CLAS Standards Training Toolkit

FACILITATORS' GUIDE for

HEALTH CARE DELIVERY ORGANIZATIONS

REVISED JANUARY 2015

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FACILITATION GUIDELINES

Introduction and Rationale

Maryland is a very diverse state, with more than 45% of its population being members of racial or ethnic minority groups, and much of the chronic disease prevalence and excess health care costs related to health disparities in the minority population.

In 2011, nearly two-thirds of Maryland's uninsured population were persons from racial and ethnic minority communities. As a result of the Affordable Care Act, health insurance reform is being fully implemented in Maryland with the expectation of insuring the vast majority of the uninsured population. However, obtaining access to health care through health insurance is not sufficient to produce good health outcomes. Health care organizations and providers must engage patients and the larger community in ways that enable them to participate as partners in managing disease and practicing prevention where they live, work, and play. This simple but essential truth makes it paramount for health care organizations to increase their cultural and linguistic competence and to develop effective patient engagement and patient-provider communication.

Culture includes a range of factors including ethnicity, language, religion, gender identity, sexual orientation, geography, and other sociological characteristics. These and numerous other factors can play a vital role in the patient-provider relationship and the health outcomes of the patient. Culture determines an individual's health beliefs and practices and can influence whether illness prevention measures are followed or whether recommended treatment is accepted. In addition, culture can influence how patients respond to and expect to be treated by health care providers. Finally, the culture of the health care provider may influence the delivery of care, and the expectations that he or she may have as to how their patients should or will respond to care and treatment regimens.

However the influence of culture takes place in conjunction with a myriad of other social and environmental determinants of health that together have an impact on health behaviors and health outcomes. The differential effect of social and environmental factors on health outcomes is compounded by differences in the quality of health care received by patients.

Improving quality, eliminating health disparities, and advancing health equity among culturally and linguistically-diverse communities is the overarching purpose the National Standards for Culturally and Linguistically-Appropriate Services (CLAS) in Health and Health Care. **This facilitator's guide and attached training and implementation resources are intended to provide an introductory overview of the CLAS Standards and corresponding steps toward achieving the purpose of the Standards at the organization level**.

Steps to an Effective CLAS Standards Training Program

The **first step** in the training process is to engage the leadership of your organization and to obtain their critical buy-in for the process. The **second step** is to conduct a CLAS organizational assessment. The assessment is a survey of key organizational personnel to determine the types of CLAS-related activities that are currently being conducted within specific units/departments of your organization as well as the organization's overall level of adherence to the CLAS Standards. The assessment also helps the training facilitators to customize the curriculum to the needs of the participants. The **third step** is to identify individuals who will participate in the training program, and to assess their awareness, knowledge, attitudes and perceptions about CLAS prior to the training. The **fourth step** is to conduct the CLAS training, preferably as a series of multiple training modules delivered over a period of time). The **fifth step** is to conduct an evaluation at pre-determined time intervals to assess post-training comprehension of individual participants and to re-assess your organization's adoption of the CLAS Standards.

1. Engage Leadership
2. Assess the Organization's CLAS Activities
3. Identify and Assess Participants
4. Deliver Training Modules
5. Evaluate - Comprehension and Adoption

Step 1.   Engage the leadership of your organization.

Implementation of the CLAS standards requires buy-in and commitment from an organization's top leadership. A short presentation of the importance of CLAS, an overview of the assessment and training program, and the time requirements of such a program should be the first step in this engagement.* Leaders can then identify individuals to perform the initial organizational assessment and recruit staff for the training program.

When possible, the leadership should play a role in the training, most easily accomplished by a formal introduction to participants—this reinforces organizational commitment to systems change and CLAS implementation. The introduction also gives leaders an opportunity to articulate their own perspectives about culturally and linguistically appropriate services, and to clarify what they expect from their staff.

* A leadership presentation template is included in the appendix.

Step 2.   Conduct an organizational assessment.

An initial assessment of your organization's culturally and linguistically appropriate service activities should be completed by the individuals identified by top leadership. Individuals involved in the assessment may include human resources, client/patient relations, and planning personnel as well as chief executive officers. **A CLAS Organizational Assessment tool developed by the Maryland Office of Minority Health and Health Disparities** can be found in the Appendix section labeled "Pre-Training Preparation". The assessment tool can be customized depending on your type of health care organization (hospital, FQHC, physician practice, etc.) and the amount of time and effort that your organization is willing to dedicate to the assessment.

Step 3. Identify and assess the training participants.

The ideal participants for the training should have the following characteristics:
- Represent a mix of middle managers, supervisory personnel, and frontline staff;
- Be committed to designing and implementing a project incorporating CLAS standards into their respective service areas;
- Be able to work collaboratively in small group settings;
- Be available and willing to participate in the full training program and follow-up activities;
- Work in or with one or more of the following units or service areas:
    - Direct patient care
    - Quality improvement
    - Human resources
    - Language and community outreach services

It is important to carefully select participants to optimize group dynamics. The following mix of personality types and demographics are suggested:
- A mix of cultural and linguistic competency "champions" (individuals who have already been exposed to and are on board with CLAS concepts) balanced with more resistant or skeptical individuals. (This combination of participants will ensure a good level of engagement while also promoting essential critical thinking when discussing practical implementation of CLAS.)
- Individuals who have successfully worked well in group settings in the past and whose potential collaboration may lead to synergistic impact. (The success of the group process and discussions depends upon the ability of the participants to work effectively with one another. Participants who already have experienced benefits from working together or have work-based commonalities that promote collaboration will help the group process significantly.)
- Individuals with overlapping responsibilities and goals who may be able to pool their resources to develop projects that have broader or more far-reaching implications than if they were to develop a project individually. (The presence of these participants in the same group allows them more time to explore opportunities to collaborate.)

▪Diverse individuals (based on ethnic, gender, religious, and other sociocultural variation) to promote richer discussions within the training group about cultural competence, language, health disparities and health equity, and other issues addressed by CLAS. (Participants from diverse cultures can share experiences that supplement the didactic components of the training and make the learning experience more realistic.)

On the day of the training, the selected participants should be given the **Participant Pre-Training Survey** (found in the "Training Resources" section of the Appendix). The purpose of the survey is to assess participant awareness, knowledge, attitudes, and perceptions about the CLAS standards, and the degree to which they are aware of CLAS-oriented programs within your organization.

Step 4.   Deliver training to participants.

A **CLAS Standards training presentation template** is included in the "Training Resources" section of the Appendix. The template is organized in the following manner:

❑ **Introduction to the National CLAS Standards**. The training participants are introduced to the CLAS Standards, the reasons why they were developed and later enhanced, and the general topics addressed by the Standards.

❑ **Making the Case for the CLAS Standards**. This section discusses ethnic diversity in Maryland, the concepts of "health disparities" and "health care disparities," and the impact of disparities on the quality of care and health outcomes for patients in Maryland. The business case for adopting the CLAS Standards is also addressed by highlighting linkages to Maryland's All-Payer Model, the Triple Aim in health care, and current practice redesign efforts.

❑ **CLAS Standards Implementation Framework**.*   The framework highlights the following six areas of action: (1) Foster cultural competence; (2) Reflect and respect diversity; (3) Ensure language access; (4) Build community partnerships; (5) Collect diversity data; and (6) Benchmark, plan, and evaluate.

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* Framework developed by the Massachusetts Department of Public Health. www.mass.gov/ eohhs/gov/departments/dph/programs/admin/heatlh-equity/clas/making-clas-happen.html

[Cont'd. -- <u>Step 4. Deliver training to participants</u>]

The discussion of each area of action begins by identifying the relevant CLAS Standards that address the specific action area. Subsequently, the concepts that underlie the area of action are discussed along with suggestions for specific action steps that organizations can take toward implementing the associated CLAS Standards.

❑ **Questions and Feedback**. Participants should be encouraged to pose questions and provide feedback throughout the training presentation. **Interactive exercises** are inserted at various intervals within the presentation template to help facilitate dialogue and to illustrate important concepts. In addition, **sample discussion questions** can be found in the "Training Resources" section of the Appendix.

The training presentation template serves merely as a starting point. The template should be adapted (and re-adapted) to meet the specific learning needs of your audience and to take into consideration pre- and post-training input and feedback from participants.

