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ELM CITY CENTER
Cultural Competency Plan
2016

Self-Assessment Checklist for Personnel Providing Primary Health Care Services were completed for staff as they attended various staff meetings

LINGUISTIC AND CULTURAL COMPETENCY GUIDELINES

The purpose of these LCC Guidelines is to improve access to culturally competent programs, services, and activities for Limited English Proficient (LEP) customers, persons who are hard of hearing or Deaf, and persons with low literacy (collectively, the Goal). LEP Customers, as used herein, includes LEP Customers, persons who are hard of hearing or Deaf, and persons with low literacy.

The State of Illinois Linguistic and Cultural Competency Guidelines (LCC Guidelines) were developed as a mechanism for improving language and cultural accessibility and sensitivity in State-funded direct human services delivered by human service organizations that receive grants and contracts to serve the residents of the State of Illinois.

LINGUISTIC AND CULTURAL COMPETENCY MANDATE:

These LCC Guidelines were developed because the Illinois Department of Human Services (DHS) must comply with the Constitution of the United States, Title VI of the Civil Rights Act of 1964, Americans with Disabilities Act of 1990, Americans with Disabilities Act Amendments Act of 2008, Illinois Human Rights Act, the 1970 Constitution of the State of Illinois and any laws, regulations or orders, federal or state, which prohibit discrimination on the grounds of race, sex, color, religion, national origin, age, ancestry, marital status, disability, or the inability to speak or comprehend the English language, and DHS Administrative Directive 01.01.01.060 (effective Feb. 15, 2001).

MISSION:

To operate quality programs and services that provide opportunities for persons with disabilities to optimize their earnings; maximize, develop, and recover skill levels needed to be as independent as they can, live in the least restrictive environment, and actively participate in community activities.

VISION: We see ourselves as:

- An organization that recognizes the capabilities of persons with disabilities and promotes their participation in all aspects of community life.
- An organization committed to improving the quality of life for persons with disabilities.
- An organization that strives to provide and maintain the highest quality services to individuals and customers.
- An organization that is governed and staffed by people who are caring, professional, and responsive to the needs of individuals.
- A financially stable and well-managed business that is an asset to the community.

POLICY STATEMENT:

It is the policy of Elm City Center that people from all backgrounds feel welcomed, valued, respected and acknowledged by Staff, Team people and Board of Directors people, regardless of their appearance, background or beliefs. Diversity issues influence nearly every aspect of our work with people, from welcoming them to the Center, employing effective interviewing techniques, gathering information, selecting appropriate service providers and securing help for a family in a manner in which it is likely to be utilized.

To effectively meet person's needs, Elm City Center personnel attempt to understand the person's world-view and adapt practices as needed and as appropriate. ECC provides services to a diversified target population regardless of age, race, color, religion, national origin, ancestry, gender, marital status, sexual orientation, physical or mental challenges, socio-economic status or any other cultural descriptors. When personal services are delivered without regard for cultural differences, people are at risk for sub-optimal care. People may be unable or unwilling to communicate their needs in an insensitive environment, reducing effectiveness of the entire process.

Consumers, families/guardians, Elm City employees, contracted providers, Board of Directors and anyone else with whom we have dealings are treated with respect, dignity and fairness. People are encouraged to seek opportunities to develop and reach their full potential as individuals, thereby achieving both professional and personal goals. This plan has no end date and will continually change as the services offered and people served by Elm City Center change. It is, and will remain, our responsibility to adapt our services to the needs of our community, our stakeholders, and people we serve.

NEED FOR CULTURALLY COMPETENT SERVICES

Numerous research projects reveal that when accessing social and medical services, people who are viewed as 'different' are often treated differently. Research also indicates that a person has better outcomes when they experience culturally appropriate interactions with providers. The path to developing cultural competency begins with self-awareness and ends with the realization and acceptance that the goal of cultural competency is an ongoing process. Providers should note that the experience of any person begins at the front door. Failure to use culturally competent and linguistically competent practices could result in the following:

- Feelings of being insulted or treated rudely
- Reluctance and fear of making future contact with the office
- Confusion and misunderstanding

- Non-compliance
- Feelings of being uncared for, looked down on and devalued
- Parents resisting to seek help for their children
- Unfilled prescriptions
- Missed appointments
- Misdiagnosis due to lack of information sharing
- Wasted time
- Increased grievances or complaints

Purpose

The Cultural Competency program aims to ensure that:

- Elm City Center meets the unique diverse needs of all people in the populations that we service
- The staff of Elm City Center value diversity within the organization and for the people that we serve
- People with limited English proficiency have their communication needs met
- Our participating providers fully recognize and are sensitive to the cultural and linguistic differences of the Elm City Center people they serve.

Objectives

The objectives of the Cultural Competency program are to:

- Work with our clients so that once people are identified that may have cultural or linguistic barriers alternative communication methods can be made available
- Utilize culturally sensitive and appropriate educational materials based on the member's race, ethnicity and primary language spoken
- Ensure that resources are available to overcome the language barriers and communication barriers that exist in the member population
- Make certain that providers care for and recognize the culturally diverse needs of the population
- Teach staff to value the diversity of both their co-workers inside the organization and the population served, and to behave accordingly

Definitions

Compliance: Compliance with the LCC Guidelines, as described herein, is an essential part of the Agreement.

Cultural competence describes a set of behaviors, attitudes and policies in a system, agency or among professionals that affect cross-cultural work, evolving over time to provide care to patients with diverse values, beliefs and behaviors, including tailoring delivery to meet patients' social, cultural, and linguistic needs. It is both a vehicle to increase access to quality care for all patient populations and a business strategy to attract new patients and market share.[1]

[1] Betancourt, Green and Carillo, *Cultural Competence in Health Care: Emerging Frameworks and Practical Approaches*, The Commonwealth Fund, October 2002

Culturally and linguistically appropriate services (CLAS): Health care services that are respectful of, and responsive to, cultural and linguistic needs.[2]The U.S. Department of Health and Human Services, Office of Minority Health, has issued national CLAS standards. Elm City Center is committed to a continuous effort to perform according to those standards. The delivery of culturally competent services requires providers and/or employees to possess a set of attitudes, skills, behaviors, and policies which enable the organization and staff to work effectively in cross-cultural situations. It reflects an understanding of the importance of acquiring and using knowledge of the unique health-related beliefs, attitudes, practices, and communication patterns of beneficiaries and their families to improve services, strengthen programs, increase community participation, and eliminate disparities in health status among diverse population groups. [3]

Individual Cultural Competence: Acquisition of the values, knowledge, skills and attributes that allows an individual to work appropriately in cross-cultural situations.

Organizational Cultural Competence: Systems and organizations approve, and in some cases mandate, the incorporation of cultural knowledge into policymaking, infrastructure and practice. An example of an LEP practice would include: requiring written material translated, adapted, and or provided in alternative formats based on needs and preferences of the populations served.

Language Access: Assuring language access means providing language assistance services including bilingual personnel and interpreter services, at no cost to each LEP customer, at key points of contact, in a timely manner. Interpretation and translation services must comply with all relevant federal, state and local mandates governing language access. Consumers must engage in evaluation of language access and other communication to ensure quality and satisfaction. Importantly, Title VI of the Civil Rights Act of 1964 prohibits discrimination on the basis of race, color or national origin including actions that *delay, deny, or provide different* quality services to a particular individual or group of individuals. *See* Civil Rights Act of 1964, Pub. L. 88–352, July 2, 1964, 78 Stat. 241, as amended.

Meaningful Access: Providers and their subcontractors, providing services subject to 7 C.F.R. § 272.4(b) are required to take reasonable steps to ensure meaningful access to their services and programs by LEP Customers. Compliance involves the balancing of four factors: 1) the number and proportion of eligible LEP Customers, 2) the frequency of contact with LEP Customers, 3) the importance or impact of the contact upon the lives of the person(s) served, and 4) the resources available to the organization. This four-factor analysis (LEP Assessment) may be applied to the different types of programs or activities the Provider provides to determine the level of language assistance measures sufficient to assure full compliance or to demonstrate reasonable efforts.

Periodic Review: DHS may periodically review the Provider's compliance with these LCC Guidelines, its LCC Plan and the terms of its contract. Without limitation, the Provider's failure to cooperate in providing information regarding its compliance with these LCC Guidelines or its LCC Plan, or the provision of false or misleading information or statements concerning compliance, customer base, good faith efforts, or any other material fact or representation shall

[2] *National Standards for Culturally and Linguistically Appropriate Services in Health Care*, U.S. Department of Health and Human Services, Office of Minority Health, December 2000.

