

Nebraska Infant Mortality COIIN SDOH Learning Network
1/23/21017

Project Title: Assessment Tools for Organizations in the Areas of Culturally- and Linguistically-Appropriate Services, Trauma-Informed Care, Health Literacy, and Equity

Objectives:

- a) Collect at least two examples of assessment tools in the public domain that either provide or are easily adaptable to measurement in organizations.
- b) Assess examples for usability and applicability.
- c) If appropriate, select and suggest assessment tools for small-scale PDSA testing.

Results:

CLAS ASSESSMENT

NE DHHS OHDHE CLAS Self-Assessment Survey

<https://www.surveymonkey.com/r/DX3K22N?sm=XsTpAO8HmXOAHxqxilAIUg%3d%3d>

NE DHHS OHDHE CLAS Client Satisfaction Survey

<http://dhhs.ne.gov/publichealth/Documents/OHDHE%20-%20CLAS%20Client%20Satisfaction%20Survey%202%20DB.pdf>

Massachusetts state public health CLAS assessment tool (*Attachment 1*)

http://www.mass.gov/eohhs/searchresults.html?output=xml_no_dtd&client=mg_eohhs&proxystylesheet=mass.gov&getfields=* &ie=UTF-8&oe=UTF-8&tlen=215&sitefolder=eohhs&filter=0&requiredfields=&startsite=EOHHSx&q=CLAS+assessment&site=EOHHSx&x=0&y=0

NE COIIN SDOH CLAS PDSA Assessment Tool (*Attachment 2*)

A Summary of Awareness, Knowledge, Adoption and Implementation of the National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health and Health Care at NE Department of Health and Human Services. (August 2016) (*Attachment 3*)

<http://dhhs.ne.gov/publichealth/MCAH/Pages/Infant-Mortality-COIIN-SDOH.aspx>

TRAUMA INFORMED CARE

The Trauma Informed Care Project Trauma Informed Organizational Self-Assessment (*Attachment 4*)

<http://www.traumainformedcareproject.org/>

Trauma-Informed Organizational Capacity Scale (TIC Scale) (*Attachment 5*)

<http://www.air.org/resource/trauma-informed-organizational-capacity-scale>

HEALTH LITERACY

Ten Attributes of Health Literate Health Care Organizations (*Attachment 6*)

https://nam.edu/wp-content/uploads/2015/06/BPH_Ten_HLit_Attributes.pdf

Health Literacy, the Newest Vital Sign (*Attachment 7*)

http://www.pfizer.com/health/literacy/healthcare_professionals/public_policy_researchers/current_research_in_health_literacy

http://www.pfizer.com/health/literacy/public_policy_researchers/nvs_toolkit

EQUITY PRACTICES

State Health Department Organizational Self-Assessment for Achieving Health Equity (*Attachment 8*)

http://barhii.org/download/toolkit/nacdd_he_toolkit.pdf

Foundational Practices for Health Equity: A Learning and Action Tool for State Health Departments (*Attachment 9*)

http://healthimpactcc.org/wp-content/uploads/2016/08/DRAFT-Health-Equity-Learning-and-Action-Tool_HRSA-COIN.pdf

From the National CoIIN SDOH Learning Network: Assessing Readiness for Change. The Organizational Change Recipients' Beliefs Scale (OCRBS). (*Attachment 10*)

(Bonus) Related to Next CoIIN SDOH meeting on Health Equity in All Policies

Australasian Collaborative for Health Impact Assessment (ACHIA). Equity Focused Health Impact Assessment Framework. (2004). http://hiacconnect.edu.au/old/files/EFHIA_Framework.pdf

(Bonus) ASSESSING SOCIAL DETERMINANTS OF HEALTH

Measuring What Works to Achieve Health Equity: Metrics for the Determinants of Health (*Attachment 11*)

<https://www.preventioninstitute.org/>

Michigan Health Equity Status Report: Focus on Maternal and Child Health (*Attachment 12*)

<http://prime.mihealth.org/files/2013-11-05/HE.Status.Rpt.2013.pdf>

Suggested for Discussion:

1. Which assessment(s) do you think has/have highest priority in motivating and improving health equity practices in organizations?
2. Do you think it is important to apply metrics (numerical value representing quantitative or qualitative progress and trends in relation to identified goal)? Why or Why Not?
3. What is missing from these assessment tools?
4. Do you think any of the assessment instruments are worthy of testing in organizations? If so, which, and why?
5. Discuss the level or type of organization or operations (state public health, local public health, provider, human resources/workforce, business relationships) of interest for assessment.



CLAS Self Assessment Tool

The following questions are designed to help programs identify their own challenges and goals and develop a work plan with concrete tasks to achieve or address them and using basic elements of Culturally and Linguistically Appropriate Services (CLAS) standards. DPH considers CLAS work to be an ongoing improvement project. Your contract manager will help support your efforts to implement CLAS as part of your contractual expectations, and will monitor continuous improvement based on your program's self assessment and proposed work plan.

Organization

Organization Name: []

Address:

[]

[]

City: [], State: [] Zip: []

Contact Person for CLAS Implementation

First Name: [] Last Name: []

Title: []

Telephone: () - E-Mail: []

Culturally Competent Leadership and Workforce

1. Does your program **recruit, retain, and promote** staff that reflects the cultural diversity of the community? (*CLAS Standard 3*) **Check one.**
 - Our staff fully reflects the cultural diversity of our community.
 - Our staff partially reflects the cultural diversity of our community.
 - Our program staff does not currently reflect the cultural diversity of our community.
2. Does your program have **written policies and procedures** that support recruitment, retention, training and promotion practices? (*CLAS Standard 2*) **Check one.**
 - All Our staff are aware of / universally trained on them.
 - Not all our staff are aware of / universally trained on them.
 - Our program does not currently have written policies and procedures that support these diversity practices.
3. Do program staff members at all levels and disciplines receive **training** in culturally- and linguistically-appropriate service delivery? (*CLAS Standard 4*) **Check ALL that apply.**
 - Training is provided to staff as standard part of orientation for new hires at all levels and disciplines.
 - Training is provided at least once a year to staff at all levels and disciplines.
 - Training is provided, but not in a standardized / routine manner.
 - Our program does not currently provide this training.

Language Access / Communication

4. Does your program provide **timely professional interpreter** services, at no cost, to all Limited English Proficiency (LEP) clients, including those clients who use American Sign Language? (*CLAS Standard 5, Federal mandate*) **Check one.**
 - Always
 - Most of the time
 - Sometimes
 - Our program does not currently provide timely professional interpreter services.

