.36	4.50				4.36
3	4.67	4.56	4.78	4.33	4.44	4.78	4.78			4.62
4	4.40	4.40	4.50	4.40	4.30	4.30	4.30	4.30	4.30	4.36
5	4.64	4.64	4.71							4.67
6	4.67	4.75	4.67	4.83	4.67	4.67	4.67	4.67		4.70
7	4.88	4.75	4.75	4.75						4.78
8	4.44	4.78	4.78							4.67
9	4.73	4.73	4.82	4.64						4.73
10	4.78	5.00	4.89	4.78	4.78					4.84
11	4.62	4.54	4.08							4.41
12	4.38	4.25	4.38	4.50	4.13	4.50				4.35
13	4.50	4.38	4.38	4.38	4.50	4.50	4.50	4.38	4.50	4.44
14	4.73	4.91	4.73							4.79

shortage of skilled healthcare workers in the United States has made it possible for foreign-born and foreign-trained healthcare professionals to migrate to this country to work. Such a migration pattern presents major implications for the U.S. healthcare industry, including language barriers that require the use of interpreters, distrust between patients and providers caused by miscommunication and differing cultural beliefs and values about diseases and treatments, and cross-cultural conflict among healthcare staff that can affect the functioning of a unit. Together, these factors threaten to lower the quality of care, raise the resources devoted to ancillary services, cause providers to spend time on activities that are not reimbursable, and prolong medical encounters. In turn, they may lead to higher healthcare costs, reduced profitability, and increased liability risks.

To attract and retain high-quality professionals from diverse backgrounds and to maximize organizational performance, healthcare leaders must articulate a commitment to cultural competency and initiate strategies at the organizational, structural, and clinical levels. Assessing an organization's and/or its unit's cultural competency is an important step toward fostering a productive, efficient, and harmonious workplace for a diverse workforce. Developing and promoting culturally competent interactions among staff and between providers and patients greatly

contribute to excellence in modern healthcare delivery. Our validation study, conducted with a panel of cultural competency experts, reveals that the COA360 is a valid measure. The tool can be used in conjunction with cultural competency interventions, helping with assessing or reassessing initiatives, with benchmarking or comparing units as part of a quality improvement program, or with preparing for Joint Commission accreditation.

REFERENCES

Anderson, L. M., S. C. Scrimshaw, M. T. Fullilove, J. E. Fielding, J. Normand, and the Task Force on Community Preventive Services. 2003. "Culturally Competent Healthcare Systems: A Systematic Review." *American Journal of Preventive Medicine* 24 (3 Suppl): 68–79.

Beach, M. C., E. G. Price, T. L. Gary, K. A. Robinson, A. Gozu, A. Palacio, C. Smarth, M. W. Jenckes, C. Feuerstein, E. B. Bass, N. R. Powe, and L. A. Cooper. 2005. "Cultural Competence: A Systematic Review of Health Care Provider Educational Interventions." *Medical Care* 43 (4): 356–73.

Betancourt, J. R., A. R. Green, J. E. Carrillo, and E. R. Park. 2005. "Cultural Competence and Health Care Disparities: Key Perspectives and Trends." *Health Affairs* 24 (2): 499–505.

Brach, C., and I. Fraser. 2000. "Can Cultural Competency Reduce Racial and Ethnic Health Disparities? A Review and Conceptual Model." *Medical Care Research and Review* 57 (Suppl 1): 181–217.

———. 2002. "Reducing Disparities Through Culturally Competent Health Care: An Analysis of the Business Case." *Quality Management in Health Care* 10 (4): 15–28.

Dreachslin, J. L., and V. L. Myers. 2007. "A System Approach to Culturally and Linguistically Competent Care." *Journal of Healthcare Management* 52 (4): 220–26.

Hayes-Bautista, D. E. 2003. "Research on Culturally Competent Healthcare Systems: Less Sensitivity, More Statistics." *American Journal of Preventive Medicine* 24 (3 Suppl): 8–9.

Joint Commission. 2007. "Office of Minority Health National Culturally and Linguistically Appropriate Services (CLAS) Standards Crosswalked to Joint Commission 2007 Standards for Hospitals, Ambulatory, Behavioral Health, Long Term Care, and Home Care." [Online information; retrieved 12/31/07.] www.jointcommission.org/NR/rdonlyres/5EABBEC8-F5E2-4810-A16F-E2F148AB5170/0/hlc_omh_xwalk.pdf.

Kairys, J. A., J. Orzano, P. Gregory, C. Stroebel, B. DiCicco-Bloom, B. Roemheld-Hamm, F. A. Kobylarz, J. G. Scott, L. Coppola, and B. F. Crabtree. 2002. "Assessing Diversity and Quality in Primary Care Through the Multimethod Assessment Process (MAP)." *Quality Management in Health Care* 10 (4): 1–14.

Lewis, M. G. 2007. "A Cultural Diversity Assessment and the Path to Magnet Status." *Journal of Healthcare Management* 52 (1): 64–70.

Office of Minority Health, U.S. Department of Health and Human Services. 2001. *National Standards for Culturally and Linguistically Appropriate Services in Health Care: Final Report.* [Online information; retrieved 12/31/07.] www.omhrc.gov/assets/pdf/checked/finalreport.pdf.

Remus, B. 2004. "Lack of Cultural Competency: A Business and Clinical Risk." *Journal of Healthcare Risk Management* 24 (4): 5-11.