[3] Centers for Medicare and Medicaid Services (precise source document uncertain).

constitute a material breach of this Agreement and entitle DHS to declare a default, terminate the contract, or exercise those remedies provided for in the Agreement or at law or in equity.

Records: The Provider shall maintain a record of all relevant data with respect to the access of programs, services, and activities by LEP Customers for a period of at least five years after the completion of this Agreement. Complete access to these records, and data reasonably related to a representation by the Provider regarding these LCC Guidelines or the LCC Plan, shall be granted by the Provider upon 48 hours' written notice by DHS.

National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health and Health Care[4]

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 thro ugh 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.

[4] https://www.thinkculturalhealth.hhs.gov/Content/clasvid.asp

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.

Rationale

Performing in a culturally competent manner is not just good for our people, it is good for business. Elm City Center endorses the view, promulgated by the federal government,[5] that achieving cultural competence will help us to:

- Improve services and care for current people (improved understanding leads to better satisfaction)
- Increase market penetration by appealing to potential culturally and linguistically diverse people
- Enhance the cost-effectiveness of service provision
- Reduce potential liability from medical errors and Title VI (Civil Rights Act) violations.[6]

Achieving cultural competency is an on-going process, not a single act. With that knowledge, this document sets forth Elm City Center' approach toward becoming a more culturally competent organization.

[5] *Planning Culturally and Linguistically Appropriate Services: A Guide for Managed Care Plans*, Centers for Medicare and Medicaid Services and Agency for Health Care Research and Quality, 2003.

[6] Title VI of the Civil Rights Act specifically requires that managed care organizations provide assistance to persons with limited English proficiency, where a significant number of the eligible population is affected. Department of Justice regulations (28 CFR Section 42.405(d)(1)) state: "Where a significant number or proportion of the population eligible to be served or likely to be directly affected by a federally assisted program needs service or information in a language other than English in order effectively to be informed of or to participate in the program, the recipient shall take reasonable steps, considering the scope of the program and the size and concentration of such population, to provide information in appropriate languages to such persons. This requirement applies with regard to written material of the type which is ordinarily distributed to the public."

LINGUISTIC AND CULTURAL COMPETENCE ELEMENTS AND INDICATORS

The table below lists the LCC Guideline elements and the respective indicators. The indicators as listed demonstrate a full level of compliance.

LINGUISTIC AND CULTURAL COMPETENCY ELEMENTS	INDICATORS
1. Organizations should have a linguistic and cultural competence plan for the funded program(s) or for the organization as a whole that includes clear goals, outcomes, policies and procedures related to the provision of culturally and linguistically appropriate services.	1. The LCC Plan addresses in a meaningful way the guidelines in this document and is consistent with the organization's mission. 2. The LCC Plan has defined short-term and long-term goals and outcomes that improve services to LEP Customers, persons who are hard of hearing or Deaf, and persons with low literacy. 3. The LCC Plan identifies a staff member responsible for overseeing its implementation.
2. Organizations should implement strategies to recruit, retain, and promote at all levels, diverse personnel and leadership that are representative of the demographic characteristics of the service area. Regular staff training should be incorporated as a key element to strengthen and enhance cultural competency.	1. The LCC Plan demonstrated hiring, retention and promotion of staff of racial and ethnic backgrounds representative of target population served. 2. The LCC Plan notes that personnel at different levels receive ongoing education and training in culturally and linguistically service delivery. 3. The LCC Plan establishes requirements for specific language skills in job descriptions and remuneration for language skills.
3. Organizations should provide hearing impaired and language assistance services, including bilingual personnel and interpreter services, at no cost to each LEP Customer, or those who are hard of hearing or Deaf, at key points of contact, in a timely manner that facilitates maximum access to services.	1. The LCC Plan includes evidence that appropriate interpretation services are provided to the LEP Customers in a timely manner. 2. The LCC Plan includes an assessment of personnel and interpreters' ability to effectively communicate in a language other than English or to provide American Sign Language in their specific field of service. 3. The LCC Plan notes that family, friends, or other unlicensed or untested individuals are not used to provide interpretation services.

4. Organizations should provide to consumers in their preferred language both verbal and written notices of their right to receive language assistance services that are culturally appropriate.	1. The LCC Plan notes that easily understood consumer-related materials and visible notices are posted in languages of commonly encountered groups represented in the service area. 2. The LCC Plan notes that pertinent written, oral, and symbolic consumer materials, including consent forms, statement of rights forms, posters, signs, and audio tape recordings, are available in the language of the consumer, including Braille, and available at all key points of access. 3. The LCC Plan puts quality assurance measures in place to verify accuracy of translated documents.
5. Organizations should collect customer data to ensure that every effort is made to provide consumers with effective, understandable and respectful services, provided in the consumer's preferred language and in a manner sensitive to cultural beliefs and practices.	1. The LCC Plan is data driven, based on analysis of verifiable demographic and service data, including the consumers' self-identified primary spoken language, race, ethnicity, need for language assistance and how language assistance was provided (*e.g.* on-site interpreter, telephone interpreter, preferred interpreter or brought own interpreter). 2. The LCC Plan uses the data to assess new and emerging community and population needs. 3. The LCC Plan notes that the organization tracks consumer satisfaction with language access services and organizational sensitivity to consumer culture.

DRAFTING AN LCC PLAN

Providers must provide an LCC Plan to serve LEP Customers as described above. Providers should include any additional information that will add clarity to the Provider's proposed LCC Plan to provide access to services for LEP Customers

The following is a guide for drafting the LCC Plan submission:

1. Identifying the LEP Customers Who May Need Assistance: Describe the number or proportion of LEP Customers eligible to be served or encountered. Use the four factor analysis to provide an assessment of need and required effort, *i.e.* include the LEP Assessment. As described in section 2.5, the four factors are: 1) the number and proportion of eligible LEP Customers, 2) the frequency of contact with LEP Customers, 3) the importance or impact of the contact upon the lives of the person(s) served, and 4) the resources available to the organization.
2. Organizational or Program LCC Plan: Provide a general description of the linguistic and cultural competence plan for the funded program(s) or for the organization as a whole that includes clear goals, outcomes, policies and procedures related to the provision of culturally and linguistically appropriate services.

3. Diverse Personnel and LCC Training: Describe the strategies used to recruit, retain and promote at all levels, diverse personnel and leadership that are representative of the demographic characteristics of the service area. Provide a list of personnel positions that receive ongoing education and training in culturally and linguistically appropriate service delivery.

4. Language Assistance Measures: Describe any language assistance services, such as bilingual personnel and interpreter services, cost of services, point of accessing the services, and how the services are delivered. Describe efforts and solicitations to secure the services of a Provider to provide interpretation or translation services, or other services (e.g. LCC Provider) that will assist the Provider in meeting the Goal. Describe the use of services from available minority community organizations; minority business groups; local, state, and federal minority business offices; and other organizations that provide assistance in meeting the Goal.

5. Providing Notice to the LEP Customers: Describe practices established to ensure consumers receive both verbal and written notices, in their preferred language, of their right to receive language assistance or American Sign Language services. List any consumer-related materials and signage that are in languages of commonly encountered groups represented in the service area, including the languages in which the materials are available.

6. Quality Assurance: Describe the procedures that ensure that consumers receive effective, understandable and respectful services, provided in the consumer's preferred language and in a manner sensitive to cultural beliefs and practices including a description of data collection procedures.

Plan Components

1. NEEDS ASSESSMENT –

Activities we conduct to identify the cultural and linguistic needs of the communities and people we serve, as well as health disparities present in the enrolled population and the community at large.

Data Analysis

When provided with information from our clients regarding the cultural and linguistic needs of their populations, Elm City Center will review the data provided and will:

- Compare the data with information available regarding the cultural and linguistic composition of our network
- Assess the customer service center to ensure that assistance with people' requests for information or complaints and grievances are handled with the utmost regard to cultural and linguistic diversities

Whenever possible, we will team up with public health entities and private groups having a similar charter, to share information that will guide all health service organizations in each region and community in directing resources where they will yield the most benefit.