Overall, the training presentation provides an opportunity for participants to examine various themes that impact the health care delivery process and health outcomes, including socioeconomic barriers and facilitators for patient compliance; patient-provider communication; unconscious bias and stereotyping; and health beliefs and decision-making. The CLAS Standards implementation framework also provides a chance for participants to identify systems and organizational-level factors that would mitigate the impact of the various barriers to quality health care and health equity. Moreover, participants can discuss how the CLAS Standards can be (1) applied to their specific service and practice areas and (2) integrated throughout the organization as a whole by collaborating and pooling resources across different departments.

Beyond the benefits of the fruitful discussions and action steps which may be prompted by the CLAS Standards training, your organization may wish to formalize the training for accreditation purposes or to offer continuing education (CE) credits for participants. Therefore the training could be tailored with relevant learning objectives that meet accreditation and CE needs.

[Cont'd. -- <u>Step 4. Deliver training to participants</u>]

Some examples of learning objectives for the training include the following:

<u>Knowledge learning objectives</u>

By the completion of the training, you should have acquired the knowledge to –
1. Describe the CLAS standards and why they were developed.
2. Define health disparities, cultural competence, health literacy, and unconscious bias.
3. Describe factors that contribute to health disparities.
4. Describe how health disparities affect quality of care for patients of diverse backgrounds.
5. Describe the impact of (individual and professional) culture on health care decision-making.
6. Describe the impact of health literacy and language barriers on health care treatment and compliance.
7. Describe the potential impact of the CLAS standards on improvements in quality of care, improvements in health equity, and reductions in health disparities.

<u>Behavioral learning objectives</u>

By the completion of the training, you should be able to –
1. Assess how your service area or organization currently responds to issues addressed by the CLAS Standards.
2. Identify your own role for collaboration with others to implement the CLAS Standards within your service area or organization.
3. Implement three or more action steps to better utilize the diversity of your staff in delivering culturally and linguistically-appropriate care to patients.
4. Implement three or more methods of partnering with the community in order to improve quality of care for diverse patient populations.
5. Make recommendations on how to integrate the CLAS Standards into your health care organization's strategic planning process and operational practices, policies, and procedures.
6. Develop performance benchmarks to monitor your organization's implementation of the National CLAS Standards.

Step 5. Evaluate comprehension and adoption of the CLAS Standards.

The evaluation process is designed to measure the following:
- Participants' satisfaction with the quality of the CLAS Standards training session;
- Participants' comprehension of the CLAS Standards and related subject matter; and,
- Your organization's adoption of the CLAS Standards.

A **Participant Satisfaction Survey** should be administered immediately after the training session in order to assess the overall quality of the training facilitation; the usefulness of the interactive exercises; and whether learning objectives were met. In addition, participants should be asked to complete a **Post-Training Survey**, either immediately following the training session or at another pre-determined time interval. Setting a later time interval would be helpful in measuring longer-term retention of the subject matter.

The Post-Training Survey is designed to re-assess participants' awareness, knowledge, attitudes, and perceptions about the CLAS Standards, and to determine whether participants feel prepared to begin planning and implementing CLAS-related projects within their department or service area.

A CLAS Standards **Organizational Re-Assessment** should be conducted at three to six months after the CLAS training session. The purpose of the re-assessment is to determine what formal practice and policy redesign is being implemented to ensure delivery of culturally and linguistically appropriate services to patients and clients.

Templates for the **Participant Satisfaction Survey**, **Participant Post-Training Survey**, and the **Organizational Re-Assessment Tool** can all be found in the "Training Resources" section of the Appendix.

Integration into Continuous Quality Improvement

The CLAS Standards contain several elements that provide a means for ongoing monitoring and feedback by staff, patients and the community to help improve services and long-term health outcomes. The CLAS Standards training presented here is an introductory presentation that is best followed by focused, skill-building workshops. Subsequent workshops could emphasize specific topics that are mentioned in the introductory presentation, such as the following:

- Recognizing and addressing unconscious bias.
- Resolving cross-cultural conflicts and grievances.
- Developing a formal Communication and Language Assistance Plan.
- Effective collaboration with certified medical interpreters and limited English proficient patients.
- Qualified Bilingual Staff training.
- Developing easy-to-use health education materials.
- Use of health literacy and "plain language" principles in patient-provider communication.
- Developing a plan for community engagement.
- Demographic data collection training.
- Strategic planning and benchmarking for culturally and linguistically-appropriate service delivery.

Due to the more narrowly focused topics of the individual workshops, a more targeted group of managers and frontlines staff members could be invited to participate based on their roles and service areas. Furthermore, feedback from training participants is yet another means of identifying additional areas for training and improvement in service delivery.

For more information or technical assistance, please contact::

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MHHD E-Newsletter: http://bit.ly/12ECsOL

INTRODUCTION TO THE NATIONAL CLAS STANDARDS

CLAS Standards Training Project

Funded by HHS/OMH (Grant # 1 STTMP 131091-01-00)

[INSERT DATE]

Session Overview

- **Introduction to the National CLAS Standards**

- *Making the case for the CLAS Standards*

  - Diversity and Health Disparities in Maryland and Baltimore City

  - The Business, Ethical and Social Case for CLAS

- **CLAS Standards Implementation**

  - Concepts

  - Discussion

  - Action Steps/Strategies

- **Questions and Feedback**

- **Post-Training Questionnaire**

- **Closing**

Introduction to the CLAS Standards

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Purpose of the National CLAS Standards

The enhanced National CLAS Standards are intended to advance health equity, improve quality, and help eliminate health care disparities by establishing a blueprint for individuals as well as health and health care organizations to implement culturally and linguistically appropriate services.

Source:
HHS/Office of Minority Health. Think Cultural Health Website. Available at: https://www.thinkculturalhealth.hhs.gov/content/clas.asp

Maryland Office of Minority Health and Health Disparities

What are the National CLAS Standards?

- The National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care

- First published by the HHS Office of Minority Health in 2000

- Provided a framework for organizations to best serve the nation's diverse communities

- Underwent an Enhancement Initiative from 2010 to 2013

- Launched the enhanced CLAS Standards in April 2013

Maryland Office of Minority Health and Health Disparities

What are the enhanced National CLAS Standards?

Standard 1
Principal Standard

Standards 2-4
Governance, Leadership & Workforce

Standards 5-8
Communication & Language

Standards 9-15
Engagement, Continuous Improvement & Accountability

* Please see handout for further details about the CLAS Standards.

Making the Case for the CLAS Standards: Diversity & Health Disparities in Maryland

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Video Clip

"What Kind of Asian Are You?"

http://www.youtube.com/watch?v=DWynJkN5HbQ

Maryland Office of Minority Health and Health Disparities
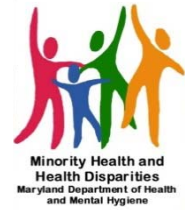
Maryland is One of the Most Racial/Ethnic Diverse States

Maryland Population by Race and Hispanic Ethnicity, 2010 Census

	Maryland	% of MD
Total	5,773,552	100.0%
Race, regardless of Hispanic Ethnicity:		
White (one race)	3,359,284	58.2%
Black or African American (one race)	1,700,298	29.4%
American Indian/Alaska Native(one race)	20,420	0.4%
Asian (one race)	318,853	5.5%
Native Hawaiian/Pac Islander (one race)	3,157	0.1%
Other race (one race)	206,832	3.6%
Two or more races)	164,708	2.9%
Hispanic Ethnicity, regardless of Race:		
	470,632	8.2%

Maryland Office of Minority Health and Health Disparities

Maryland is One of the Most Racial/Ethnic Diverse States

Minority Health and Health Disparities

Racial or Ethnic Minority Population (Number and Percent), by Jurisdiction, Maryland 2010

Maryland Counties	% Racial/Ethnic Minority
Prince George's County	85.1%
Baltimore City	72.0%
Charles County	51.6%
Montgomery County	50.7%
Somerset County	47.9%
Howard County	40.8%
Baltimore County	37.3%
Dorchester County	33.8%
Wicomico County	33.4%
Anne Arundel County	27.6%
St. Mary's County	23.5%
Frederick County	22.2%
Kent County	21.9%
Caroline County	21.8%
Talbot County	21.0%
Harford County	20.8%
Calvert County	20.3%
Worcester County	19.7%
Washington County	16.7%
Queen Anne's County	12.7%
Cecil County	12.6%
Allegany County	11.8%
Carroll County	8.8%
Garrett County	2.7%
Maryland Total	45.3%

Garrett 819 · Allegany 8,892 · Washington 24,682 · Frederick 51,740 · Carroll 14,706 · Baltimore 300,473 · Baltimore City 446,841 · Harford 50,822 · Cecil 12,760 · Kent 4,414 · Montgomery 493,012 · Howard 117,113 · Anne Arundel 148,270 · Queen Anne's 6,065 · Caroline 7,213 · Prince George's 734,567 · Talbot 7,953 · Charles 75,646 · Calvert 18,057 · Dorchester 11,037 · Wicomico 32,966 · St. Mary's 24,749 · Somerset 12,674 · Worcester 10,123

% Racial/Ethnic Minority

- 0% - 9.9%
- 10% - 18.9%
- 19% - 32.9%
- 33% - 39.9%
- 40% - 100%

Date Map Created: February 2011

45% minority

4 jurisdictions > 50% minority

6 jurisdictions >40% minority

9 jurisdictions >33% minority

out of 24 jurisdictions

Maryland Office of Minority Health and Health Disparities

What are Health Disparities?