13. Does your program use REL **client** data to help design, deliver and evaluate program services? (*CLAS Standard 11*) **Check one.**
- REL client data always used to design/deliver program services
- REL community data used most of the time to design/deliver program services
- REL client data sometimes used to design/deliver program services
- REL client data never used to design/deliver program services
14. Does your program **participate in partnerships** with other agencies that target the diverse cultural groups in your service area/population? (*CLAS Standard 13*) **Check one.**
- Our program participates in partnerships with other agencies that target all of the diverse cultural groups in our service area/population.
- Our program participates in partnerships with other agencies that target some of the diverse cultural groups in our service area/population.
- Our program does not currently participate in partnerships with other agencies that target the diverse cultural groups in our service area/population.
15. Have you used the *Making CLAS Happen* manual? (An electronic version of the manual is posted on the DPH Office of Health Equity's website: www.mass.gov/dph/healthequity)
- Yes
- No, not yet

Work Plan

Think of the area most meaningful or relevant to your program's goals and challenges. Select one or more of the questions above and briefly describe what you will do to improve your CLAS efforts this year. Activities/workplans should be realistic and attainable, appropriate to your program/staff capacity. Your DPH contract manager will review, monitor and support your efforts. The DPH CLAS manager is available to provide technical assistance—call 617-994-9806 or email: rodrigo.monterrey@state.ma.us.

Identify a current challenge or goal of your program:

List current challenge or goal here. Text limit approx. 4 paragraphs. (Example: Increasing HPV vaccination rates among boys 11-21 y.o. at school-based health center)

Which question number(s) from above relate(s) to that challenge or goal: [(Example: 7, 8, 12 and 13)]

What will you do to address or achieve your challenge or goal through CLAS?

List activities here. Text limit approx. 4 paragraphs. (Example: find and disseminate HPV information materials designed specifically for boys 11-21 y.o. in different languages)

How will you measure progress in addressing or achieving your identified challenge or goal?

List your measures here. Text limit approx. 2 paragraphs. (Example: HPV-series completion rates among boys 11-21 y.o., number of materials distributed, follow-up questions regarding materials at time of intervention)

What impact on health outcomes do you expect as a result of these activities?

List desired impact here. Text limit approx. 2 paragraphs. (Example: reducing rates of HPV infection and HPV-related cancer)

March 28, 2016

Dear Colleague:

Thank you for participating in this rapid-cycle quality improvement activity, also known as Plan-Do-Study-Act, or PDSA. This particular activity looks at the implementation of CLAS standards, Culturally- and Linguistically-Appropriate Services, in health and human services. Thank you for participating in CLAS PDSA #1, which looks at state-level contract managers and implementation of CLAS through Requests for Applications, contracts, or other subrecipient agreements. Results will be reported in short summary form only, without any personal identifiers of individual, unit, or division, and will be used primarily for planning the next cycle of PDSA.

You will be identified only as 1A.

This project is conducted on behalf of the Nebraska CoIIN, which is the Collaboration and Innovation Implementation Network, to reduce infant mortality in our state. A small group of the CoIIN is working with the World Health Organization's framework of strategies to address the social determinants of health disparities. We thank you for participating these efforts. For more information, please contact me.

Sincerely,

Kathy Karsting, RN, MPH
Program Manager, Maternal Child Adolescent Health
kathy.karsting@nebraska.gov
402-471-0160

Attached:

CLAS PDSA Instructions for Participants
Baseline Data Collection
CLAS Self-Assessment Tool
CLAS Education Information

**CLAS PSDA #1
Baseline Data Collection**

Respondent: 1A
Date Completed: _____

1. Have you previously been provided orientation or training on CLAS implementation? (Includes materials to review, training activities). If yes, please briefly describe:
2. Do you presently work with policies or procedures, contract language, or other organizational expectations, related to CLAS?
3. On a scale of 1 (low) to 5 (high), to what extent do you think you are in the position to influence how subrecipients and local service agencies address the needs of diverse populations?
4. In agreements you manage, is the subrecipient prompted to identify the language, culture, literacy, disability, and/or trauma needs of individuals provided services?
5. In your work setting, are data routinely collected on the race, ethnicity, language, literacy, or need for accommodations due to disability among persons receiving services?
6. If CLAS topics are in subrecipient agreements you manage, to what extent on a scale of 1 (little, none) to 5 (high, active monitoring) do your subrecipient monitoring activities include a focus on CLAS?

*Please review Educational Piece, and Complete the CLAS self-assessment score sheet.
Return this page and score sheet to Kathy Karsting.
Thank You!*

CLASS PDSA #1
Educational Option and CLAS Priority

Respondent: 1A
Date Completed: _____

After completing baseline data collection, we ask you to carry out one of two educational options to refresh or update your knowledge of CLAS standards. Below, please indicate the educational option you select and complete. After completing the educational option, please tell us what you think is the most important aspect of CLAS implementation.

OPTION 1:

View a 22-minute video on CLAS standards and language considerations, "A Primer on Communication and Language Assistance," found at: https://www.thinkculturalhealth.hhs.gov/GUIs/GUI_Webinar.asp?id=10

OPTION 2:

Read a two-page fact sheet about CLAS standards, available at:
<https://www.thinkculturalhealth.hhs.gov/pdfs/NationalCLASStandardsFactSheet.pdf>

OPTION 3:

Read the Executive Summary for national CLAS standards, available at:
https://www.thinkculturalhealth.hhs.gov/CLAS/Clas_Overview.asp

PLEASE COMPLETE:

I selected Option _____ and completed on (date) _____.

In 2-3 sentences, what do you think is the most important aspect of CLAS implementation:



**A Summary of Awareness, Knowledge, Adoption, and
Implementation of the
*National Standards for Culturally and Linguistically
Appropriate Services (CLAS) in Health and Health Care*
at
Nebraska Department of Health and Human Services**

August 2016

Prepared for:
Nebraska Department of Health and Human
Services (DHHS)
301 Centennial Mall South, PO Box 95026
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Prepared by:
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Guide to Completing the Agency Self-Assessment

Purpose

The Agency Self-Assessment for Trauma-Informed Care is intended to be a tool that will help you assess your organization's readiness to implement a trauma-informed approach. Honest and candid staff responses can benefit your agency by helping to identify opportunities for program and environmental change, assist in professional development planning, and can be used to inform organizational policy change.

How to Complete the Agency Self-Assessment

The *Self-Assessment* is organized into five main "domains" or areas of programming to be examined:

- Supporting Staff Development
- Creating a Safe and Supportive Environment
- Assessing and Planning Services
- Involving Consumers
- Adapting Policies

Agency staff completing the *Self-Assessment* are asked to read through each item and use the scale ranging from "strongly disagree" to "strongly agree" to evaluate the extent to which they agree that their agency incorporates each practice into daily programming. Staff members are asked to answer based on their experience in the program over the past twelve months.