Demographics

People QuickFacts	Morgan County	Illinois
Population, 2014 estimate	34,929	12,880,580
Population, 2013 estimate	35,038	12,890,552
Population, 2010 (April 1) estimates base	35,551	12,831,587

People QuickFacts	Morgan County	Illinois
Population, percent change - April 1, 2010 to July 1, 2014	-1.7%	0.4%
Population, percent change - April 1, 2010 to July 1, 2013	-1.4%	0.5%
Population, 2010	35,547	12,830,632
Persons under 5 years, percent, 2013	5.3%	6.2%
Persons under 18 years, percent, 2013	20.2%	23.5%
Persons 65 years and over, percent, 2013	17.7%	13.5%
Female persons, percent, 2013	49.6%	50.9%
White alone, percent, 2013 (a)	91.3%	77.7%
Black or African American alone, percent, 2013 (a)	6.3%	14.7%
American Indian and Alaska Native alone, percent, 2013 (a)	0.3%	0.6%
Asian alone, percent, 2013 (a)	0.5%	5.1%
Native Hawaiian and Other Pacific Islander alone, percent, 2013 (a)	Z	0.1%
Two or More Races, percent, 2013	1.6%	1.8%
Hispanic or Latino, percent, 2013 (b)	2.3%	16.5%
White alone, not Hispanic or Latino, percent, 2013	89.4%	62.7%
Living in same house 1 year & over, percent, 2009-2013	81.0%	86.8%
Foreign born persons, percent, 2009-2013	1.8%	13.8%
Language other than English spoken at home, pct age 5+, 2009-2013	3.0%	22.3%
High school graduate or higher, percent of persons age 25+, 2009-2013	88.1%	87.3%
Bachelor's degree or higher, percent of persons age 25+, 2009-2013	20.7%	31.4%
Veterans, 2009-2013	2,997	727,919
Mean travel time to work (minutes), workers age 16+, 2009-2013	18.8	28
Housing units, 2014	15,411	5,307,222
Homeownership rate, 2009-2013	69.9%	67.5%
Housing units in multi-unit structures, percent, 2009-2013	16.9%	32.9%
Median value of owner-occupied housing units, 2009-2013	$91,000	$182,300
Households, 2009-2013	13,926	4,772,723
Persons per household, 2009-2013	2.32	2.63
Per capita money income in past 12 months (2013 dollars), 2009-2013	$24,337	$29,666
Median household income, 2009-2013	$46,809	$56,797
Persons below poverty level, percent, 2009-2013	14.4%	14.1%
Business QuickFacts	Morgan County	Illinois
Private nonfarm establishments, 2013	843	315,364
Private nonfarm employment, 2013	12,331	5,209,070
Private nonfarm employment, percent change, 2012-2013	-2.5%	1.7%
Nonemployer establishments, 2013	1,971	928,461
Total number of firms, 2007	2,795	1,123,817
Black-owned firms, percent, 2007	S	9.5%
American Indian- and Alaska Native-owned firms, percent, 2007	F	0.5%
Asian-owned firms, percent, 2007	F	5.3%
Native Hawaiian and Other Pacific Islander-owned firms, percent, 2007	F	0.1%
Hispanic-owned firms, percent, 2007	F	5.0%
Women-owned firms, percent, 2007	25.3%	30.5%
Manufacturers shipments, 2007 ($1000)	D	257,760,713

People QuickFacts	Morgan County	Illinois
Merchant wholesaler sales, 2007 ($1000)	425,549	231,082,768
Retail sales, 2007 ($1000)	403,082	165,450,520
Retail sales per capita, 2007	$11,399	$12,947
Accommodation and food services sales, 2007 ($1000)	44,423	25,469,026
Building permits, 2014	2	20,579
Geography QuickFacts	Morgan County	Illinois
Land area in square miles, 2010	568.79	55,518.93
Persons per square mile, 2010	62.5	231.1
FIPS Code	137	17
Metropolitan or Micropolitan Statistical Area	Jacksonville, IL Micro Area	
(a) Includes persons reporting only one race.		
(b) Hispanics may be of any race, so also are included in applicable race categories.		
FN: Footnote on this item for this area in place of data		
NA: Not available		
D: Suppressed to avoid disclosure of confidential information		
X: Not applicable		
S: Suppressed; does not meet publication standards		
Z: Value greater than zero but less than half unit of measure shown		
F: Fewer than 100 firms		
Source: US Census Bureau State & County QuickFacts		

Disability POPULATION Statistics for Illinois **From Pooled 2005-2007 ACS PUMS Data**

Subject	With a Disability	% With a Disability	Without a Disability	% Without a Disability	Total Population	% of Total Population	Sample Size
Population	**Total**	**% of Population**	**Total**	**% of Population**	**Total**	**% Ages 5+**	**Sample Size**
Ages 5+	1,473,870	12.7%	10,155,140	87.3%	11,629,010	N/A%	14,470
Ages 21-64	749,130	10.2%	6,627,840	89.8%	7,376,970	63.4%	9,042
Ages 16-64	797,680	9.7%	7,419,750	90.3%	8,217,430	70.7%	9,980

Demographics -- Ages 21-64	Total	% of Ages 21-64 w/ Disability	Total	% of Ages 21-64 w/o Disability	Total	% of Ages 21-64	Sample Size
Male	362,090	48.3%	3,278,600	49.5%	3,640,690	49.4%	4,477
Female	387,040	51.7%	3,349,240	50.5%	3,736,280	50.6%	4,565
White	513,520	68.5%	4,890,580	73.8%	5,404,100	73.3%	8,589
Non-White	235,600	31.4%	1,737,260	26.2%	1,972,860	26.7%	453
Hispanic	85,390	11.4%	961,740	14.5%	1,047,130	14.2%	525
Non-Hispanic	663,730	88.6%	5,666,100	85.5%	6,329,830	85.8%	8,517
Education -- Ages 21-64	**Total**	**% of Ages 21-64 w/ Disability**	**Total**	**% of Ages 21-64 w/o Disability**	**Total**	**% of Ages 21-64**	**Sample Size**
Less Than High School Degree	166,570	22.2%	672,680	10.1%	839,250	11.4%	610
High School Degree (Including GED)	257,180	34.3%	1,734,840	26.2%	1,992,020	27.0%	2,921
Some College or Associate's degree	222,460	29.7%	2,040,070	30.8%	2,262,530	30.7%	3,435
Bachelor's Degree or Higher	102,920	13.7%	2,180,250	32.9%	2,283,170	30.9%	2,076

Labor Force Participation -- Ages 16-64	Total	% of Ages 16-64 w/ Disability	Total	% of Ages 16-64 w/o Disability	Total	% of Ages 16-64	Sample Size
Employed	311,540	39.1%	5,554,160	74.9%	5,865,700	71.4%	7,653
n Labor Force, Not Employed *	59,100	7.4%	420,780	5.7%	479,880	5.8%	4,449
In Labor Force	370,640	46.5%	5,974,950	80.5%	6,345,590	77.2%	7,936

Labor Force Participation -- Ages 21-64	Total	% of Ages 21-64 w/ Disability	Total	% of Ages 21-64 w/o Disability	Total	% of Ages 21-64	Sample Size
Employed	297,840	39.8%	5,220,800	78.8%	5,518,640	74.8%	7,152
In Labor Force, Not Employed *	51,200	6.8%	328,790	5.0%	379,990	5.2%	3,456
In Labor Force	349,040	46.6%	5,549,590	83.7%	5,898,630	80.0%	7,377

Transportation to Work -- Ages 21-64	Total	% of Employed, Ages 21-64 w/ Disability	Total	% of Employed, Ages 21-64 w/o Disability	Total	% of Employed, Ages 21-64	Sample Size
Employed, Not Currently at Work	26,660	9.0%	134,800	2.6%	161,460	2.9%	242
Work at Home	11,140	3.7%	172,140	3.3%	183,280	3.3%	363
Car, Truck or Van	218,150	73.2%	4,286,430	82.1%	4,504,580	81.6%	6,047
Mass Transit	26,260	8.8%	437,350	8.4%	463,610	8.4%	99
Other	15,630	5.2%	190,080	3.6%	205,710	3.7%	401