Disparities in health refer to differences between two or more population groups in health outcomes and in the prevalence, incidence, or burden of disease, disability, injury or death.
(Kaiser Family Foundation)

Disparities in health care refer to racial or ethnic differences in the quality of healthcare that are not due to access-related factors or clinical needs, preferences, and appropriateness of intervention.

(Institute of Medicine)

In particular, we focus on……

Avoidable differences in health that result from cumulative social disadvantage.

(Adapted from The Connecticut Multicultural Health Partnership. Faces of Disparity. http://www.ctmhp.org)

Maryland Office of Minority Health and Health Disparities

What Causes Health Disparities??

- Inequities in the social determinants of health?

- Environmental risk factors?

- Institutional factors?

- Provider factors?

- Patient factors?

Sources: (1) Smedly BD et al. *Unequal Treatment*: Confronting Racial and Ethnic Disparities in Health Care. Institute of Medicine, 2002. (2) AMA. *Health Disparities*. Presentation, 2007. http://www.ama-assn.org/resources/doc/mss/ph_disparities_pres.pdf

Maryland Office of Minority Health and Health Disparities

Quality of Care and Health Disparities – Are We Seeing Progress?

❑ According to the latest HHS/AHRQ **National Healthcare Disparities Report** (2013),

1) Health care quality and access are suboptimal, especially for minority and low-income groups.

2) Overall quality is improving, but disparities are not changing.

- Only 70% of recommended care is actually received.
- Minorities and individuals living in poverty have worse quality measures overall.

3) Improvements are lagging most in:

- Quality of ambulatory care, diabetes care, and maternal and child health care; and,
- Addressing the increased disparities in cancer screening
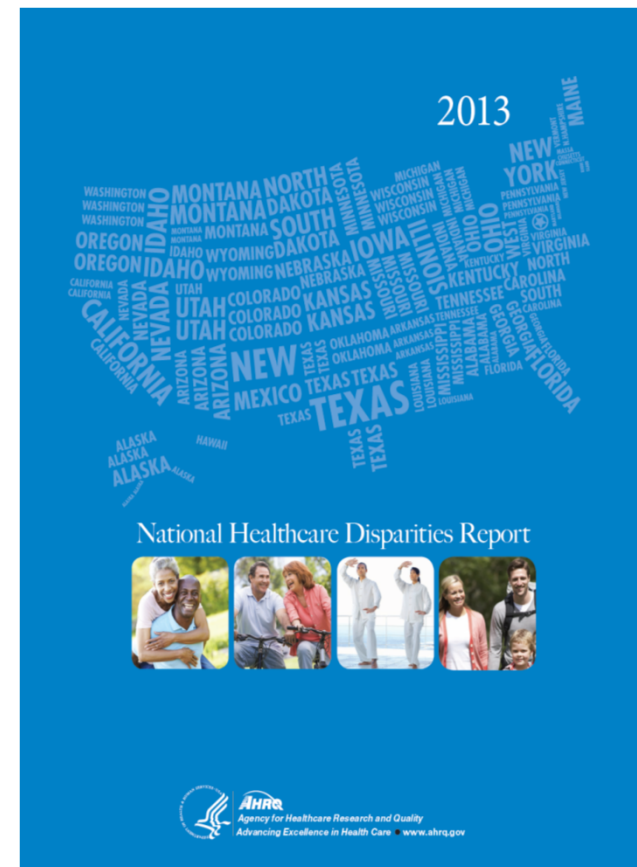
Source: HHS/AHRQ. National Healthcare Disparities Report, 2013. Available at: http://www.ahrq.gov/research/findings/nhqrdr/nhdr13/2013nhdr.pdf

Progress in Elimination of Health Disparities in Maryland

❑ Between 2000 and 2012 **the gaps** between the Black and White age-adjusted death rates (Black rate minus White rate) **were reduced** as follows: *(Maryland Vital Statistics Annual Report data)*

- For All-cause Mortality,   the gap was reduced by 56%

- For Cancer Mortality,   the gap was reduced by 58%

- For Heart Disease Mortality,   the gap was reduced by 33%

- For Stroke Mortality,   the gap was reduced by 64%

- For Diabetes Mortality,   the gap was reduced by 52%

- For HIV/AIDS Mortality,   the gap was reduced by 66%

Maryland Office of Minority Health and Health Disparities
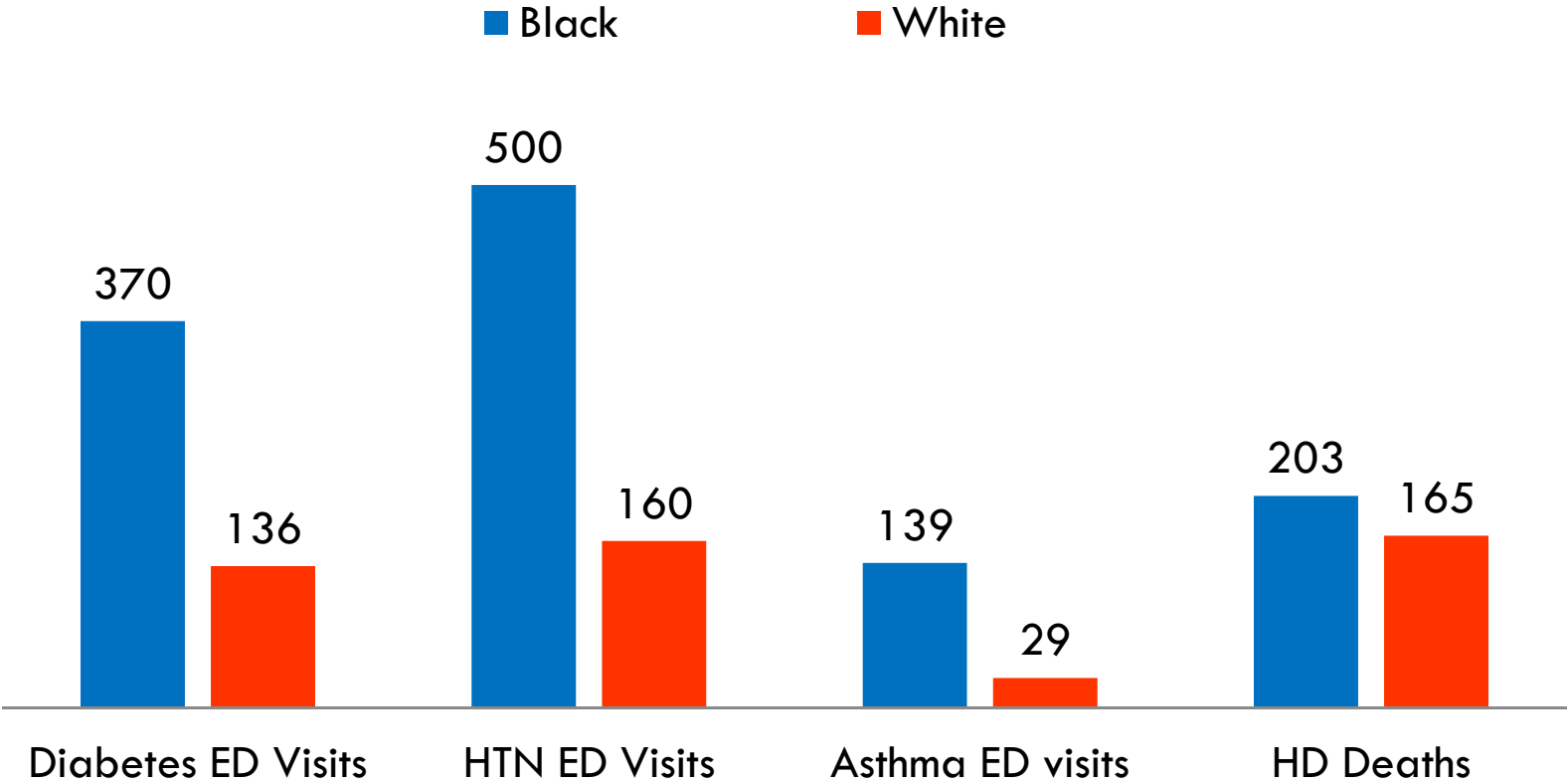
Importance of Disparities – Per Capita Total Hospital Cost by Race (FY 2013)