Responses to the *Self-Assessment* items should remain anonymous and staff should be encouraged to answer with their initial impression of the question as honestly and accurately as possible. Remember, staff members are not evaluating their individual performance, but rather, the practice of the agency as a whole. Staff should complete the *Self-Assessment* when they have ample time to consider their responses; this may be completed in one sitting or section-by-section if time does not allow.

Agencies may distribute the tool in either Word or Excel format. Some agencies may prefer to use an electronic method (such as Survey Monkey) to assist with data collection and analysis.

How to Compile and Examine Self-Assessment Results

It is helpful for the agency to have a designated point person to collect completed assessments and compile the results. Detailed suggestions and The "Toolkit" are on the Trauma Informed Care Website <http://www.traumainformedcareproject.org/>

To identify potential areas for change, look for statements where staff responses are mostly "strongly disagree" and "disagree"; these are the practices that could be strengthened. In addition, pay attention to those responding with "do not know" as this could indicate that the practice is lacking, or perhaps there is a need for additional information or clarification. Finally, it is helpful to examine items where the range of responses is extremely varied. This lack of consistency among staff responses may be due to a lack of understanding about an item itself, a difference of perspective based on a person's role in the agency, or a misunderstanding on the part of some staff members about what is actually done on a daily basis.

This instrument was created by Orchard Place/Child Guidance Center's Trauma Informed Care Project, adapted from the National Center on Family Homelessness Trauma-Informed Organizational Self-Assessment and "Creating Cultures of Trauma-Informed Care: A Self Assessment and Planning Protocol" article by Roger D. Fallot, Ph.D. & Maxine Harris, Ph.D.

Trauma-Informed Organizational Self-Assessment

Please complete the assessment, reading each item and rating from strongly disagree to strongly agree based on your experience in the organization over the last year. Use your initial impression: **Remember you are evaluating the agency not your individual performance.**

Agency/Program: _____

Today's Date: _____

Name of Staff (optional): _____

I. Supporting Staff Development

A. Training and Education	Strongly Disagree	Disagree	Agree	Strongly Agree	Do Not Know	Not applicable to my role
Staff at all levels of the program receive training and education on the following topics:						
1 What traumatic stress is.						
2 How traumatic stress affects the brain and body.						
3 The relationship between mental health and trauma.						
4 The relationship between substance use and trauma.						
5 The relationship between homelessness and trauma.						
6 How trauma affects a child's development.						
7 How trauma affects a child's attachment to his/her caregivers.						
8 The relationship between childhood trauma and adult re-victimization (e.g. domestic violence, sexual assault).						
9 Different cultural issues (e.g. different cultural practices, beliefs, rituals).						
10 Cultural differences in how people understand and respond to trauma.						
11 How working with trauma survivors impacts staff.						
12 How to help consumers identify triggers (i.e. reminders of dangerous or frightening things that have happened in the past)						
13 How to help consumers manage their feelings (e.g. helplessness, rage, sadness, terror)						
14 De-escalation strategies (i.e. ways to help people to calm down before reaching the point of crisis)						
15 How to develop safety and crisis prevention plans.						
16 What is asked in the intake assessment.						
17 How to establish and maintain healthy professional boundaries.						

B. Staff Supervision, Support and Self-Care		Strongly Disagree	Disagree	Agree	Strongly Agree	Do Not Know	Not applicable to my role
18	Staff members have regular team meetings.						
19	Topics related to trauma are addressed in team meetings.						
20	Topics related to self-care are addressed in team meetings (e.g. vicarious trauma, burn-out, stress-reducing strategies).						
21	Staff members have a regularly scheduled time for individual supervision.						
22	Staff members receive individual supervision from a supervisor who is trained in understanding trauma.						
23	Part of supervision time is used to help staff members understand their own stress reactions.						
24	Part of supervision time is used to help staff members understand how their stress reactions impact their work with consumers.						
25	The agency helps staff members debrief after a crisis.						
26	The agency has a formal system for reviewing staff performance.						
27	The agency provides opportunities for on-going staff evaluation of the program/agency.						
28	The agency provides opportunities for staff input into program practices.						
29	Outside consultants with expertise in trauma provide on-going education and consultation.						

II. Creating a Safe and Supportive Environment

A. Establishing a Safe Physical Environment		Strongly Disagree	Disagree	Agree	Strongly Agree	Do Not Know	Not applicable to my role
1	Agency staff monitors who is coming in and out of the program/agency.						
2	Staff members ask consumers for their definitions of physical safety.						
3	The environment outside the organization is well lit.						
4	The common areas within the organization are well lit.						
5	Bathrooms are well lit.						
6	Consumers can lock bathroom doors.						

**A. Establishing a Safe Physical Environment
Continued**

		Strongly Disagree	Disagree	Agree	Strongly Agree	Do Not Know	Not applicable to my role
7	The organization incorporates child-friendly decorations and materials.						
8	The organization provides a space for children to play.						
9	The organization provides consumers with opportunities to make suggestions about ways to improve/change the physical space.						

B. Establishing a Supportive Environment

		Strongly Disagree	Disagree	Agree	Strongly Agree	Do Not Know	Not applicable to my role
Information Sharing							
10	The organization reviews rules, rights and grievance procedures with consumers regularly.						
11	Consumers are informed about how the program responds to personal crises (e.g. suicidal statements, violent behavior and mandatory reports).						
12	Consumer rights are posted in places that are visible (e.g. room checks, grievance policies, mandatory reporting rules).						
13	Materials are posted about traumatic stress (e.g. what it is, how it impacts people, and available trauma-specific resources).						
Cultural Competence							
14	Program information is available in different languages.						
15	Staff &/or consumers are allowed to speak their native languages within the agency.						
16	Staff &/or consumers are allowed to prepare or have ethnic-specific foods.						
17	Staff shows acceptance for personal religious or spiritual practices.						
18	Outside agencies with expertise in cultural competence provide on-going training and consultation.						
Privacy and Confidentiality							
19	The agency informs consumers about the extent and limits of privacy and confidentiality (kinds of records kept, where/who has access, when obligated to make report to police/child welfare).						
20	Staff and other professionals do not talk about consumers in common spaces.						