Travel Time to Work --	Total	% of Employed, Ages 21-64 w/ Disability	Total	% of Employed, Ages 21-64 w/o Disability	Total	% of Employed, Ages 21-64	Sample Size
Employed, Not Currently at Work	26,660	9.0%	134,800	2.6%	161,460	2.9%	242
Work at Home	11,140	3.7%	172,140	3.3%	183,280	3.3%	363
1-15 Minutes	100,340	33.7%	1,800,480	34.5%	1,900,820	34.4%	4,611
16-30 Minutes	86,890	29.2%	1,620,440	31.0%	1,707,330	30.9%	1,088
31-60 Minutes	59,160	19.9%	1,247,910	23.9%	1,307,070	23.7%	11,140
More Than an Hour	13,650	4.6%	245,030	4.7%	258,680	4.7%	2,052
% of Poverty Level -- Ages 5+	**Total**	**% of Population w/ Disability**	**Total**	**% of Population w/o Disability**	**Total**	**% of Ages 5+**	**Sample Size**
Below 100%	280,980	19.1%	1,041,990	10.3%	1,322,970	11.4%	1,114
100%-149%	188,660	12.8%	699,810	6.9%	888,470	7.6%	1,065
150%-199%	164,040	11.1%	764,940	7.5%	928,980	8.0%	1,304
200%-299%	269,650	18.3%	1,636,550	16.1%	1,906,200	16.4%	2,809
300%-399%	191,810	13.0%	1,524,550	15.0%	1,716,360	14.8%	2,337
400%-499%	125,700	8.5%	1,229,840	12.1%	1,355,540	11.7%	1,811
500%+	253,020	17.2%	3,257,480	32.1%	3,510,500	30.2%	4,030
Lived at Current Location One Year Ago -- Ages 5+	Total	% of Population w/ Disability	Total	% of Population w/o Disability	Total	% of Ages 5+	Sample Size
Yes, same house (non-movers)	1,302,960	88.4%	8,701,030	85.7%	10,003,990	86.0%	12,416
No, different house in US	170,910	11.6%	1,454,110	14.3%	1,625,020	14.0%	2,054
Language Other than English at Home -- Ages 5+	**Total**	**% of Population w/ Disability**	**Total**	**% of Population w/o Disability**	**Total**	**% of Ages 5+**	**Sample Size**
No, speaks only	1,241,690	84.2%	7,848,270	77.3%	9,089,960	78.2%	13,635

English							
Yes, speaks another language	232,180	15.8%	2,306,870	22.7%	2,539,050	21.8%	835

* NOTE that the percentages in the rows for the Labor Force, Not Employed individuals are NOT to be confused with unemployment rate. The unemployment rate is the percentage of individuals in the labor force who are not employed. The percentages in the rows are calculated for individuals 16-64 and individuals 21-64, regardless of labor force participation. To calculate the unemployment rate, which is NOT provided in the tables, divide the number of people who are unemployed by the number of people in the labor force, for each population of interest.

Note: Population does not include residents of institutional and noninstitutional group quarters. Read more about the ACS and group quarters

Disability POPULATION Statistics for Calhoun, Cass, Greene, Macoupin, Morgan and Scott Counties, Illinois

From Pooled 2005-2007 ACS PUMS Data

Subject	With a Disability		Without a Disability		Total Population		Sample Size
Population	Total	% of Pop	Total	% of Pop	Total	% Ages 5+	Sample Size
Ages 5+	20,720	18.6%	90,560	81.4%	111,280	N/A%	5,539
Ages 21-64	10,630	15.6%	57,370	84.4%	68,000	61.1%	3,181
Ages 16-64	11,220	14.9%	64,250	85.1%	75,470	67.8%	3,530
Male	5,450	51.3%	28,070	48.9%	33,520	49.3%	1,553
Female	5,180	48.7%	29,300	51.1%	34,480	50.7%	1,628
White	10,330	97.2%	56,180	97.9%	66,510	97.8%	3,134
Non-White	300	2.8%	1,190	2.1%	1,490	2.2%	47
Hispanic	370	3.5%	1,380	2.4%	1,750	2.6%	42
Non-Hispanic	10,260	96.5%	55,980	97.6%	66,240	97.4%	3,139
Less Than High School Degree	2,140	20.1%	4,160	7.3%	6,300	9.3%	289
High School Degree (Including GED)	4,690	44.1%	22,400	39.0%	27,090	39.8%	1,305
Some College or Associate's degree	3,100	29.2%	19,750	34.4%	22,850	33.6%	1,062
Bachelor's Degree or Higher	700	6.6%	11,050	19.3%	11,750	17.3%	525
Employed	4,490	40.0%	49,400	76.9%	53,890	71.4%	2,482
In Labor Force, Not Employed *	920	8.2%	3,940	6.1%	4,860	6.4%	210
In Labor Force	5,410	48.2%	53,340	83.0%	58,750	77.8%	2,692

Subject	With a Disability		Without a Disability		Total Population		Sample Size
Not in Labor Force	5,810	51.8%	10,920	17.0%	16,730	22.2%	838
Employed	4,230	39.8%	46,200	80.5%	50,430	74.1%	2,330
In Labor Force, Not Employed *	820	7.7%	2,920	5.1%	3,740	5.5%	163
In Labor Force	5,050	47.5%	49,110	85.6%	54,160	79.7%	2,493
Not in Labor Force	5,580	52.5%	8,250	14.4%	13,830	20.3%	688

Transportation to Work -- Ages 21-64	Total	% of Employed, Ages 21-64 w/ Disability	Total	% of Employed, Ages 21-64 w/o Disability	Total	% of Employed, Ages 21-64	Sample Size
Employed, Not Currently at Work	220	5.2%	1,070	2.3%	1,290	2.6%	65
Work at Home	120	2.8%	1,110	2.4%	1,230	2.4%	67
Car, Truck or Van	3,640	86.1%	42,830	92.7%	46,470	92.2%	2,130
Mass Transit	N/A	N/A%	N/A	N/A%	N/A	N/A%	6
Other	160	3.8%	1,150	2.5%	1,310	2.6%	62
Travel Time to Work -- Employed, Ages 21-64	**Total**	**% of Employed, Ages 21-64 w/ Disability**	**Total**	**% of Employed, Ages 21-64 w/o Disability**	**Total**	**% of Employed, Ages 21-64**	**Sample Size**
Employed, Not Currently at Work	220	5.2%	1,070	2.3%	1,290	2.6%	65
Work at Home	120	2.8%	1,110	2.4%	1,230	2.4%	67
1-15 Minutes	2,210	52.2%	20,390	44.1%	22,600	44.8%	969
16-30 Minutes	800	18.9%	11,100	24.0%	11,900	23.6%	616
31-60 Minutes	740	17.5%	10,460	22.6%	11,200	22.2%	502
More Than an Hour	130	3.1%	2,070	4.5%	2,200	4.4%	111
% of Poverty Level -- Ages 5+	**Total**	**% of Population w/ Disability**	**Total**	**% of Population w/o Disability**	**Total**	**% of Ages 5+**	**Sample Size**

Below 100%	3,590	17.3%	8,880	9.8%	12,470	11.2%	559
100%-149%	3,690	17.8%	5,940	6.6%	9,630	8.7%	540
150%-199%	2,710	13.1%	8,560	9.5%	11,270	10.1%	561
200%-299%	3,940	19.0%	17,890	19.8%	21,830	19.6%	1,150
300%-399%	2,800	13.5%	16,900	18.7%	19,700	17.7%	1,002
400%-499%	1,460	7.0%	13,450	14.9%	14,910	13.4%	757
500%+	2,530	12.2%	18,930	20.9%	21,460	19.3%	970

Lived at Current Location One Year Ago -- Ages 5+	Total	% of Population w/ Disability	Total	% of Population w/o Disability	Total	% of Ages 5+	Sample Size
Yes, same house (non-movers)	17,720	85.5%	79,840	88.2%	97,560	87.7%	5,039
No, different house in US	3,000	14.5%	10,720	11.8%	13,720	12.3%	500

Language Other than English at Home -- Ages 5+	Total	% of Population w/ Disability	Total	% of Population w/o Disability	Total	% of Ages 5+	Sample Size
No, speaks only English	19,970	96.4%	86,850	95.9%	106,820	96.0%	5,404
Yes, speaks another language	740	3.6%	3,700	4.1%	4,440	4.0%	135

* Percentages in the rows for the Labor Force, Not Employed individuals are NOT to be confused with unemployment rate. The unemployment rate is the percentage of individuals in the labor force who are not employed. The percentages in the rows are calculated for individuals 16-64 and individuals 21-64, regardless of labor force participation. To calculate the unemployment rate, which is NOT provided in the tables, divide the number of people who are unemployed by the number of people in the labor force, for each population of interest.
NOTE: Population does not include residents of institutional and noninstitutional group quarters. Read more about the ACS and group quarters

Culture.
The Culture of Morgan county is 90% white, 8% black, and 2% other. As a rural farming community, it has been this way for many years. That is starting to change as employers in Beardstown have hired large numbers of workers from Mexico and Africa. Beardstown has a very rapidly growing Latin population that has simply not hit Jacksonville yet.