Legend:
- TOTAL
- 85+
- 75-84
- 65-74
- 55-64
- 45-54
- 15-44
- 5-14
- 0-4

White:
- $2,355
- $7,420
- $6,855
- $4,818
- $2,955
- $2,151

Black:
- $2,682
- $9,511
- $8,410
- $5,846
- $4,442
- $3,254

Other Races:
- $1,309
- $9,854
- $6,594
- $3,392
- $2,153
- $1,410

HSCRC
Health Services Cost
Review Commission
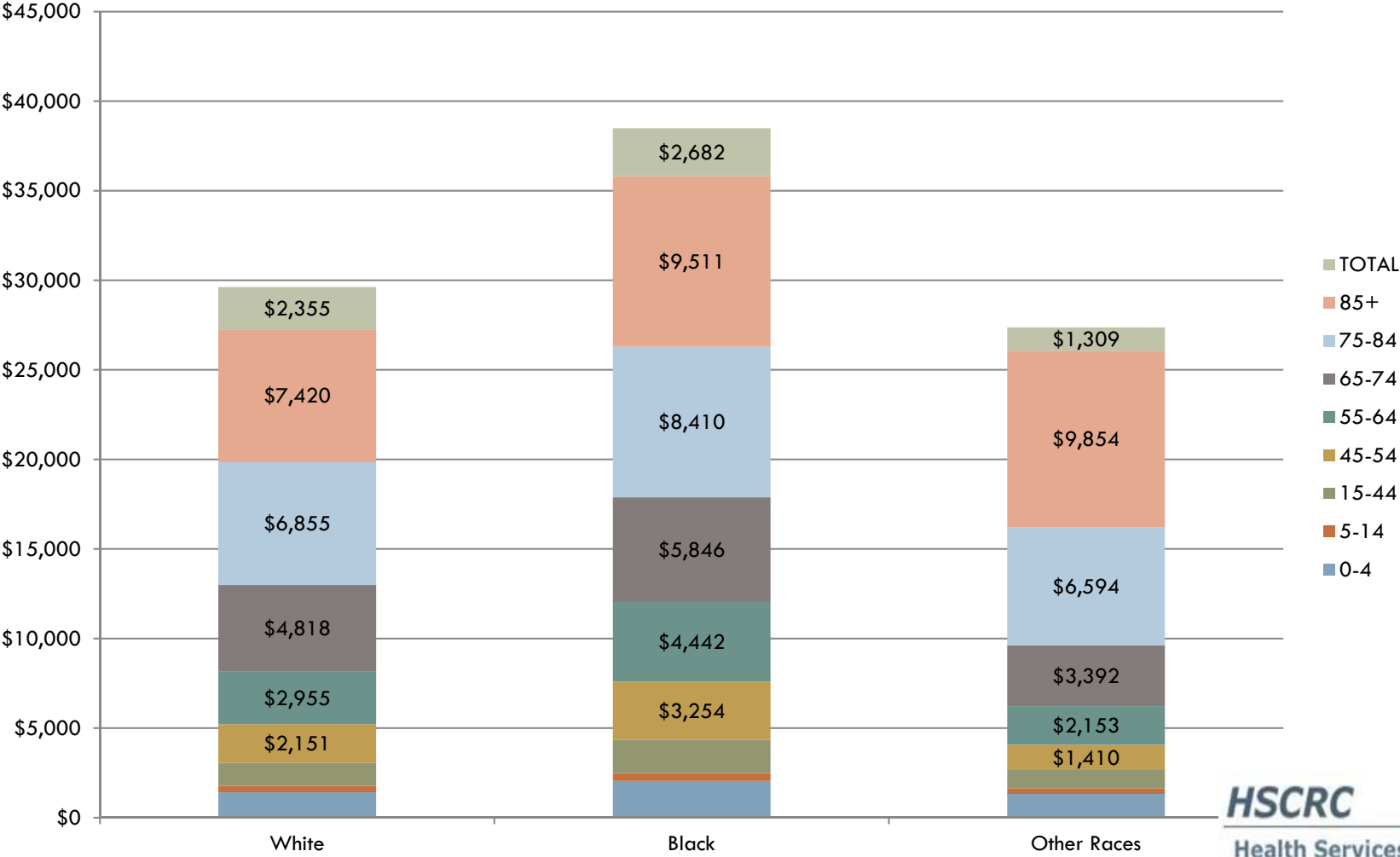
Potentially Avoidable Utilization
by Race (FY 2013)
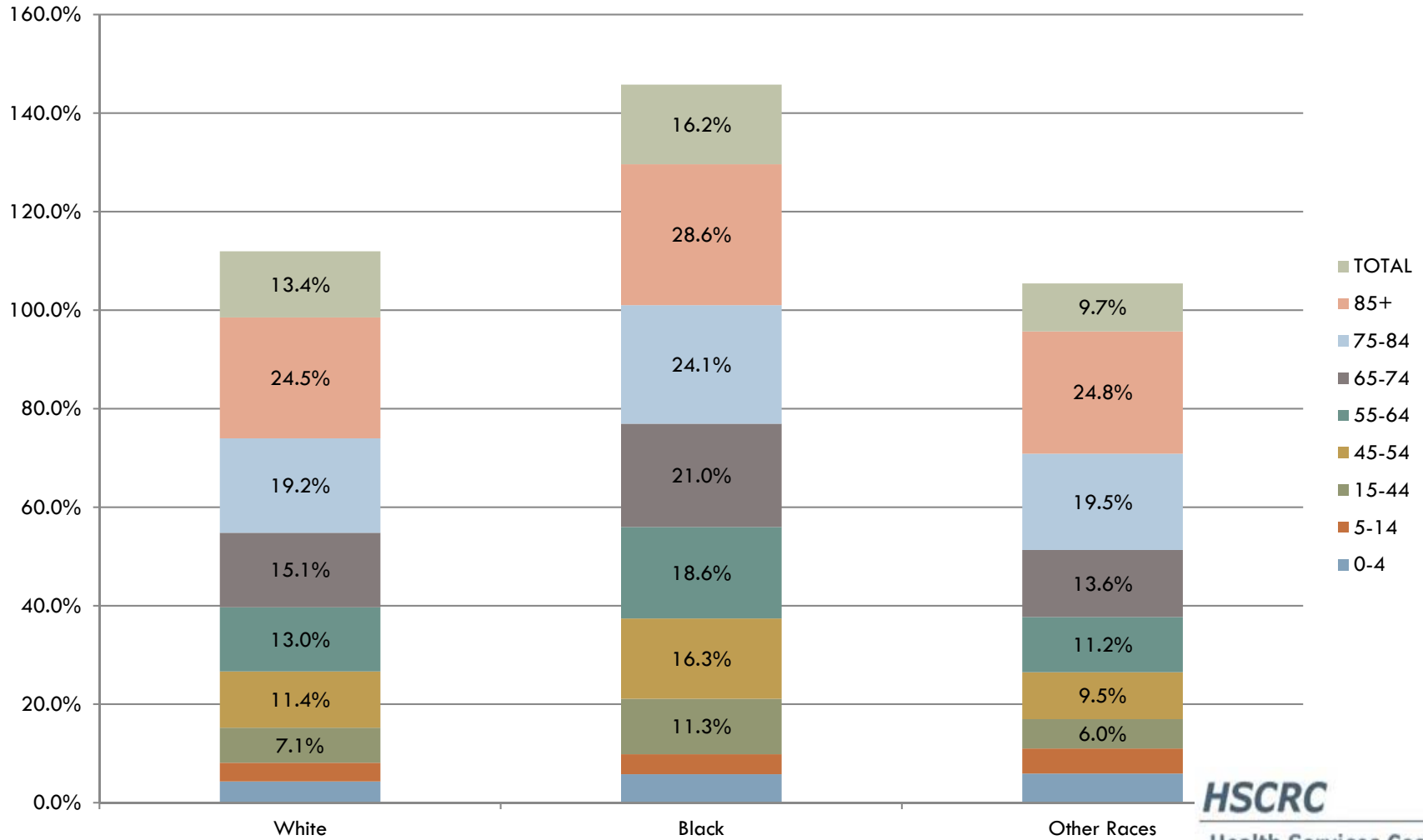
Readmission Rates by Race (FY 2014)
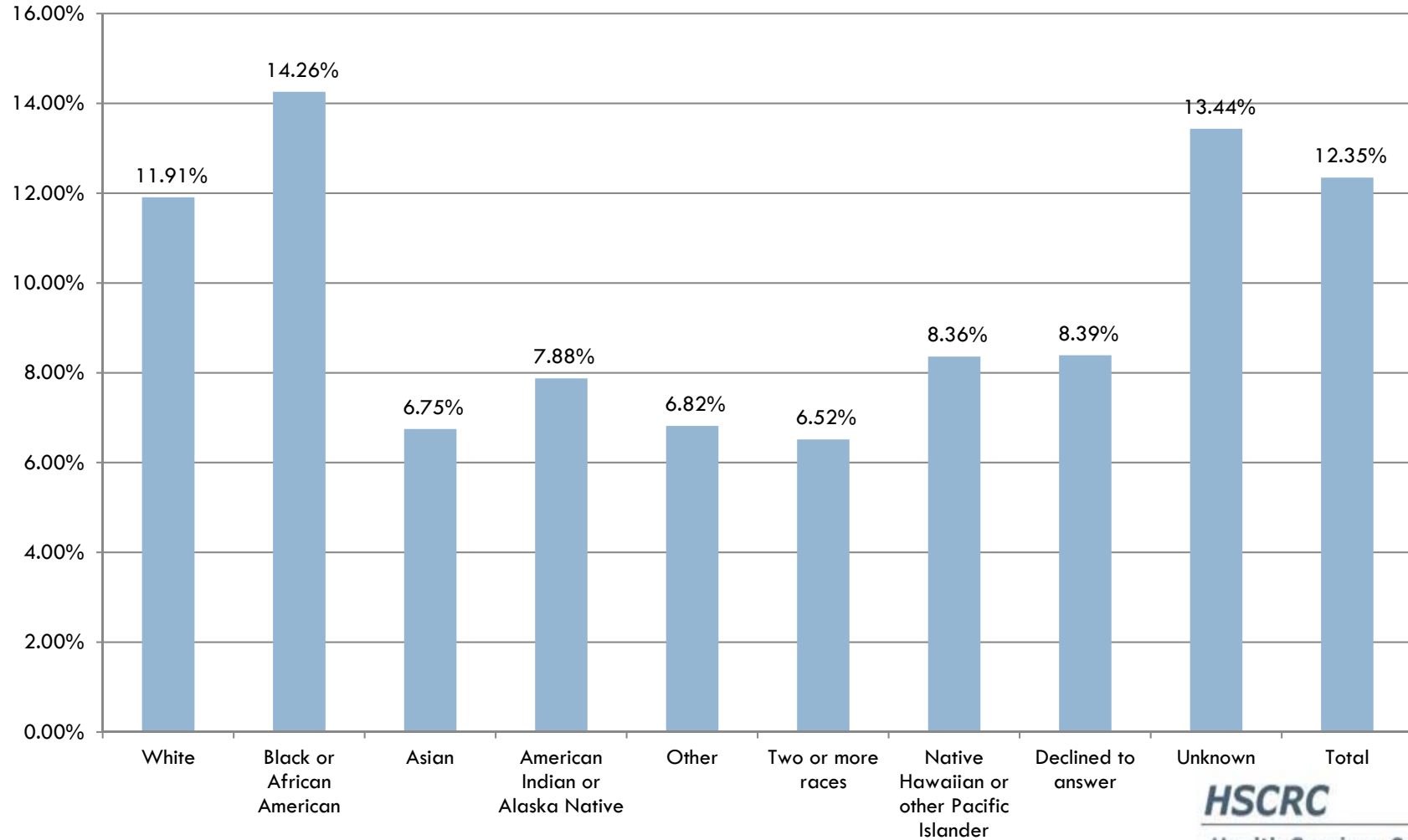
Cost of Disparities in Maryland