		Strongly Disagree	Disagree	Agree	Strongly Agree	Do Not Know	Not applicable to my role
Privacy and Confidentiality Continued							
21	Staff does not talk about consumers outside of the agency unless at appropriate meetings.						
22	Staff does not discuss the personal issues of one consumer with another consumer.						
23	Consumers who have violated rules are approached in private.						
24	There are private spaces for staff and consumers to discuss personal issues.						
Safety and Crisis Prevention Planning							
For the following item, the term "safety plan" is defined as a plan for what a consumer and staff members will do if the consumer feels threatened by another person outside of the program.							
25	Written safety plans are incorporated into consumers' individual goals and plans.						
For the following item, the term "crisis-prevention plan" is defined as an individualized plan for how to help each consumer manage stress and feel supported.							
26	Each consumer has a written crisis prevention plan which includes a list of triggers, strategies and responses which are helpful and those that are not helpful and a list of persons the consumer can go to for support.						
Open and Respectful Communication							
27	Staff members ask consumers for their definitions of emotional safety.						
28	Staff members practice motivational interviewing techniques with consumers (e.g. open-ended questions, affirmations, and reflective listening).						
29	The agency uses "people first" language rather than labels (e.g. 'people who are experiencing homelessness' rather than 'homeless people').						
30	Staff uses descriptive language rather than characterizing terms to describe consumers (e.g. describing a person as 'having a hard time getting her needs met' rather than 'attention seeking').						
Consistency and Predictability							
31	The organization has regularly scheduled procedures/opportunities for consumers to provide input.						
32	The organization has policy in place to handle any changes in schedules.						
33	The program is flexible with procedures if needed, based on individual circumstances.						

III. Assessing and Planning Services

A. Conducting Intake Assessments	Strongly Disagree	Disagree	Agree	Strongly Agree	Do Not Know	Not applicable to my role
The intake assessment includes questions about:						
1 Personal strengths.						
2 Cultural background.						
3 Cultural strengths (e.g. world view, role of spirituality, cultural connections).						
4 Social supports in the family and the community.						
5 Current level of danger from other people (e.g. restraining orders, history of domestic violence, threats from others).						
6 History of trauma (e.g. physical, emotional or sexual abuse, neglect, loss, domestic/community violence, combat, past homelessness).						
7 Previous head injury.						
8 Quality of relationship with child or children (i.e. caregiver/child attachment)						
9 Children's trauma exposure (e.g. neglect, abuse, exposure to violence)						
10 Children's achievement of developmental tasks.						
11 Children's history of mental health issues.						
12 Children's history of physical health issues.						
Intake Assessment Process						
13 There are private, confidential spaces available to conduct intake assessments.						
14 The program informs consumers about why questions are being asked.						
15 The program informs consumers about what will be shared with others and why.						
16 Throughout the assessment process, the program staff observes consumers on how they are doing and responds appropriately.						
17 The program provides an adult translator for the assessment process if needed.						

Intake Assessment Follow-Up							
18	Based on the intake assessment, adults &/or children are referred for specific services as necessary.						
19	Re-assessments are done on an on-going and consistent basis.						
20	The program updates releases and consent forms whenever it is necessary to speak with a new provider.						
B. Developing Goals and Plans							
21	Staff collaborates with consumers in setting their goals.						
22	Consumer goals are reviewed and updated regularly.						
23	Before leaving the program, consumers and staff develop a plan to address any future needs.						
C. Offering Services and Trauma-Specific Interventions							
24	The program provides opportunities for care coordination for services not provided within that organization.						
25	The program educates consumers about traumatic stress and triggers.						
26	The program has access to a clinician with expertise in trauma and trauma-related interventions (on-staff or available for regular consultation).						

IV. Involving Consumers

A. Involving Current and Former Consumers		Strongly Disagree	Disagree	Agree	Strongly Agree	Do Not Know	Not applicable to my role
1	Current consumers are given opportunities to evaluate the program and offer their suggestions for improvement in anonymous and/or confidential ways (e.g. suggestion boxes, regular satisfaction surveys, meetings focused on necessary improvements, etc)						
2	The program recruits former consumers to serve in an advisory capacity.						
3	Former consumers are invited to share their thoughts, ideas and experiences with the program.						

V. Adapting Policies

A. Creating Written Policies		Strongly Disagree	Disagree	Agree	Strongly Agree	Do Not Know	Not applicable to my role
1	The program has a written statement that includes a commitment to understanding trauma and engaging in trauma-sensitive practices.						
2	Written policies are established based on an understanding of the impact of trauma on consumers and providers.						
3	The program has a written commitment to demonstrating respect for cultural differences and practices.						
4	The program has written policy to address potential threats to consumers and staff from natural or man-made threats (fire, tornado, bomb threat, and hostile intruder).						
5	The program has a written policy outlining program responses to consumer crisis/staff crisis (i.e. Self harm, suicidal thinking, and aggression towards others).						
6	The program has written policies outlining professional conduct for staff (e.g. boundaries, responses to consumers, etc).						
B. Reviewing Policies							
1	The program reviews its policies on a regular basis to identify whether they are sensitive to the needs of trauma survivors.						
2	The program involves staff in its review of policies.						
3	The program involves consumers in its review of policies.						

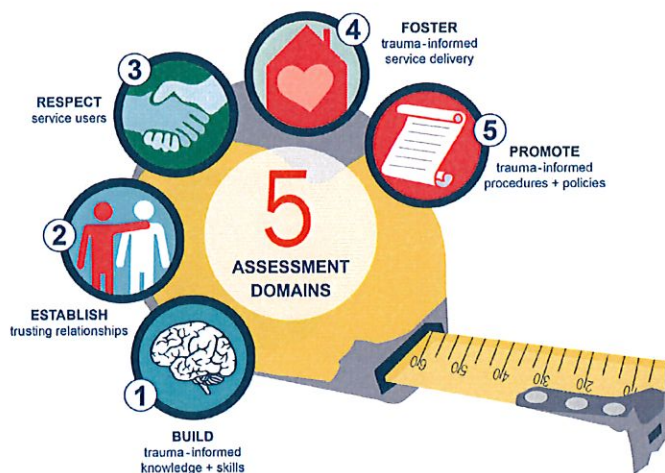


Trauma-Informed Organizational Capacity Scale (TIC Scale)

An Agency-Wide Assessment

What is the TIC Scale?

The Trauma-Informed Organizational Capacity Scale (TIC Scale)* is the first brief, psychometrically validated instrument to measure organizational trauma-informed care across health and human service settings. The TIC Scale includes 35 items across five domains: 1) Build trauma-informed knowledge and skills; 2) Establish trusting relationships; 3) Respect service users; 4) Foster trauma-informed service delivery; and 5) Promote trauma-informed procedures and policies. Items represent the strongest indicators of trauma-informed care based on a sample of 424 respondents representing 68 human service agencies including behavioral health, housing and homelessness, child welfare, domestic violence, and community health and hospitals. The TIC Scale provides scores for each domain and an overall score.



Why Use the TIC Scale?