The culture of Jacksonville has a definite impact on people with disabilities due to the concentration of people with disabilities who attend Illinois School for the Deaf, Illinois School for Visually Impaired, Four River Special Education District, and until recently, Jacksonville Developmental Center. Jacksonville as a whole is used to and accommodates large numbers of people with disabilities**.** In addition there are over 20 group homes associated with Pathway, Elm City Center, Community Living Options, and Alvin Eades Center (deaf residential),

The culture of Elm City Center focuses on people with disabilities which range from physical impairments to barely noticeable intellectual delays. The stereotype of what a disability is often gets in the way of other people's interaction. There are several distinct cultures within the ECC system, each has their own specific issues**:**

- People who are independent – supports may be as simple as balancing a checkbook and getting around Jacksonville, holding a job, or being involved with local community activities.
- People living in residential settings
    - Group homes – CILAS, 8 beds, 16 beds - Many of these people need some form of 24 hour supervision due to some limitation in decision making
    - Family – living with parents, siblings, grandparents. Often more involved in community activities because of family activities. Family provides a similar style of 24 hour supervision.
- People who are deaf – a very strong culture in Jacksonville because of the Illinois School for the Deaf. They essentially have their own language (ALS) and often tend to socialize together. Group homes are specialized in Alvin Eades Center.
- People who have spent significant time living in state institutions – People who have lived in State Operated Developmental Centers (SODCs) often have behavioral patterns that have come from institutional living where virtually everything is done for them. Many people coming from SODCs have limited ADL skills and often simply do not know how to interact with others. SODC culture gets very ingrained so it is often difficult to tell the difference between a disability and learned behavior. People in SODCs usually arrived there after some behavior/activity in community settings where they clearly could not take care of themselves or involved the police.

Age.
Age is not a specific issue. The range of ages is wide and tends to match the community. There is a drift toward older groups of people who stay with Elm City (and similar programs for alone time).

Gender.
Gender mix is not significantly different than the general population. When JDC was active the male census of people with increased behavioral issues was much higher.

Sexual orientation.
Sexual orientation is a very mixed situation. There are many dating/long term/marriage relationships among the people served by Elm City, just as you would find in the community. Sexual activity is not significantly different than any other human 18-50 years old. In SODCs, sexual activity becomes focused in who is available. In community settings, orientation drifts to more heterosexual activity because there is more opportunity. Learning when, where, and how to develop appropriate sexual activity can become a problem when living in supportive living situations. Accommodations are often needed.

Spiritual beliefs.
Spiritiual issues in Jacksonville can be very limited for non-Christian based religions. Christian based churches are easy to find and in large numbers. Jewish synagoges, Muslim temples, Buddhist shrines and similar non-Christian places of worship simply do not exist in the entire county. The closest are in Springfield which is 35 miles away. Many people we serve attend church regularly, while the numbers of people for whom religion is not important is about the same as the general population.

Socioeconomic status.
As a group most people coming to Elm City have limited financial resources. There are some significant exceptions. Since many people living in group homes their financial situation is managed. They often have very limited dollars to spend and the choice on where/how to spend that money will be made by someone else. Without assistance many people we serve fall into severe financial trouble very quicjkly. The ability to help people balance their financial needs/understand/follow/apply for state benefits is a huge staff requirement. Many of the people we serve simply cannot do it on their own. Others have a difficult time managing their money which requires consistent help.

Language.
The major languages at Elm City are English and American Sign Language. Just as people may have poor English skills, many people have poor ASL skills, Elm City has staff skilled in ALS, but even then it takes time to understand what a person with limited ASL skills is really saying. Spanish is an occasional language and it is common to have a staff member who speaks Spanish well enough. Almost no other language is used locally. Interpretation services are available.

Community-based Support

Our success requires linking with other groups having the same goals. Elm City Center reaches out to community-based organizations that support racial and ethnic minorities and the disabled to be sure that the community's existing resources for people having special needs are utilized to their full potential. The goal is to coordinate the deployment of resources, as well as to take full advantage of the bonds that may exist between the community-based entities and the covered population.

2. ORGANIZATIONAL READINESS

Steps Elm City Center takes to make certain that we have the platforms, systems, and people skills needed to operate in a culturally competent manner.

Management Accountability for Cultural Competency

The Board of Directors maintains ultimate responsibility for the activities related to cultural competency. The Chief Executive Officer is a member of the Board and is responsible for ensuring implementation of Elm City Center' Cultural Competency program. The Management Team, comprised of the unit leaders of all departments of Elm City Center is responsible for ensuring that culturally sensitive training occurs in their respective areas.

Elm City Center will review client-provided needs assessments and, where possible, work with community-based organizations to ensure that Elm City Center services the entire population in accordance with cultural competency objectives.

Diversity and Language Abilities of Staff

Elm City Center recruits diverse talented staff to work in all levels of the organization. We do not discriminate with regard to race, religion or ethnic background when hiring staff. Elm City Center ensures that bilingual staff is hired for functional units that have direct contact with people to meet the needs identified. ASL is the most common translation required. Where we provide services to significant numbers of people who speak languages other than English or ALS, Elm City Center will either recruit staff bilingual in English plus one of those other languages or establish communication with a language line vendor, as needed.

Diversity and Suitability of Provider Network

Elm City Center recruits providers to ensure that the network includes a diverse array of providers to care for the population served. We intend to have providers and supportive services that value diversity and are committed to serving people of racial and ethnic minorities. Though it is unlikely that the make-up of the provider network will reflect the composition of the enrolled population exactly, Elm City Center strives to achieve the best match possible in each community.

Elm City Center captures information from providers regarding their own and their staff's language abilities. This information is maintained on the website so that people can choose providers that speak the languages that they do.

Education on Cultural Responsiveness

All new Elm City Center staff must attend cultural competency training within three (3) months of the date of hire. For most staff this is included in the mandatory Direct Service Provider training with classroom criteria provided by the Illinois Department of Human resource. Major elements of the training include:

- The rationale and need for providing culturally and linguistically competent services
- Effective approaches to communicating information to Medicaid beneficiaries
- Gauging people' perception (i.e., fearful versus trustful) of providers and their staff

Elm City Center also incorporates diversity exercises into staff meetings to ensure that staff respects diversity within the organization and among the enrolled population. At each performance appraisal period, Elm City Center staff is evaluated on their respect for diverse backgrounds as a core value that Elm City Center measures. Staff will be assessed for their cultural competency through testing, direct observation, and monitoring of patient/consumer satisfaction.

Linguistic Services

Preparation of Materials

- Readability – Materials that are used for member marketing, enrollment, education, etc. are tested for readability and must be scored at the 5th grade level or lower.
- Language other than English – Materials are routinely prepared in English. Upon request, Elm City Center will prepare materials in any other languages spoken by five percent or more of the client's member population, if requested.
- Whenever we learn that a segment of the population that is under five percent, but not negligible, speaks a language other than English, we will explain how the prospective member or active member can contact a translation service to assist with interpretation.
- Materials for persons with cognitive impairments – Materials will be specially prepared in large-print versions for people who can see but not read normal size print, or in Braille or audiotape for people who are legally blind.

Foreign Language Translation Services

- Communication with Elm City Center –Elm City Center uses interpreter services as needed to communicate with people who have limited English proficiency. Elm City Center pays all costs of commercial language services required by its people.
- Special Services for Persons with Hearing Impairments – Elm City Center's people who are deaf or hard of hearing may require devices or services to aid them in communicating effectively with their providers. Several ECC staff are very proficient in ALS. People who are hearing impaired can be asked if they would like a certified interpreter—such as a computer assisted real-time reporter, oral interpreter, cued speech interpreter, or sign-language interpreter—to be present during a visit to the provider. Elm City maintains a list of phone numbers and locations of interpreter services, by county. If the use of an interpreter is not appropriate, Elm City will offer the person the chance to specify what other type of auxiliary aid or service they prefer.
- Also, Provider Services and Provider Relations staff will educate providers on what they can do to make facilities more accessible for individuals with hearing impairments, such as the following:
    - Ensure a quiet background for the patient
    - Reduce echoes to enhance sound quality
    - Add lighting to enhance visibility
    - Install flashing lights that work in conjunction with auditory safety alarms
    - Clearly identify all buildings, floors, offices and room numbers
    - Include a TTY (teletypewriter) or TDD (telecommunications devices for deaf persons) in the office

Functional Illiteracy– Often hidden from view is the fact that many people who speak English as their native language cannot read at a level that allows them to perform basic tasks such as filling out forms used in everyday transactions. Fearing embarrassment, seldom do such people identify themselves to staff or to network providers. Nevertheless, we are committed to making best efforts to help these individuals so that they can get the most out of their health care plan.