- **Minority Health Disparities cost Maryland between <u>1 and 2 Billion Dollars per year</u> of _direct medical costs._**

- **In Baltimore City, excess charges from Black/White hospitalization disparities alone were <u>$279 Million in 2011</u>.**

  - **_These are just the hospital charges , NOT including physician fees for hospital care, emergency department charges, or any outpatient costs._**

Source: Estimated from <u>The Economic Burden Of Health Inequalities in the United States</u>, Thomas A. LaVeist, Ph.D., Darrel J. Gaskin, Ph.D., and Patrick Richard, Ph.D. which was funded by the Joint Center for Political and Economic Studies.
http://jointcenter.org/sites/default/files/Economic%20Burden%20of%20Health%20Inequalities%20Fact%20Sheet.pdf

Maryland Office of Minority Health and Health Disparities

The Case for the CLAS Standards

The Case for Culturally and Linguistically Appropriate Services

Changing Demographics	In Maryland, the population is 58% non-Hispanic White; 8% Hispanic; 29% Black; 5% Asian American; 0.1% Native Hawaiian and Pacific Islander; and 0.4% American Indian/Alaska Native. By 2018, the White and non-White population in MD will be of equal size.
Cost of Health and Health Care Disparities	Minority health disparities cost Maryland between $1 Billion and $2 Billion per year of direct medical costs. In 2011, excess charges in Maryland from Black/White hospitalization disparities alone were $814 Million. (Source: Maryland Office of Minority Health and Health Disparities)
Medicare Waiver	Financial Tests and Quality Targets make it necessary for hospitals to know their patients and develop tailored strategies to keep patients out of the hospital and to help manage the health of the community.
Industry Standards	Joint Commission Hospital Accreditation Standards; National Committee on Quality Assurance (NCQA) Patient-Centered Medical Home Standards
Federal Statutes and Regulations	Affordable Care Act (2010); Plain Writing Act of 2010, Americans with Disabilities Act (1990); Section 504 of the Rehabilitation Act of 1973; Title VI of the Civil Rights Act of 1964; Executive Order 13166 of August 2000: Improving Access to Services for Persons with Limited English Proficiency; Federal and State community benefit reporting and needs assessments

Minority Health and Health Disparities

The Case for Culturally and Linguistically Appropriate Services

Minority Health and Health Disparities

Medical Errors	**Limited English proficient (LEP) patients who may not be able to communicate effectively with their health care providers are at greater risk for medical errors.** (Source: Agency for Healthcare Research and Quality. (2012). *Improving Patient Safety Systems for Patients with Limited English Proficiency*. Rockville: U.S. HHS Agency for Healthcare Research and Quality.)
Readmissions	**Racial and ethnic minorities are more likely to be readmitted for certain chronic conditions than their non-Hispanic White counterparts.** (Source: Agency for Healthcare Research and Quality. *Improving Patient Safety Systems for Patients with Limited English Proficiency*. Rockville: U.S. HHS Agency for Healthcare Research and Quality, 2012.)
Length of Stay	**Length of a hospital stay for LEP patients was significantly longer when professional interpreters were not used during both admission and discharge.** (Source: Lindholm M, et al. *Professional Language Interpretation and Inpatient Length of Stay and Readmission Rates*. J Gen Intern Med, Oct 2012; 27(10):1294-9.)
Treatment Adherence	**Effective patient-provider communication can increase treatment adherence, reduce unnecessary diagnostic services, and improve health outcomes.** (Source: American Medical Association, Ethical Force Program. *The AMA Ethical Force Program Toolkit: Improving Communication – Improving Care*. 2008.)