Exposure to trauma is common among children, youth, and adults in health and human service settings. Service systems must be prepared to identify and address trauma that, if ignored, can impact quality of care, degree of trust in providers, service use, and ultimately, health outcomes. Organizational trauma-informed care is a system-wide approach to addressing trauma that ensures the entire service delivery system is grounded in an awareness and understanding of trauma and its impact and designed to foster healing and resilience for everyone in the system. All dimensions of an organization – mission, culture, and practice – are aligned to support wellbeing and success and lessen the detrimental effects of trauma on individuals, communities, and organizations.

The TIC Scale provides an unprecedented opportunity for health and human service organizations to measure the extent to which they provide trauma-informed care agency-wide at single point in time or repeatedly to assess for changes in level of trauma-informed care. The tool provides a common definition and measure of organizational trauma-informed care for a wide range of service systems.

How Do You Use the TIC Scale?

The TIC Scale is administered online and takes approximately 15 minutes to complete. The tool may be completed by all staff at all levels and across all programs or departments within an organization. To accurately assess an organization's degree of adoption, we encourage organizations to ensure that as many staff as possible completes the TIC Scale. Staff members are asked to rate the extent to which they agree that their organization incorporates each of the measure's 35 items.

Organizations can use the TIC Scale to:

- Determine their baseline for organization-wide trauma-informed care;
- Target strategic planning and professional development activities;
- Monitor change over time; and
- Assess whether improvements in organizational trauma-informed care influence success for service users.

The TIC Scale can be administered across health and human service agencies as a common measure of trauma-informed care. Individual organizational scores can be analyzed collectively to determine the extent to which a larger system is trauma-informed.

The American Institutes for Research (AIR) provides organizations and systems access to the instrument, a comprehensive analysis of results tailored to each organization or system, and consultation to review results and next steps. AIR believes that the TIC Scale represents one aspect of a larger change process. Our expert staff is available to support organizations in assessing and implementing organizational trauma-informed care. If you are interested in additional information about the TIC Scale and our training and technical assistance in this area please contact:

Kathleen Guarino at kguarino@air.org

Learn more about AIR's Framework for Building Trauma-Informed Organizations and Systems at <http://www.air.org/resource/framework-building-trauma-informed-organizations-and-systems>.

*AIR served as sole funder in the development of the Trauma-Informed Organizational Capacity Scale with the Center for Social Innovation and leveraged its prior work, served on the expert panel, provided methodological expertise, and acted in an advisory capacity. AIR shares distribution rights to the instrument with the Center for Social Innovation where the tool is also known by the name "TICOMETER".

Ten Attributes of Health Literate Health Care Organizations

Cindy Brach, Debra Keller, Lyla M. Hernandez, Cynthia Baur, Ruth Parker, Benard Dreyer, Paul Schyve, Andrew J. Lemerise, and Dean Schillinger*

June 2012

THE ATTRIBUTES

A health literate health care organization (see Figures 1A and 1B):

1. Has leadership that makes health literacy integral to its mission, structure, and operations.
2. Integrates health literacy into planning, evaluation measures, patient safety, and quality improvement.
3. Prepares the workforce to be health literate and monitors progress.
4. Includes populations served in the design, implementation, and evaluation of health information and services.
5. Meets the needs of populations with a range of health literacy skills while avoiding stigmatization.
6. Uses health literacy strategies in interpersonal communications and confirms understanding at all points of contact.
7. Provides easy access to health information and services and navigation assistance.
8. Designs and distributes print, audiovisual, and social media content that is easy to understand and act on.
9. Addresses health literacy in high-risk situations, including care transitions and communications about medicines.
10. Communicates clearly what health plans cover and what individuals will have to pay for services.



Dear Healthcare Professional:

Thank you for your interest in the Newest Vital Sign (NVS), the first tool available to assess health literacy in English and Spanish.

Research shows that patients with low health literacy are less likely to comply with prescribed treatment and medical instructions from their physician. Identifying patients who are at risk for low health literacy allows physicians to apply specific clear health communication techniques that may enhance understanding. The NVS is a simple and fast way to identify those patients. The tool, which tests literacy skills for both numbers and words*, has been validated against a previously validated measure of health literacy (test of functional health literacy in adults, the TOFHLA) and has been shown to take approximately 3 minutes to administer.

In addition to the NVS tool, we are also including information to help enhance patient-provider communication. In this folder, you will find the following materials:

- NVS Tool (nutrition label and scoring sheet tear-off pad, both two-sided in English/Spanish)
- The NVS Implementation Guide
- *Ask Me 3* (fact sheet on free educational materials from the non-profit Partnership for Clear Health Communication)
- *Help Your Patients Succeed* (tips for improving communication with your patients)
- *Why Does An Ice Cream Label Work* (fact sheet explaining NVS design)

The Newest Vital Sign is Pfizer Inc's most recent contribution to the health literacy movement. For more than nine years, Pfizer has been committed to raising awareness of developing solutions for low health literacy. The overall goal of our Clear Health Communication Initiative is to positively impact the health care system by enhancing patient-provider communication to increase compliance and improve patient health outcomes.

The Newest Vital Sign and companion materials are available to medical, private, and public health providers at no cost. To learn more about our efforts to improve health literacy, please visit www.pfizerhealthliteracy.com.

Sincerely,

Richard C. Hubbard, M.D.
Senior Director, External Medical Affairs
Pfizer Inc

*Literacy is defined as the understanding and application of words (prose), numbers (numeracy), and forms, etc. (document).



February 2011



Implementation Guide for the Newest Vital Sign

Health literacy—the ability to read, understand, and act upon health information—is now known to be vital for good patient care and positive health outcomes. According to the Institute of Medicine’s groundbreaking report on health literacy, nearly half of all American adults—90 million people—have difficulty understanding and using health information. When patients lack the ability to understand and act upon medical information, it can put their health at risk.

The Newest Vital Sign (NVS) is a new tool designed to quickly and simply assess a patient’s health literacy skills. It can be administered in only 3 minutes and is available in English and Spanish. The patient is given a specially designed ice cream nutrition label to review and is asked a series of questions about it. Based on the number of correct answers, health care providers can assess the patient’s health literacy level and adjust the way they communicate to ensure patient understanding.

There are many ways to integrate the NVS into a private practice or clinic setting to improve communication with patients. Improved communication can help increase your patients’ ability to understand and act upon the information you provide, ultimately improving patient satisfaction and health outcomes.

How to Use the Newest Vital Sign

1. Who and when to administer the Newest Vital Sign.

- **A nurse (or other trained clinic staff)** is the preferred administrator of the Newest Vital Sign.
- Administer at the same time that other vital signs are being taken.

2. Ask the patient to participate.

A useful way to ask the patient is an explanation similar to this:

“We are asking our patients to help us learn how well they can understand the medical information that doctors give them. Would you be willing to help us by looking at some health information and then answering a few questions about that information? Your answers will help our doctors learn how to provide medical information in ways that patients will understand. It will only take about 3 minutes.”