We begin by encouraging our staff and providers' office staffs to look for telltale signs of literacy problems. These personnel then attempt, with sensitivity and discretion, to help the member with the immediate need, such as completing a form. We will also try to guide the member to appropriate community resources that can help the member improve his or her literacy skills.

Website adaptations – Elm City Center' website has been updated to improve the content and interactive capabilities available to people and prospective people.

3. PROGRAM DEVELOPMENT

The implementation of programs to link Elm City Center to community resources, to enhance the cultural and linguistic capabilities of our participating providers and to educate people so that their experience with Elm City Center and our providers is more positive and their outcomes are more favorable.

Linkage to Community

Elm City Center is dedicated to partnering with community organizations to promote cultural understanding and to meet the needs of the diverse population. Wherever possible, Elm City Center will pursue linkages with national, state-level and local organizations dedicated to advancing both the broad interests and the health interests of groups having needs for culturally-based supports. To reinforce community ties, Elm City Center will focus on recruiting staff that have roots in the community. We will make it known to our member population when there are openings, in the hope that some of our own people might become Elm City Center staff.

Provider Education

Elm City Center educates providers regarding Cultural Competency program through documents and direct conversation. The topic will be covered regularly in Elm City Center' newsletter and staff meetings. We will distribute appropriate reference materials to providers as well—for example, the national CLAS standards. All Providers receive a Cultural Competency Checklist, approved by the federal Centers for Medicare and Medicaid Services, to assess their cultural competency in their offices. (See Appendix.) Use of the tool is voluntary for providers at the present time. Elm City Center will arrange for appropriate follow-up assistance to providers who, after using it, report a need for help in becoming more culturally competent.

4. PERFORMANCE IMPROVEMENT

Ongoing identification of opportunities to improve the operation of the Cultural Competency Program or to improve outcomes through new responses to cultural and linguistic. Elm City Center is committed to conducting performance improvement projects both pertaining to culturally and linguistically appropriate services and related to health care disparities identified in the population served.

Provider Performance Monitoring

In the event that people file complaints or grievances with Elm City Center concerning a provider that behaves in a manner inconsistent with standards for culturally and linguistically appropriate services, Elm City Center will investigate the matter with the same degree of concern applied to any other complaint or grievance. Offending providers will be expected to take corrective measures, and Elm City Center will follow up to make certain that such action indeed was taken. If we observe patterns in complaint and grievance information that suggest there are systemic deficiencies in a staff member's conformance to cultural competency aims, we will investigate the causes and define broad performance improvement projects to eliminate the weakness.

Ongoing Self-Assessment

Process and Tools

Elm City Center will regularly assess the cultural competency of the company to ensure that we are meeting the diverse needs of our people, providers, and staff. A component of the assessment will be focus groups of people, providers, and staff to explore the needs of all Elm City Center constituent groups and to listen to suggestions for improving our Cultural Competency program. Annually the Cultural Competency program will be reviewed, revised, and presented to the Quality Improvement Committee and the Board of Directors to ensure compliance with the program objectives.

Reporting

All measures will be reported to the Quality Improvement Committee and Board of Directors for recommendations, interventions, and approval.

Determination of Performance Improvement Projects

Benchmarking Against Best Practices

The Quality Improvement Department will review the literature on innovations and best practices in cultural competency at least once yearly. The results of this review will be compared to the findings of the assessment (above) to identify gaps between Elm City Center' Cultural Competency program and the state of the art.

Setting Priorities and Assignments

Elm City Center, at least annually, presents member demographics and provider demographics to the Quality Improvement Committee. The QI Committee is responsible for setting priorities and assigning owners for quality improvement activities and ensuring that continuous quality improvement is incorporated throughout the organization.

Linking Cultural Competency/CLAS with Other Quality Improvement Efforts

Elm City Center' Quality Improvement Committee is charged with ensuring that there is an active feedback loop between the cultural competency activities and other quality improvement efforts. When opportunities for improvement are identified in either of the two domains, the department staff and the committee are expected to explore ways to introduce that improvement opportunity into the other realm.

POLICY AND GOVERNANCE LEVEL

Role/Responsibility: Develop and implement policies that promote cultural and linguistic values within the organizational structure.			
Action Steps	Time Frame	Responsible	Benchmarks
Allocate funding/resources for cultural competence training.		Board of Directors/ Executive Director	Staff will be allowed a minimum of 6 hours per year for cultural competence training
Review and evaluate client demographics (i.e., gender, age, race, residency) to identify potential gaps in services and ensure that the Center is responding appropriately to access issues.		Board of Directors	The Board will review client demographics for CY 2015 compiled by the Executive Director
Review, evaluate and update CLC plan			The Board will conduct an annual review of the CLC Plan, determine whether action steps have been implemented, and update the Plan as necessary. The Executive Director will ensure that the current version of the CLC Plan is posted on the CAC webpage.

ADMINISTRATION/MANAGEMENT LEVEL

Role/Responsibility: Develop an organizational structure, administrative guidelines, and system of evaluation to ensure that services are effective, efficient, accessible, and of high quality.			
Action Steps	Time Frame	Responsible	Benchmarks
Assess/modify the physical facility to reflect the population, to be welcoming, clean, and attractive by providing cultural art, magazines, refreshments, etc.		Board of Directors and Executive Director	The Executive Director will conduct a semi-annual assessment of the facility to ensure that the facility is inviting to all people and respects the diversity of our clients. Elm City Center will purchase magazines, decorations, interview aids, etc. that reflect the needs and interests of the population served.
Assess the physical facility and make modifications, if necessary,		Board of Directors	The Executive Director will assess the facility on a semi-annual basis to ensure that the facility is accessible by persons with

to ensure that the facility is accessible by persons with disabilities			disabilities and will consult with plant staff to ensure that any identified modifications are completed.
Ensure that consumers and families have access to services in their language of choice.			Staff will enlist interpreters to ensure that interviews conducted at ECC are conducted in the person's language of choice and that the social history process is conducted in the caregiver(s)' language of choice. ECC staff will maintain a current list of language and sign-language interpreters.

PRACTITIONER LEVEL

Role/Responsibility: Work through and with the Multidisciplinary Team, families, and service providers to ensure that clients receive services which are responsive to and respectful of the family's racial and ethnic cultural traditions, beliefs, values, and preferred language and which increase the likelihood of engagement.			
Action Steps	Time Frame	Responsible	Benchmarks
Read CLC Plan and sign that the Plan is understood and that practices will be implemented within the designated time period.		Board of Directors/ Executive Director	The Executive Director will ensure that all existing staff read and acknowledge in writing any revisions to the CLC Plan within 1 month of adoption by the CAC Board.
Ensure that consumers, families, and guardians have a primary decision-making role in the development of their service plan. Ensure that the consumer's preference/needs are present in the plan.		Board of Directors	During the social history process, the Case Manager will inquire about the family's ethnic/cultural background/issues, language preferences, and will identify their natural and informal supports and document findings in the case file. The Case Manager will document this process in the client's case record
Develop a system of local providers, organizations, and other community supports.		Case Managers	The Case Manager will maintain a up to date library of community-based resources for assisting ECC clients through participation in trainings, support groups, public presentations, etc. The Case Manager will identify any materials requiring translation in order to be accessible to clients whose primary language is other than English.

Collect demographic data on clients served by the CAC		Case managers	Collect and enter data on race, ethnicity and primary language of individuals and families in case files and within the management information system

CONSUMER/CLIENT/INDIVIDUAL LEVEL

Role/Responsibility: Build the consumer voice in the overall implementation of culturally responsive practices.			
Action Steps	Time Frame	Responsible	Benchmarks
Parents/caregivers will be given an opportunity to provide feedback about ECC policies and procedures and to assist the ECC in evaluating services through completion of quarterly client satisfaction surveys.		Board of . Directors and Executive Director	Among other things, the client satisfaction survey will attempt to measure the client's perception of the cultural sensitivity of CAC services.

Part 1 - Linguistic and Cultural Competency Assessment (LCC Assessment)

The LCC Assessment is the first component of the Linguistic and Cultural Competency Plan. As of 2015, this is a requirement of DHS funded programs

Element 1: Assessment: Needs and Capacity

The following questions will guide organizations assessing their current capacity to provide meaningful access to services for persons with Limited English Proficient (LEP) or individuals with hearing, vision and speech disabilities.

Persons who are Limited English Proficient or "LEP" -do not speak English as their primary language and have a limited ability to read, speak, write, or understand English. These individuals may be entitled language assistance with respect to a particular type or service, benefit, or encounter.