Reynolds, D. 2004. "Improving Care and Interactions with Racially and Ethnically Diverse Populations in Healthcare Organizations." *Journal of Healthcare Management* 49 (4): 237–49.

Siegel, C., E. D. Chambers, G. Haugland, R. Bank, C. Aponte, and H. McCombs. 2000. "Performance Measures of Cultural Competency in Mental Health Organizations." *Administration and Policy in Mental Health* 28 (2): 91–106.

Siegel, C., G. Haugland, and E. D. Chambers. 2003. "Performance Measures and Their Benchmarks for Assessing Organizational Cultural Competency in Behavioral Health Care Service Delivery." *Administration and Policy in Mental Health* 31 (2): 141–70.

U.S. Census Bureau. 2001. "The White Population." [Online information; retrieved 12/31/07.] www.census.gov/prod/2001pubs/c2kbr01-4.pdf.

———. 2002. "Historical Census Statistics on Population Totals by Race, 1790 to 1990, and by Hispanic Origin, 1970 to 1990, for the United States, Regions, Divisions, and States." [Online information; retrieved 12/31/07.] www.census.gov/population/www/documentation/twps0056.html.

Weech-Maldonado, R., J. L. Dreachslin, K. H. Dansky, G. De Souza, and M. Gatto. 2002. "Racial/Ethnic Diversity Management and Cultural Competency: The Case of Pennsylvania Hospitals." *Journal of Healthcare Management* 47 (2): 111–24.

Wilson-Stronks, A., and E. Galvez. 2007. "Hospitals, Language, and Culture: A Snapshot of the Nation." [Online information; retrieved 12/31/07.] www.jointcommission.org/NR/rdonlyres/E64E5E89-5734-4D1D-BB4D-C4ACD4BF8BD3/0/hlc_paper.pdf.

Zambrana, R. E., C. Molnar, H. B. Munoz, and D. S. Lopez. 2004. "Cultural Competency as it Intersects with Racial/Ethnic, Linguistic, and Class Disparities in Managed Healthcare Organizations." *American Journal of Managed Care* (Spec No): SP37–44.

PRACTITIONER APPLICATION

Hoffman Moka Lantum, MD, PhD, director, Medical Services Business Improvement, Excellus BlueCross BlueShield, Rochester, New York

Healthcare organizations are becoming aware of the changing demographics of the populations they serve. Less widely accepted is that cultural competency is an organizational asset that could competitively affect the quality and cost of health outcomes. Hesitance to implement cultural competency-driven priorities in healthcare organizations was in part a result of the lack of understanding of the relationship between culture and health outcomes. Numerous studies have been published over the past decade that unequivocally established a link between race, ethnicity, and linguistic barriers and substandard health outcomes (Smedley, Stith, and Nelson 2003). These data set a foundation for a national agenda to eliminate cultural barriers in healthcare delivery (Office of Minority Health 2001). Healthcare organizations, including health plans, have begun implementing the Culturally and Linguistically Appropriate Services (CLAS) Standards developed by the Office of Minority Health (2001). However, many organizations struggle to implement programs and strategies to curb health disparities because they lack a systematic approach to evaluate their own cultural competency.

LaVeist and colleagues present in this article the COA360, a tool that comprehensively measures cultural competency at the organizational level. COA360 variables seek to collect data from all touch points that span the continuum of care. The inclusion of administrative, clinical, and community inputs facilitates the incorporation of CLAS guidelines into operational plans.

Health plans can integrate COA360 measures into other quality and outcomes measures and enhance their cultural competency internally (within its business) and externally (among providers in their network). The method of scoring the 14 CLAS Standards can enable health plans that are seeking to boost cultural competency and accessibility to providers in their network to prioritize and thus properly allocate

resources. In turn, providers can benchmark and monitor the impact associated with their investments in cultural competency training, hitherto unknown to many organizations.

Healthcare organizations are currently limited by their ability to measure variations in quality of care on the basis of race and ethnicity. To this day, many health plans do not collect race and ethnicity information in their claims databases; hence, they are unable to assess differences in utilization patterns based on race and ethnicity (NIHCM 2007). Current instruments to measure service quality and outcomes are dichotomous in nature and are focused on whether or not a service was delivered. These instruments do not allow for assessing outcomes relative to cultural needs, perceptions, and satisfaction (Sofaer 2002). The COA360 is less dichotomous in design given that its questionnaires are issued to a broad audience and the qualitative data complement the factual measures reported by the institution. The scores can thus serve as surrogate indicators of customer satisfaction specific to the experiences of ethnic and racial minorities. As such, the tool is a vital asset to payers, providers, and policymakers interested in equitable accessible to and delivery of healthcare.

In conclusion, the COA360 is an instrument that can facilitate implementation and render the CLAS Standards and the related Joint Commission standards operational. Successful implementation of the COA360 by healthcare organizations, notably the health plans, is critical to funding programs that are focused on eliminating health disparities.

REFERENCES

National Institute of Health Care Management Foundation (NIHCM). 2007. [Online information; retrieved 12/31/07.] www.nihcm.org.

Office of Minority Health, U.S. Department of Health and Human Services. 2001. *National Standards for Culturally and Linguistically Appropriate Services in Health Care: Final Report.* [Online information; retrieved 12/31/07.] www.omhrc.gov/assets/pdf/checked/finalreport.pdf.

Smedley, B. D., A. Y. Stith, and A. R. Nelson. 2003. *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care.* Washington, DC: National Academies Press.

Sofaer, S. 2002. "Qualitative Research Methods." *International Journal of Quality Health Care* 14 (4): 329–36.