3. Hand the nutrition label to the patient.

The patient can and should retain the nutrition label throughout administration of the Newest Vital Sign. The patient can refer to the label as often as desired.

4. Start asking the 6 questions, one by one, giving the patient as much time as needed to refer to the nutrition label to answer the questions.

- There is no maximum time allowed to answer the questions. The average time needed to complete all 6 questions is about 3 minutes. However, if a patient is still struggling with the first or second question after 2 or 3 minutes, the likelihood is that the patient has limited literacy and you can stop the assessment.
- **Ask the questions in sequence.** Continue even if the patient gets the first few questions wrong. However, **if question 5 is answered incorrectly, do not ask question 6.**
- **You can stop asking questions if a patient gets the first four correct.** With four correct responses, the patient almost certainly has adequate literacy.
- **Do not prompt patients who are unable to answer a question.** Prompting may jeopardize the accuracy of the test. Just say, "Well, then let's go on to the next question."
- **Do not show the score sheet to patients.** If they ask to see it, tell them that "I can't show it to you because it contains the answers, and showing you the answers spoils the whole point of asking you the questions."
- **Do not tell patients if they have answered correctly or incorrectly.** If patients ask, say something like: "I can't show you the answers till you are finished, but for now you are doing fine. Now let's go on to the next question."

5. Score by giving 1 point for each correct answer (maximum 6 points).

- **Score of 0-1** suggests high likelihood (50% or more) of limited literacy.
- **Score of 2-3** indicates the possibility of limited literacy.
- **Score of 4-6** almost always indicates adequate literacy.
- **Record the NVS score** in the patient's medical record, preferably near other vital sign measures.

Best Practices for Implementation: Summary

- A nurse (or other trained clinic staff) is the preferred administrator of the NVS.
- Administer the NVS at the same time that the patient's other vital signs are being taken.
- Record the NVS score in the patient's chart, preferably near other vital sign measures.
- Tailor communication to ensure patient understanding.

Why Does an Ice Cream Label Work as a Predictor of the Ability To Understand Medical Instructions?

A patient's ability to read and analyze any kind of nutrition label requires the same analytical and conceptual skills that are needed to understand and follow a provider's medical instructions. The skills, which are known as *health literacy*, are defined as the understanding and application of words (prose), numbers (numeracy), and forms (documents).

The use of an ice cream label is especially relevant as recent research in the *American Journal of Preventive Medicine* (November 2006) has shown that poor comprehension of food labels correlated highly with low-level literacy and numeracy skills. However, the study found that even patients with better reading skills could have difficulties interpreting the labels.

Whether reading a food label or following medical instructions, patients need to:

- Remember numbers and make mathematical calculations.
- Identify and be mindful of different ingredients that could be potentially harmful to them.
- Make decisions about their actions based on the given information.

PROSE LITERACY:

Clinical example: The patient has scheduled some blood tests and is instructed in writing to fast the night before the tests. The skill needed to follow this instruction is **Prose Literacy**.

Ice cream label example: The patient needs this skill to read the label and determine if he can eat the ice cream if he is allergic to peanuts.

NUMERACY:

Clinical example: A patient is given a prescription for a new medication that needs to be taken at a certain dosage twice a day. The skill needed to take the medication properly is **Numeracy**.

Ice cream label example: The patient needs this same skill to calculate how many calories are in a serving of ice cream.

DOCUMENT LITERACY:

Clinical example: The patient is told to buy a glucose meter and use it 30 minutes before each meal and before going to bed. If the number is higher than 200, he should call the office. The skill needed to follow this instruction is **Document Literacy**.

Ice cream label example: The patient needs this skill to identify the amount of saturated fat in a serving of ice cream and how it will affect his daily diet if he doesn't eat it.

A-1

Nutrition Facts

Serving Size ½ cup
 Servings per container 4

Amount per serving

Calories 250 Fat Cal 120

%DV

Total Fat 13g 20%

Sat Fat 9g 40%

Cholesterol 28mg 12%

Sodium 55mg 2%

Total Carbohydrate 30g 12%

Dietary Fiber 2g

Sugars 23g

Protein 4g 8%

*Percentage Daily Values (DV) are based on a 2,000 calorie diet. Your daily values may be higher or lower depending on your calorie needs.

Ingredients: Cream, Skim Milk, Liquid Sugar, Water, Egg Yolks, Brown Sugar, Milkfat, Peanut Oil, Sugar, Butter, Salt, Carrageenan, Vanilla Extract.



Score Sheet for the Newest Vital Sign Questions and Answers

READ TO SUBJECT:

This information is on the back of a container of a pint of ice cream.

1. If you eat the entire container, how many calories will you eat?
Answer: 1,000 is the only correct answer

2. If you are allowed to eat 60 grams of carbohydrates as a snack, how much icecream could you have?
Answer: Any of the following is correct: 1 cup (or any amount up to 1 cup), half the container. Note: If patient answers "two servings," ask "How much ice cream would that be if you were to measure it into a bowl?"

3. Your doctor advises you to reduce the amount of saturated fat in your diet. You usually have 42 g of saturated fat each day, which includes one serving of ice cream. If you stop eating ice cream, how many grams of saturated fat would you be consuming each day?
Answer: 33 is the only correct answer

4. If you usually eat 2,500 calories in a day, what percentage of your daily value of calories will you be eating if you eat one serving?
Answer: 10% is the only correct answer

READ TO SUBJECT:

Pretend that you are allergic to the following substances: penicillin, peanuts, latex gloves, and bee stings.

5. Is it safe for you to eat this ice cream?
Answer: No

6. Ask only if the patient responds "no" to question 5): Why not?
Answer: Because it has peanut oil.

ANSWER CORRECT?

Yes	No

Number of correct answers:

Interpretation

- Score of 0-1 suggests high likelihood (50% or more) of limited literacy.
- Score of 2-3 indicates the possibility of limited literacy.
- Score of 4-6 almost always indicates adequate literacy.

Appendix II

Matrix of Organizational Characteristics and Workforce Competencies

What are the characteristics of a state health department that can effectively address health inequities?