The assessment should include the Four- Factor Analysis for LEP:

- Factor 1: The number or proportion of eligible LEP customers,
- Factor 2: The frequency of contact with LEP Customers,
- Factor 3: The importance or impact of the contact upon the lives of the person (s) served, and
- Factor 4: The resources available to the organization

1.1 Provider Background

Question	Response
1. What is the name of your organization?	Elm City Center Contact information: (Tom Frederick, 217-245-9504, tom.frederick@elmcity.org)
2. If this plan is a 'Master Plan' which is intended to cover more than one contract, Please list the sites and staff contact information that are part of this Master Plan	Sites covered include: Walnut Campus, Social center, CILAs at Appomatox, Shiloh, and Westfair, Group Home at Brooklyn
3. What is your organization's annual operating budget**?**	• Under $5,000,000.00
4. How many customers does your organization serve annually**?**	• Less than 500
5. How many people are employed by your organization	• 51-100

Factor 1: The number or proportion of eligible LEP custormers:

Question	Response
1. How many total LEP individuals are eligible to be served within your organizations' project area? (Eligible Service Area)	200
2. What are the top five primary languages used by individuals in your project or service area other than English?	• English • ALS • Spanish

Question	Response
	• French

Factor 2: The Frequency of contact with LEP Customers

Question	Response
1. Does your organization have a process for surveying, collecting and/or recording primary language data for individuals that participate in your programs and activities?	Survey comes through the database where we collect information on languages spoken
2. How many LEP individuals received service at your organization during the previous state fiscal year (for example- State FY 15 plan will include data collected in State FY14)	• 26-50
3. What are the primary languages of the individuals served at your organization during the previous state fiscal year (	• English • ALS

Factor 3: The importance or impact of the contact upon the lives of the person (s) served

Question	Response
1. List the types of services your organization provides**.**	• Developmental Training • Day Program • Residential • Employment

Factor 4: The Resources available to the organization

Question	Response
1. What are the resources needed at your organization that provides meaningful access for LEP persons?	• Several staff and consumers are fluent in ALS. None are certified at ALS. Their knowledge comes from daily activity and use. • Several consumers use versions of ASL that are unique to them.
2. Which of these resources are currently in place at your agency?	• TTY • Braille materials • Knowledgeable staff
3. Is there a staff member(s) in your organization assigned to coordinate/and or facilitate language access activities?	No, it is simply a part of our operations
4. What are the points of contact where an LEP person interacts with your organization?	• Telephone/Call Center • Reception/Front Desk • Intake/Referral • Case Management/Service Coordination • Customer Concerns/Appeals • TTY • Electronic Correspondence
5. How many direct service/front-line staff are employed at your agency that are bilingual? What are the languages?	• 5-6 staff ALS
6. Does your organization have a certification or assessment process that staff must complete before	No No

Question	Response
serving as interpreters for LEP individuals? Does this process include use of standardized language proficiency exams?	
7. Does your organization provide professional interpreter services?	• Staff are already employed
8. What interpreter services are available at your organization?	Direct service staff that are bilingual and have had their language proficiency assessed.
9. Although a Provider should not plan to rely on an LEP person's friends, family members to serve as informal interpreters' to provide interpretation services, are there instances when your agency permits the use of informal interpreters? Under what circumstances? If yes, what are your plans to change this practice?	We will use some help at start up, but will quickly move to staff as the primary communicators. We have no plans to change this process which has been in existence for many years.
10. Does your agency have any limitations of resources that negatively impact the provision of language assistance services?	• Limitation is the availability for interpreters. With Illinois College, MacMurray College, and Illinois School for the Deaf in Jacksonville, there has never been a shortage of interpreters is needed.
11. Does your agency offer printed materials in alternative formats?	• Braille • Large Print

1.2 Linguistic and Cultural Competence 'Master Plan'

Providers should have a linguistic and cultural competence 'Master Plan' for the funded program(s) or for the organization as a whole that includes clear goals, outcomes, policies and procedures related to the provision of culturally and linguistically appropriate services.

1. Provide a general description of your agency's short-term and long-term goals that are designed to improving service provision to LEP Customers, persons who are hard of hearing or Deaf, and persons with low literacy.

1.3 Policies and Procedures

See policies on Alternative Format for Documents; Language, Interpreters, and Methods of Communication; Cultural diversity; and Accommodation

Part II - Linguistic and Cultural Competency Plan (LCC Plan)

Elements 2 - 5: Address the Language Access Plan after completing the assessment. This is an implementation plan to address the identified needs of the LEP populations your agency serves. The written LCC plan should provide a framework for the provision of timely and reasonable language assistance. Documented in the LEP plan are language assistance services, and how staff and LEP persons can access those services.

Element 2: Language Assistance Services

The agency will provide language assistance services to ensure meaningful access to and an equal opportunity to participate fully in the services, activities, programs or other benefits administered by the agency.

2.1 On site Oral Bilingual staff

Elm City will provide Sign- Language assistance services to ensure meaningful access to and an equal opportunity to participate fully in the services, activities, programs or other benefits administered by the agency. There has been no specialized need for verbal interpretation services for many years.

2.2 On site American Sign Language Bilingual staff

Current Languages are focused on English and ASL which are the primary languages in Morgan County. We provided staff skilled in manual ASL for a person who is deaf/blind.

2.3 Personnel Strategies

The strategies used to recruit, retain, and promote at all levels, diverse personnel, and leadership are based on the population base of Morgan County which is overwhelmingly white, English speaking. ASL is a major other local language because Illinois School for the Deaf exists here.

2.4 Ongoing Education and Training

It is essential that members of the provider organization know the providers obligations to provide meaningful access to information and services for LEP persons. The LCC plan should include staff training to ensure that:

- Staff is aware and understands LEP policies and procedures.
- Staff that has contact with customers/clients is trained to work effectively with in-person and telephone interpreters.
- The more frequent the contact with LEP persons, the greater the need will be for in-depth training.

2.5 Frequency of Training and Education Programs

Once a year or as needed.

Element 3: Resources available to the Provider

3.1 Resources available to the Provider

Name of Organization: Elm City Center
Contact Person: Tom Frederick
Language(s)/Services : ALS

3.2 Designated staff will be trained to use of Video Phone and Next Talk

We do not have a video phone

3.3 Arranging/Requesting a Sign Language Interpreter

See policy on Language, Interpreters, and Methods of Communication.

3.4 Notification regarding the Availability of Language Assistance at No Cost

We have staff fluent in ALS. All services are included in the cost.

3.5 The organization should provide timely meaningful language assistance at key points of contact through the organization to receive services.

- Describe steps the provider has taken to provide timely meaningful language assistance at key points of contact through the organization to receive services. ASL fluent staff are available
- Initial Customer Contact: Describe the steps to assisting a LEP individual who seeks assistance in this area of the agency ASL fluent staff are available
- Intake and Referral: Describe the steps to assisting a LEP individual who seeks assistance in this area of the agency ASL fluent staff are available
- Case Management/Service Coordination: Describe the steps to assisting a LEP individual who seeks assistance in this area of the agency ASL fluent staff are available
- Customer Concerns, Appeals, and Grievances: Describe the steps to assisting a LEP individual who seeks assistance in this area of the agency ASL fluent staff are available

Element 4: Verbal and Written notice of right to receive Language Assistance services

Written Translations

Providers will identify, translate and make accessible in various formats, including print and electronic media, vital documents in languages other than English in accordance with assessments of need and capacity conducted under Element 1. Braille documents as translated by Illinois School for the Visually Impaired are available. Other written language texts have not been required, but could be made available through local interpreters.

4.1 List any consumer related materials, documents, and signage that are in languages of commonly encountered groups represented in the service area, including the languages in which the materials are available. Include any documents in ASL via video written ASL, or on the provider's website.

Document Name – Consumer manual - Braille

4.2 Quality Assurance of Translated documents

Describe the measures in place to verify the accuracy of translated documents. translated and printed by the Illinois School for the Visually Impaired

Element 5: Assessment: Access and Quality

For a provider to continue to be effective, the provider must periodically monitor, evaluate, and update the plan, policies and procedures.

In addition, creating a record of language assistance services can help inform programs whether there should be changes to the quantity or type of language assistance services. The monitoring and review of current policies and the types of language assistance services provided should occur on an annual basis.