More on the Business Case …

Potential for the following benefits:

- ❑ Reduces preventable service utilizations
- ❑ Reduces avoidable 30-day hospital readmissions
- ❑ Improves efficiency of care and services by decreasing barriers that slow progress
- ❑ Reduces excess hospital costs of health disparities in the patient population
- ❑ Increases cost savings (↓ number of patient treatments; ↓ hospital LOS; ↓ number of medical errors)
- ❑ Improves patient satisfaction and self-reported QOC measures
- ❑ Improves patient compliance
- ❑ Improves patient safety and reduces medical errors
- ❑ Improves risk management
- ❑ Reduces risk of sanctions and penalties

Sources: Institute for Diversity in Health Management and the Health Research & Educational Trust. *Becoming a culturally competent health care organization.* (2013) http://www.hpoe.org/Reports-HPOE/becoming_culturally_competent_health_care_organization.PDF

Adelson BL. *Beyond the Right Thing to Do: The Legal Case for CLAS Implementation.* Webinar sponsored by Hopkins Center for Health Disparities Solutions (12/3/13).

Bachrach D, et al. Addressing Patients' Social Needs: An Emerging Business Case for Provider Investment. The Commonwealth Fund. (2014) http://www.commonwealthfund.org/~/media/files/publications/fund-report/2014/may/1749_bachrach_addressing_patients_social_needs_v2.pdf

Maryland Office of Minority Health and Health Disparities

Ethical & Social Case

Potential for the following benefits:

- ❑ Facilitates increased access and quality of care for culturally diverse patients
- ❑ Increases community participation and involvement in health issues
- ❑ Promotes inclusion of all community members
- ❑ Increases mutual respect, trust and understanding
- ❑ Promotes patient and family responsibilities for health
- ❑ Increases preventive care-seeking behavior by patients

Source: Institute for Diversity in Health Management and the Health Research & Educational Trust. *Becoming a culturally competent health care organization.* *(2013)* http://www.hpoe.org/Reports-HPOE/becoming_culturally_competent_health_care_organization.PDF

Maryland Office of Minority Health and Health Disparities

Bottom Line

Persistent Health Disparities

Changing Policy Environment

Changing Demographics

CLAS Standards

Practice Redesign:

- Coordinated, efficient, high-quality care
- Patient-centered and culturally and linguistically-appropriate services

Triple Aim

Maryland Office of Minority Health and Health Disparities

Minority Health and Health Disparities
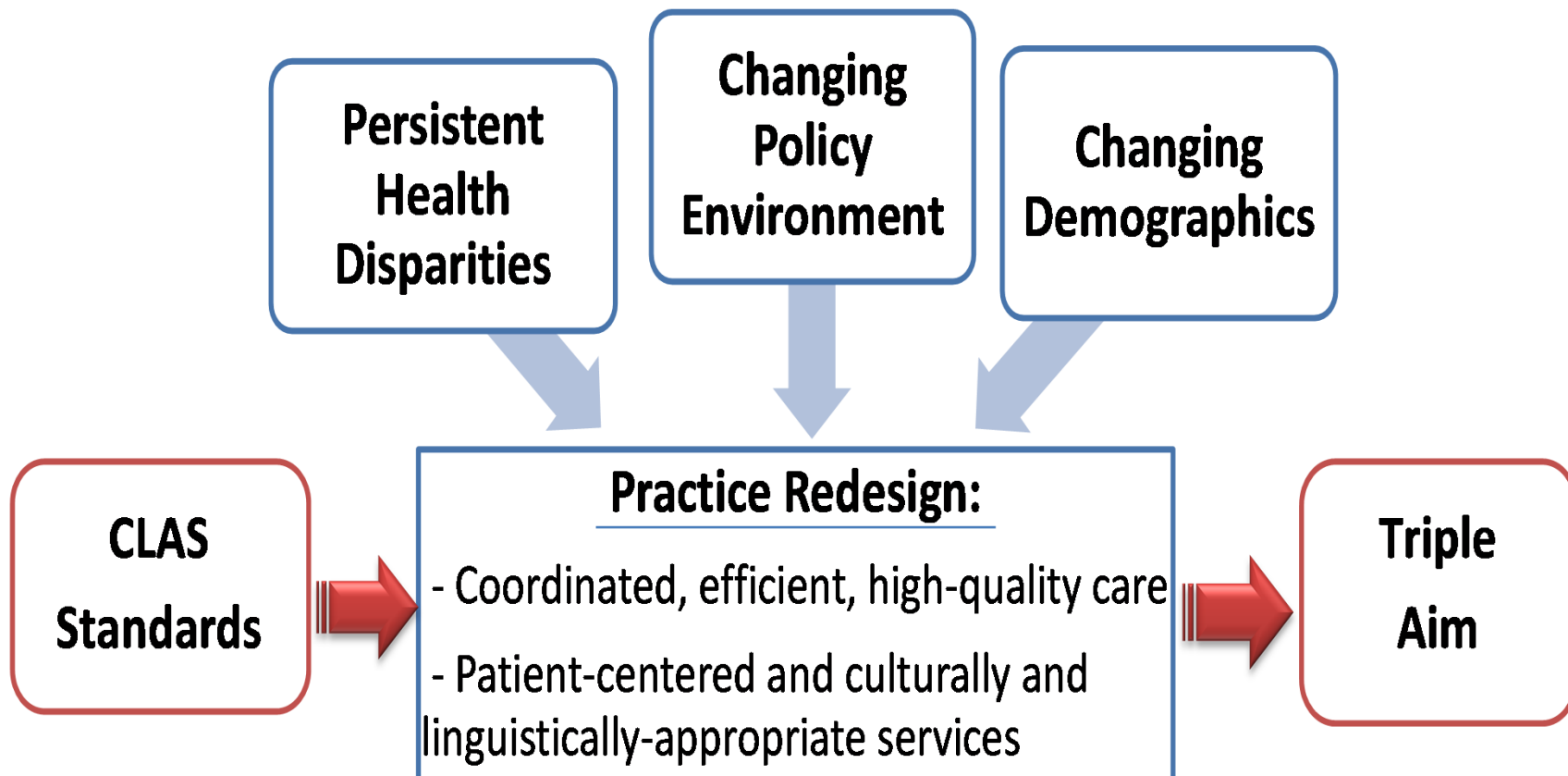
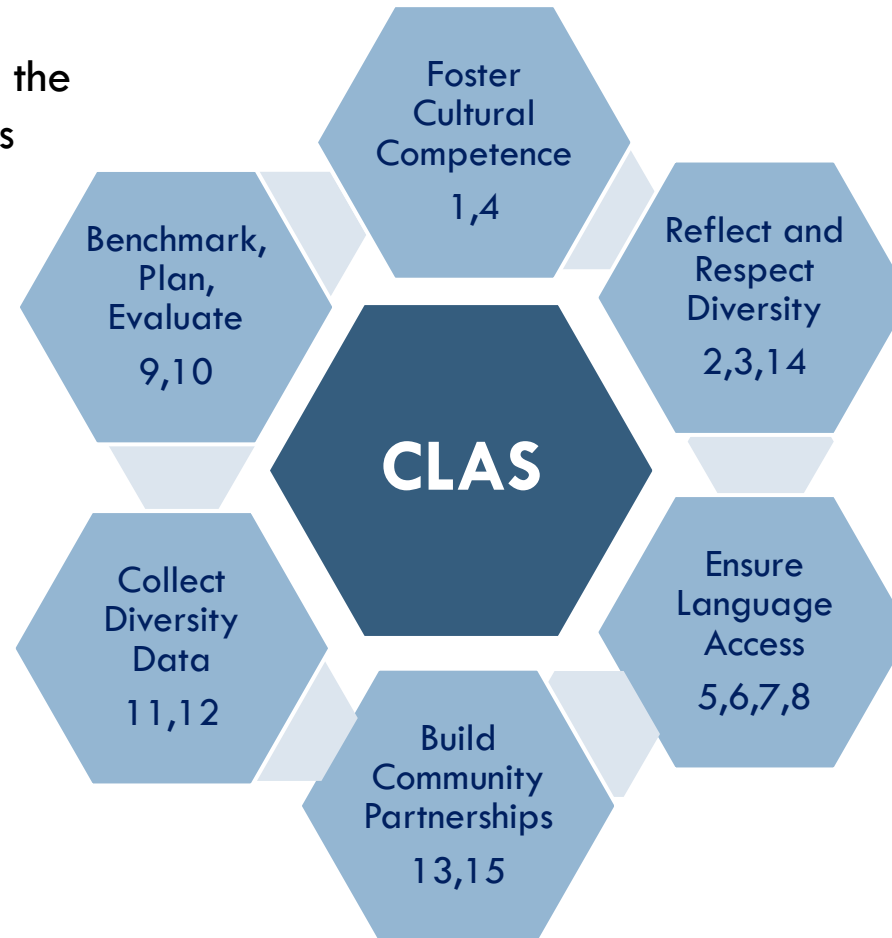# CLAS Standards Implementation

Implementation Framework:
Six Areas for Action

Numbers represent the
15 CLAS Standards

Adapted from "Making CLAS Happen", Massachusetts Department of Health
http://www.mass.gov/eohhs/gov/departments/dph/programs/admin/health-equity/clas/making-clas-happen.html

CLAS Implementation

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I. Fostering Cultural Competence

Fostering cultural competence:

- CLAS Standards

❑ **CLAS 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.