Institutional Commitment to Address Health Inequities	Hiring to Address Health Inequities	Structure that Supports True Partnerships	Support Staff to Address Health Inequities	Transparent & Inclusive Communication (community, staff, partners, etc.)
<ul style="list-style-type: none"> • Integrate public health and health equity into workforce and program development • decision making is inclusive • institutional commitment to primary prevention • institutional commitment to addressing health inequities • clear vision, goals and benchmarks • succession plan provides for continuity of vision and promotes new leadership • strategic plan and mission statement address health inequities • institutional practices reflect stated commitment to address health inequities 	<ul style="list-style-type: none"> • Human Resources operations develop and promote job specifications and qualifications that reflect the skills and characteristics desired to address health equity • Human Resources operations' incorporate social justice principles, seek diversity, reflect the populations served, expand language capacity, build the workforce's capacity to address health inequities • Human Resources operations' provide living wages, schedule flexibility and continuing education • diversity at all levels of organization 	<ul style="list-style-type: none"> • community partnerships are welcome and supported • structured to act • collaborates with other agencies and stakeholders • Applies a health in all policies (HiAP) lens • addresses the needs of community residents to promote their participation (child care, refreshments, travel reimbursement) 	<ul style="list-style-type: none"> • mentors staff • strongly supports professional growth • consistent supervision to reinforce practice • required health equity orientation and training for all new permanent staff 	<ul style="list-style-type: none"> • transparent communication • communication is multi-directional • solicits and uses partner organizations and community input • decision making is shared with partner organizations and community partners
<p>Institutional Support for Innovation</p> <ul style="list-style-type: none"> • supports innovation (thinking outside box) • time for reflective thought • time to plan 	<p>Creative Use of Categorical Funds</p> <ul style="list-style-type: none"> • categorical and other funding sources are creatively braided or interwoven to provide a continuum and are sustained over time • non silo-ed ongoing/ stable funding 	<p>Community Accessible Data & Planning</p> <ul style="list-style-type: none"> • data and needs assessments are accessible to community • integrated data are used for planning 	<p>Streamlined Administrative Process</p> <ul style="list-style-type: none"> • administrative processes are flexible and promote ease of use 	

http://barhii.org/download/toolkit/nacdd_he_toolkit.pdf

What are the skills and abilities needed by state health department staff to effectively address health inequities?

<p>Personal Attributes</p> <ul style="list-style-type: none"> • life-long learner • self-reflective • reflects the diversity of the population that is served • passionate • creative and innovative • perseverant • active listener 	<p>Knowledge of Public Health Framework</p> <ul style="list-style-type: none"> • prepares program plans • understands / uses data in a systematic approach • takes a systems approach • understands PH core functions and services • conducts evaluation • conducts assessments • develops, analyzes and advocates for policies • organizes community 	<p>Understand the Social, Environmental and Structural Determinants of Health</p> <ul style="list-style-type: none"> • understands and applies social justice principles • understands underlying causes of health inequities • understands connection between race, class, gender and health 	<p>Community Knowledge</p> <ul style="list-style-type: none"> • builds on strengths and assets of self and the community • works well and is comfortable with diversity • comfortable working in communities • knowledgeable about community issues & resources • understands current immigration patterns and issues 	<p>Leadership</p> <ul style="list-style-type: none"> • works well within the SHD and in the community and serves as liaison between the two • engages, mobilizes, coaches and mentors others • understands and navigates power dynamics • "politically astute": is committed to understanding diverse interest groups and power bases including but not limited to City and County officials, State and Federal policy makers, leaders within organizations and the wider community, and the dynamic between them, so as to lead the organization more effectively.
<p>Collaboration Skills</p> <ul style="list-style-type: none"> • employs good interpersonal skills • "team" player • shares power • trusts partners • communicates well across disciplines 	<p>Community Support</p> <ul style="list-style-type: none"> • inspires community involvement and ownership • inspires and builds trust • develops & promotes community leadership • develops & promotes community networks • values/elicits input and feedback from community and organizational partners 	<p>Problem Solving Ability</p> <ul style="list-style-type: none"> • uses negotiation and conflict resolution • willing to take risks • learns from failure 	<p>Cultural Competency Humility</p> <ul style="list-style-type: none"> • respects cultures and demonstrates cultural humility • appreciates that diverse perspectives and roles are necessary to promote public health issues • communicates effectively across cultures • interprets data effectively across cultures 	

Over time, the WHO model provides a means of monitoring indicators to see how changing conditions may decrease or increase the risk of inequitable health outcomes including – for example – early childhood adversity.

ORGANIZATION OF THE *LEARNING AND ACTION TOOL*

This first iteration of the *Learning and Action Tool* is designed specifically for state health departments. It is expected that the tool will be employed at specific intervals defined by the organization.

The *Learning and Action Tool* is organized by seven *foundational practices* that, when taken together as a whole, provide a solid foundation for public health practice to advance health equity:

- I. Expand the understanding of health in words and action**
- II. Assess and influence the policy context**
- III. Lead with an equity focus**
- IV. Use data to advance health equity**
- V. Advance health equity through continuous learning**
- VI. Support successful partnerships and strengthen community capacity**
- VII. Assure strategic and targeted use of resources**

All seven foundational practices interact with and support each other. The *Learning and Action Tool* provides operational definitions for each foundational practice, followed by a critical capabilities section to assess the organization's capacity to advance health equity.

USING THE *LEARNING AND ACTION TOOL*

The *Learning and Action Tool* is a tool that seeks to evaluate an organization's current capacity to advance health equity by expanding practice to address the social determinants of health. Ideally, the *Learning and Action Tool* should be completed by a team of individuals with significant knowledge of the organization's structures and functions. Assessing the capabilities of the organization should be done in such a way that it allows the results to be monitored for improvements over time – recognizing that capacities will differ from organization to organization as each develops competence in addressing social determinants of health and

advancing health equity.¹⁹ Each organization will have a unique experience with the *Learning and Action Tool*.

Each Foundational Practice is introduced then illustrated through a set of Critical Capabilities. Each critical capability has a list of questions meant to act as examples of specific activities that support the critical capabilities and foundational practices. Organizations may support critical capabilities with activities not listed; those activities should be included when completing the *Learning and Action Tool*.

Prior to each critical capability section is a set of questions, which allow the organization to begin to think critically about the practice:

- To what extent do we have these critical capabilities? E.g.:
 - Not at all?
 - Isolated individuals, projects, or ad hoc efforts?
 - Some existing policies, procedures, and practices to support these capabilities?
 - Widespread organizational standards that support these capabilities exist and are measured?
- What are our supports/constraints in strengthening these critical capabilities?
- What are some specific examples of how we do this? How could we better or more extensively incorporate these capabilities in our work?
- If we already have these capabilities, are we proficient? How could we improve?

Public Health organizations are urged to examine their own practices and activities against those in the *Learning and Action Tool* and then to engage in dialogue to support continuous improvement and future strategic planning.

¹⁹ A specific scoring methodology has not been developed at this time, but the intent is to develop a means for each organization to track progress along a continuum.

Assessing Readiness for Change

The *Organizational Change Recipients' Beliefs Scale* (OCRBS)* For the Infant Mortality CoIIN, Social Determinants of Health Learning Network

The Organizational Change Recipients' Beliefs Scale (OCRBS) is a 24 item assessment tool that has proven useful and effective in assessing an individual's readiness for organizational change, as well as helping to predict adoption, and institutionalization of a change. It has been validated in multiple settings, for different sizes and types of public and private organizations and industries.