5.1 What steps does your organization take to monitor the effectiveness of your Language and cultural competency plan?

We keep track of the languages used by consumers through the LAN database

5.2 Provide a description of data collection procedures used to assess language access needs.

Language information is collected in the LAN database

Self-Assessment Checklist for Personnel Providing Primary Health Care Services

Developed by: Tawara Goode, National Center for Cultural Competence, Georgetown University
Georgetown University Child Development Center-National Center for Cultural Competence

This checklist is intended to heighten the awareness and sensitivity of personnel to the importance of cultural and linguistic cultural competence in health and human service settings. It provides concrete examples of the kinds of beliefs, attitudes, values and practices, which foster cultural and linguistic competence at the individual or practitioner level.
DIRECTIONS: Select A, B, or C for each item listed below.
A = Things I do frequently
B = Things I do occasionally
C = Things I do rarely or never

Target Group Healthcare workers

Purpose
1. To increase individual awareness of practices, beliefs, attitudes and values that promotes and hinders cultural and linguistic competence in the delivery of health care.
2. To identify training needs.

PHYSICAL ENVIRONMENT, MATERIALS & RESOURCES

____ 1. I display pictures, posters, artwork and other décor that reflect the cultures and ethnic backgrounds of clients served by my program or agency.

____ 2. I insure that magazines, brochures, and other printed materials in reception areas are of interest to and reflect the different cultures of individuals and families served by my program or agency.

____ 3. When using videos, films or other media resources for health education, treatment or other interventions, I insure that they reflect the cultures and ethnic background of individuals and families served by my program or agency.

____ 4. I insure that printed information disseminated by my agency or program takes into account the average literacy levels of individuals and families receiving services.

COMMUNICATION STYLES

5. When interacting with individuals and families who have limited English proficiency I always keep in mind that:

____ • limitations in English proficiency is in no way a reflection of their level of intellectual functioning.

____ • their limited ability to speak the language of the dominant culture has no bearing on their ability to communicate effectively in their language of origin

____ • they may or may not be literate in their language of origin or English.

____ 6. I use bilingual-bicultural staff and/or personnel and volunteers skilled or certified in the provision of medical interpretation during treatment, interventions, meetings or other events for individuals and families who need or prefer this level of assistance.

____ 7. For individuals and families who speak languages or dialects other than English, I attempt to learn and use key words in their language so that I am better able to communicate with them during assessment, treatment or other interventions.

____ 8. I attempt to determine any familial colloquialisms used by individuals or families that may impact on assessment, treatment or other interventions.

____ 9. When possible, I insure that all notices and communiqués to individuals and families are written in their language of origin.

____ 10. I understand that it may be necessary to use alternatives to written communications for some individuals and families, as word of mouth may be a preferred method.

VALUES & ATTITUDES

____ 11. I avoid imposing values which may conflict or be inconsistent with those of cultures or ethnic groups other than my own.

____ 12. I screen books, movies, and other media resources for negative cultural, ethnic, or racial stereotypes before sharing them with individuals and families served by my program or agency.

____ 13. I intervene in an appropriate manner when I observe other staff or clients within my program or agency engaging in behaviors which show cultural insensitivity, racial biases andprejudice.

____ 14. I recognize and accept that individuals from culturally diverse backgrounds may desire varying degrees of acculturation into the dominant culture.

____ 15. I understand and accept that family is defined differently by different cultures (e.g. extended family people, fictive kin, godparents).

____ 16. I accept and respect that male-female roles may vary significantly among different cultures and ethic groups (e.g. who makes major decisions for the family).

____ 17. I understand that age and life cycle factors must be considered in interactions with individuals and families (e.g. high value placed on the decision of elders, the role of eldest male or female in families, or roles and expectation of children within the family).

____ 18. Even though my professional or moral viewpoints may differ, I accept individuals and families as the ultimate decision makers for services and supports impacting their lives.

____ 19. I recognize that the meaning or value of medical treatment and health education may vary greatly among cultures.

____ 20. I accept that religion and other beliefs may influence how individuals and families respond to illnesses, disease, and death.

____ 21. I understand that the perception of health, wellness and preventive health services have different meanings to different cultural or ethnic groups.

____ 22. I recognize and accept that folk and religious beliefs may influence an individual's or family's reaction and approach to a child born with a disability, or later diagnosed with a disability, genetic disorder, or special health care needs.

____ 23. I understand that grief and bereavement are influenced by culture.

____ 24. I seek information from individuals, families or other key community informants that will assist in service adaptation to respond to the needs and preferences of culturally and ethnically diverse groups served by my program or agency.

____ 25. Before visiting or providing services in the home setting, I seek information on acceptable behaviors, courtesies, customs, and expectations that are unique to the culturally and ethnically diverse groups served by my program or agency.

____ 26. I keep abreast of the major health concerns and issues for ethnically and racially diverse client populations residing in the geographic locale served by my program or agency.

____ 27. I am aware of the socio-economic and environmental risk factors that contribute to the major health problems of culturally, ethnically and racially diverse populations served by my program or agency.

____ 28. I am well versed in the most current and proven practices, treatments and interventions for major health problems among ethnically and racially diverse groups within the geographic locale served by my agency or program.

____ 29. I avail myself to professional development and training to enhance my knowledge and skills in the provision of services and supports to culturally, ethnically, racially and linguistically diverse groups.

____ 30. I advocate for the review of my program's or agency's mission statement, goals, policies, and procedures to insure that they incorporate principles and practices that promote cultural and linguistic competence.

There is no answer key with correct responses. However, if you frequently responded "C", you may not necessarily demonstrate beliefs, attitudes, values and practices that promote cultural and linguistic competence within health care delivery programs.

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The creation of this document has shamelessly borrowed ideas and text from a variety of very good documents readily available on line. We want to thank them for making their material available. If a reader finds something in this plan that meets their needs, please use what meets your need.

- Illinois Department of Human Services: 'FY15 Linguistic and Cultural Competency Guidelines and Assurances', https://www.dhs.state.il.us/page.aspx?item=66602
- Oregon Department of Human services, "Cultural Competency and Diversity at DHS, Valuing, Embracing, and Implementing – Tools for Managers", http://www.dhs.state.or.us/tools/diversity/tools/cctools-managers.pdf
- California Department of Mental Health, "Cultural Competence Plan Requirements", Office of Multicultural Services, Sacramento Ca, http://www.dmh.ca.gov/Multicultural_Services/docs/10-2_Enclosure1.pdf
- Champaign County Children's Advocacy Center, "Cultural and Linquistic Competence Plan", http://www.co.champaign.il.us/CAC/cultplan.pdf
- Avesis, "Cultural Competency Program", http://www.avesis.com/pdf/cultural_competency.pdf
- Sunshine State Health Plan, " 2011 Cultural Competency Plan, http://www.sunshinestatehealth.com/files/2011/11/2011-Cultural-Comptency-09-03-10.pdf
- Association for the Study and Development of Community for non-profits and public agencies in Howard County, Maryland, "Tips for working in a Culturally Competent Manner", http://www.firnonline.org/FIRNDoc/TipsforBuildingCultural%20Competence.pdf

The following websites offer information, examples and other resources that may be helpful in our work:

- The Society of Human Resource Management **www.shrm.org**
- National Center for Cultural Competence **nccc.georgetown.edu**
- U.S. Department of Health and Human Services **www.hrsa.gov/culturalcompetence/index.html**
- Office of Minority Health, U.S. Department of Health and Human Services **www.thinkculturalhealth.hhs.gov**
- Human Rights Campaign **www.hrc.org/resources/entry/lgbt-cultural-competence**
- http://www11.georgetown.edu/research/gucchd/nccc/ The National Center for Cultural Competence at Georgetown University increases the capacity of health care and mental health programs to design, implement and evaluate culturally and linguistically competent service delivery systems. Publications and web links available. The Cultural Competence Exchange includes success stories like this "Journey towards Cultural Competence" example from Wisconsin
- http://www.peacecorps.gov/wws/educators/enrichment/culturematters/index.html Culture Matters is a cross-cultural training workbook developed by the Peace Corps to help new volunteers acquire the knowledge and skills to work successfully and respectfully in other cultures.
- http://www.edchange.org/multicultural/ The Multicultural Pavilion offers resources and dialogue for educators, students and activists on all aspects of multicultural education.
- http://www.clas.uiuc.edu/ The Center for Culturally and Linguistically Appropriate Services collects and describes early childhood/early intervention resources and serves as point of exchange for users.
- http://ericae.net/faqs/Cognitive_Styles/Cognitive_styles.htm Information on different learning styles, possibly another dimension in understanding an individual's culture. Provided by ERIC (Educational Resources Information Center) Clearinghouse on Assessment and Evaluation at the University of Maryland.