This individual self-report questionnaire can be administered at various stages of the change process and research shows it can provide 1) a measure of current buy-in; 2) an assessment of barriers to successful organizational change; and 3) a foundation for increasing buy-in among organizational change recipients.

For the Social Determinants of Health (SDOH) Learning Network, this will be a useful tool for determining an individual's readiness for organizational change such as adopting an SDOH framework, adopting strategies to improve health equity, or advancing a Health Equity in All Policies approach. Readiness for change is one predictor of success.

* For the SDOH Learning Network, this tool was slightly modified. The original assessment instrument can be found in: Armenakis A, Bernerth J, Pitts J, and Walker H. (2007). Organizational Change Recipients' Beliefs Scale: Development of an Assessment Instrument. *Journal of Applied Behavioral Science* 2007;43:481. Downloaded from <http://jab.sagepub.com>

Also see Holt DT, Armenakis AA., Feild HS, and Harris SG. Readiness for Organizational Change: The Systematic Development of a Scale *Journal of Applied Behavioral Science*, 2007;43(2):232-255. <http://jab.sagepub.com/content/43/2/232.abstract>

Instructions:

Each state's team leader for the SDOH Learning Network should complete the OCRBS (page 2). The focus of change is action to improve social determinants of health, reduce disparities, and ensure health equity in birth outcomes.

- First, change the PDF file name by adding your state name.
- Next, you as the team leader, will answer the 24 questions based on your own individual beliefs, perceptions, opinions, and values. Only one response per team, ideally from the state team leader.
- Then, submit your completed assessments (with your answers checked) via email by sending the file back to kay.johnson@johnsongci.com

We will discuss the results, a "train-the-trainer" approach, and ways to use this assessment with your state SDOH learning team at the IM CoIIN meeting in Houston in February.

Deadline Wednesday, February 1, 2017.

Assess Your Readiness for Organizational Change

Check the box that best fits your beliefs, opinions, and perceptions..

	Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree
1. This change will benefit me.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
2. Most of my respected peers embrace the proposed organizational change.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
3. I believe the proposed organizational change will have a favorable effect on our operations.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
4. I have the capability to implement the change that is initiated.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
5. We need to change the way we do some things in this organization.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
6. With this change in my job, I will experience more self-fulfillment.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
7. The top leaders in this organization are "walking the talk."	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
8. The change in our operations will improve the performance of our organization.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
9. I can implement this change in my job.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
10. We need to improve the way we operate in this organization.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
11. The top leaders in our organization support this change.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
12. The change that we are implementing is correct for our situation.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
13. I am capable of successfully performing my job duties with the proposed organizational change.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
14. We need to improve our effectiveness by changing our operations.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
15. The change in my job assignments will increase my feelings of accomplishment.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
16. The majority of my respected peers are dedicated to making this change work.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
17. When I think about this change, I realize it is appropriate for our organization.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
18. I believe we can successfully implement this change.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
19. A change is needed to improve our operations.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
20. My immediate manager is in favor of this change.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
21. This organizational change will prove to be best for our situation.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
22. We have the capability to successfully implement this change.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
23. We need to improve our performance by implementing an organizational change.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
24. My immediate manager encourages me to support the change.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

STATE NAME: _____

Role of person who completed assessment (check one): _____ SDOH Learning Network Team Lead _____ Other

Read this first to understand more about change in the context of the SDOH Learning Network

What is the "change" this questionnaire asks about?

Each SDOH Learning Network team is aiming to change their focus, practices, and programs to improve maternal and infant health. **The change is intended to shift social determinants of health, reduce disparities, and ensure health equity in order to improve birth outcomes.** This is the change you should be thinking about as you complete this assessment.

This readiness assessment does not require that you know now what exactly the changes will be. You are being asked how you feel about change toward health equity and SDOH, what support you perceive you have for changing, if you believe change is needed, and if you have the will to change.

If you have no opinion or viewpoint, choose "neither agree nor disagree."

Thank you for completing this assessment. It will help prepare for action in the SDOH Learning Network and assist the project team develop technical assistance to meet your needs.

The following recommended health equity metrics reflect the determinants of health (structural drivers, community determinants, and healthcare).

STRUCTURAL DRIVERS

1. Neighborhood Disinvestment Index (index)
2. Gini Index⁴ (index)
3. Index of Dissimilarity⁷ (indicator)
4. Rates of incarceration by race/ethnicity (indicator)
5. Percent of residents from traditionally marginalized communities in positions of influence (indicator)
6. Geographic distribution of health: life expectancy by zip code (indicator)
7. Community Trauma (composite measure)
8. Community Readiness (composite measure)
9. Number of communities with indicator projects (indicator)

COMMUNITY DETERMINANTS

Social-cultural environment

10. Collective efficacy⁸ (index)
11. Civic engagement (composite measure)

Physical/built environment

12. Physical activity environment⁹ (index)
13. Retail Food Environment Index (index)
14. Food Marketing to Kids Group (index)
15. Housing Index¹⁰ (index)
16. Affordability of Transportation and Housing¹¹ (index)
17. Pollution Burden Score¹² (index)
18. Mobility and Transportation¹³ (index)
19. Opportunities for engagement with arts, music and culture¹⁴ (index)
20. Per capita dollars spent for park space per city/neighborhood (indicator)
21. Safe place to walk within 10 minutes of home (indicator)
22. Alcohol outlet density (indicator)
23. Number of comprehensive smoke-free policies in places that prohibit smoking in all indoor areas of work-sites and public places (indicator)
24. Community Safety Scorecard¹⁵ (index)
25. Number of cities with a comprehensive, multi-sector violence prevention plan (indicator)

Economic environment

26. Number of living wage policies in place (indicator)
27. Academic achievement (composite measure)
28. Local wealth (composite measure)
29. Complete and livable communities¹⁶ (index)
30. School Environment¹⁷ (index)
31. Percent of families who say it's hard to find the child care they need (indicator)
32. Workplace safety (composite measure)

HEALTHCARE SERVICES

33. Percent of patients that can access a place they call their "medical care home" within two weeks' time (indicator)
34. Patient satisfaction with medical encounters as a measure of culturally and linguistically appropriate care (indicator)
35. Number of medical schools that integrate healthcare disparities and community learning throughout entire curriculum and training (indicator)

https://www.preventioninstitute.org/sites/default/files/publications/Measuring%20What%20Works%20to%20Achieve%20Health%20Equity-%20Metrics%20for%20the%20Determinants%20of%20Health_Executive_Summary.pdf

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