❑ **CLAS Standard #4:** Educate and train governance, leadership, and workforce in culturally and linguistically appropriate policies and practices on an ongoing basis.

Fostering cultural competence:

– Complementary Concepts

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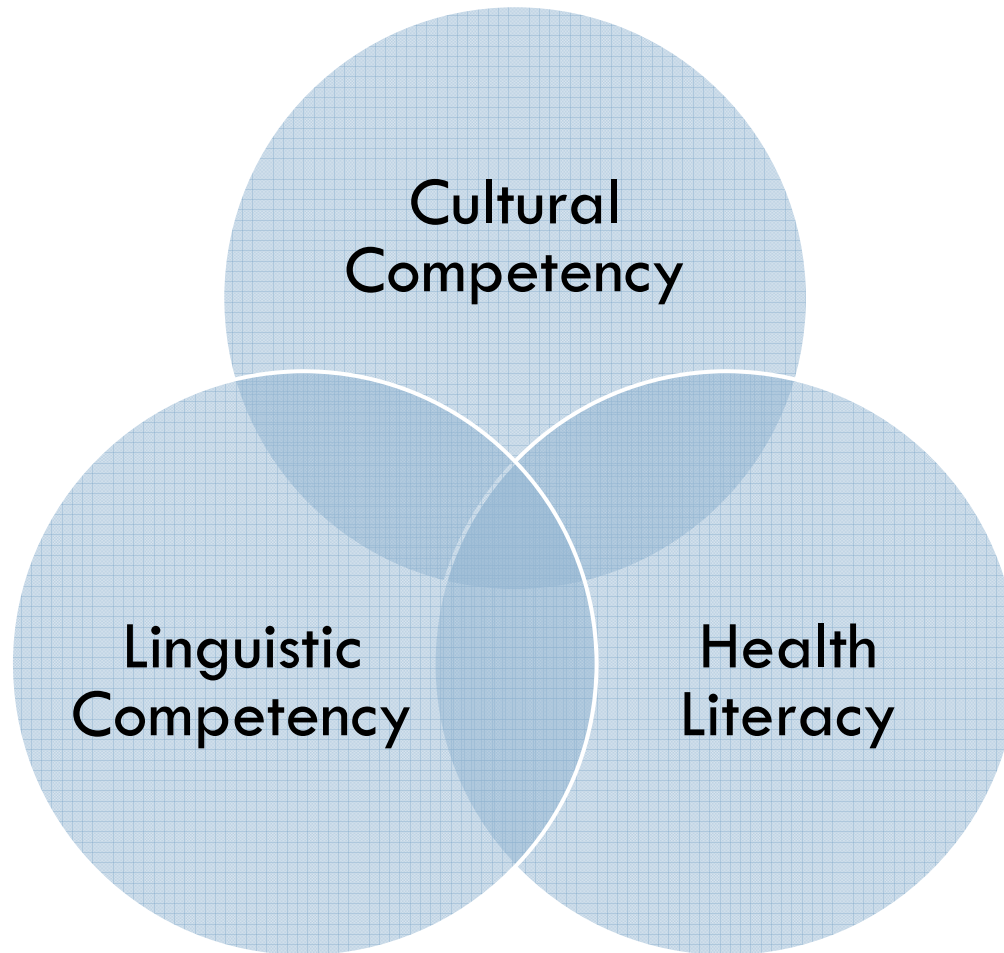
Fostering cultural competence:

– What is cultural competency?

- ❑ A set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among professionals that enables effective work in cross-cultural situations (Source: http://minorityhealth.hhs.gov/templates/browse.aspx?lvl=2&lvlID=11)

- ❑ Cultural competency can be described as the ability of health organizations and professionals to:

  - ❑ Recognize the cultural beliefs, values, attitudes, traditions, language preferences, and health practices of diverse populations
  - ❑ Understand how these cultural factors interact with the biological, social, economic, and physical environment of an individual client or patient
  - ❑ Apply this knowledge to produce a positive health outcome

  (Source: http://minorityhealth.hhs.gov/templates/browse.aspx?lvl=2&lvlID=11)

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Fostering cultural competence:
– Diverse Intersections of Health

Race	Ethnicity
HEALTH BELIEFS	
Culture	Religion

?? ?? Others?? ?? ??

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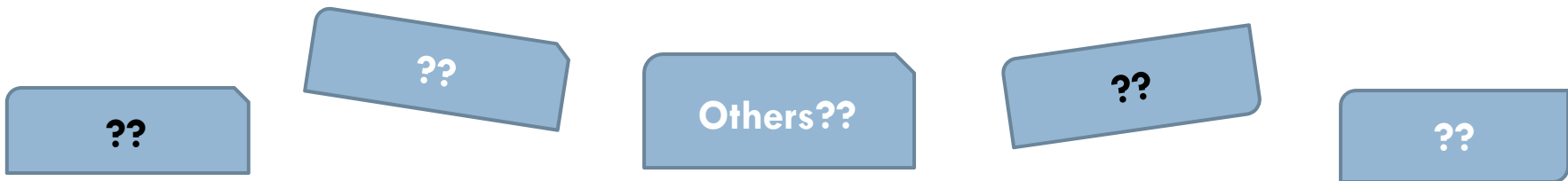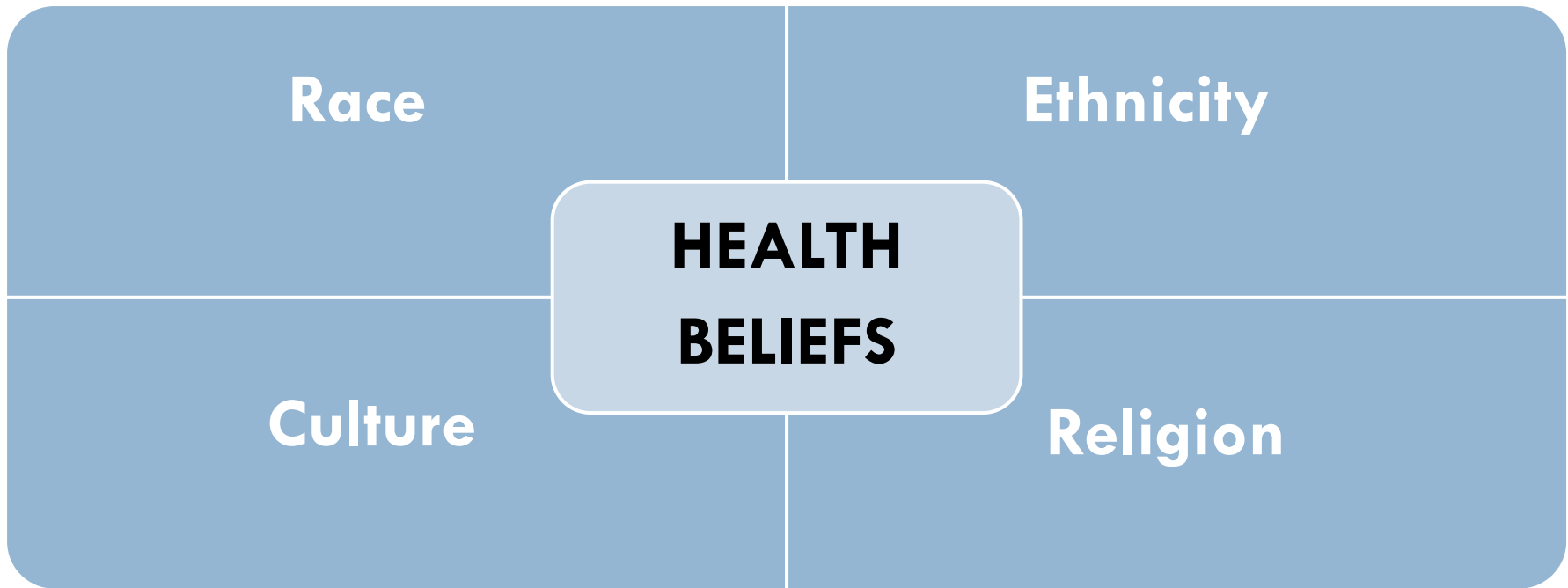
Fostering cultural competence:

– We all have health beliefs …

❑ **Group Exercise**: Let's break into small groups to discuss what we learned from family and friends during childhood/adulthood about two common conditions:

  ❑ What causes you to catch a cold?

  ❑ What things should a woman <u>not do</u> when pregnant?

[Participants will report back and share their "findings" with the larger group.]

Source: National Center for Cultural Competence. Georgetown University, Center for Child and Human Development.
http://nccc.georgetown.edu/projects/sids/dvd/health%20beliefs.pdf

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Fostering cultural competence:

– Health beliefs may influence …

- ❑ When care is sought.

- ❑ Expectations about care.

- ❑ Reactions to illness.

- ❑ Adherence to recommendations.

- ❑ Adoption of healthy behaviors.

Source: Adapted from Michelle Gourdine & Associates. *Cultural Competency: A Provider Perspective*. Webinar sponsored by the Maryland Women's Coalition for Health Care Reform webinar series, "Leveraging Health Care Reform: Cultural Competency and Health Literacy Strategies.". (12/13/13)

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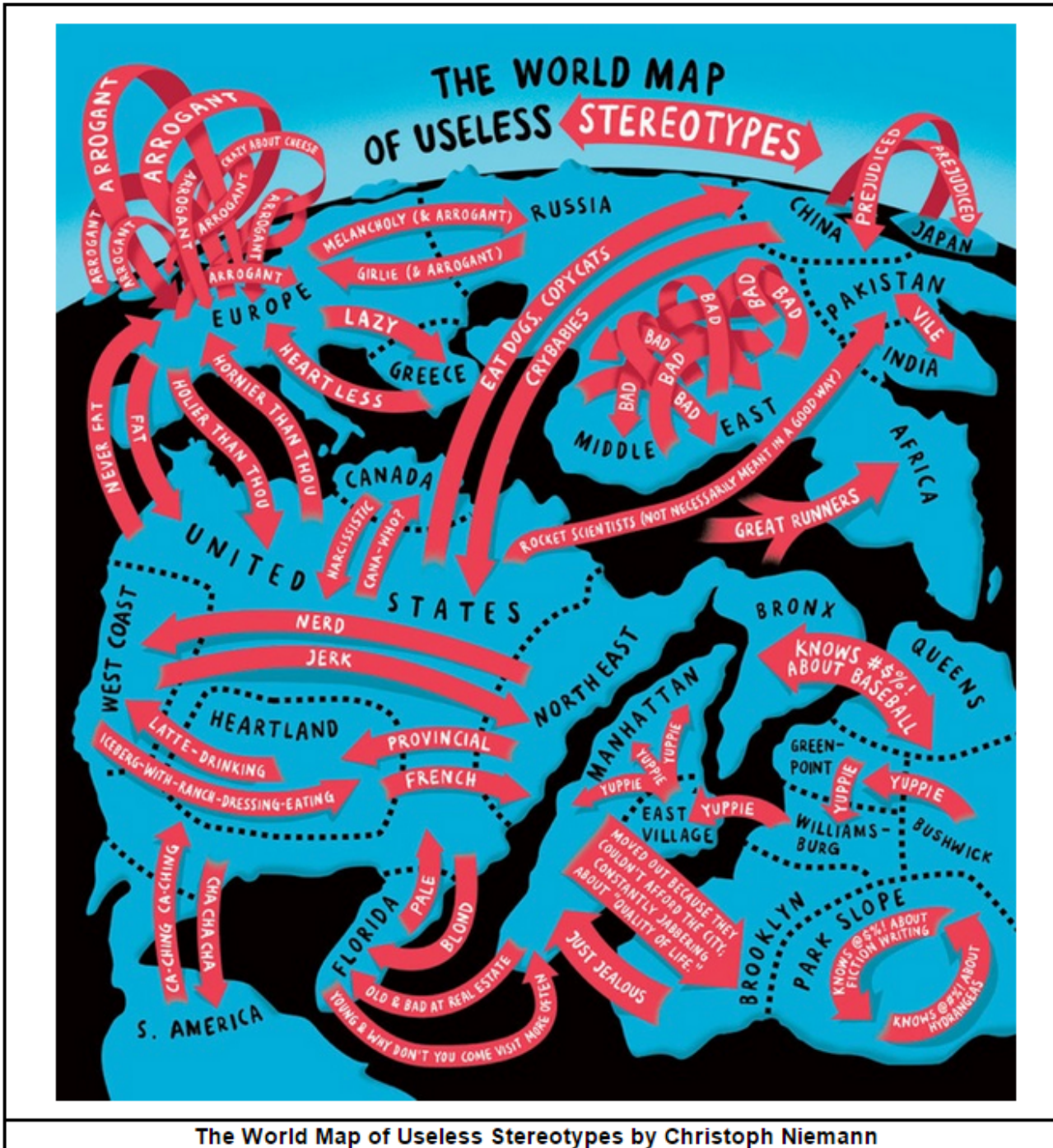
The World Map of Useless Stereotypes by Christoph Niemann

Fostering cultural competence:

– Unconscious Bias

☐ 'Our implicit people preferences, formed by our socialization, our experiences, and by our exposure to others' views about other groups of people'

- They cause us to have feelings and attitudes about other people based on characteristics such as race, ethnicity, age, and appearance.

- They are **pervasive**. Everyone possesses them, even people with avowed commitments to impartiality.

- They are **malleable**. Our brains are incredibly complex, and the implicit associations that we have formed can be gradually unlearned.

Source: The Kirwan Institute at Ohio State University (Available at: http://kirwaninstitute.osu.edu/research/understanding-implicit-bias/)

Fostering cultural competence:

– Recognizing Your Biases

Write down the first thing you think of when you see
the following terms?

- An older person:
- A Muslim:
- A fundamentalist Christian:
- An atheist
- A black person:
- A 50 year-old white male:
- A person in a wheelchair:
- A person from Vietnam:
- A gay man:
- A female engineer:

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Fostering cultural competence:

– What is linguistic competency?

❑ The capacity to communicate effectively, and convey information in a manner that is easily understood by diverse audiences including persons of limited English proficiency, those who have low literacy skills or are not literate, individuals with disabilities, and those who are deaf or hard of hearing

❑ Linguistic competency requires:

■ Organizational and provider capacity to respond effectively to the health and mental health literacy needs of populations served.

■ Organizational policies, structures, practices, procedures, and dedicated resources to support this capacity.

(Source: Goode & Jones (modified 2009). National Center for Cultural Competence, Georgetown University Center for Child & Human Development. http://nccc.georgetown.edu/foundations/frameworks.html#ccdefinition)

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Importance of Cultural & Linguistic Competence

☐ Health care services that are respectful of and responsive to the health beliefs, practices and cultural and linguistic needs of diverse patients can help bring about positive health outcomes.

☐ The increasing population growth of racial and ethnic communities and linguistic groups, each with its own cultural traits and health profiles, presents a challenge to the health care delivery service industry in this country.

☐ The provider and the patient each bring their individual learned patterns of language and culture to the health care experience, which must be transcended to achieve equal access and quality health care.

Source: http://minorityhealth.hhs.gov/templates/browse.aspx?lvl=2&lvlID=11

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Fostering cultural competence:
– What is Health Literacy

The degree to which individuals have the capacity to obtain, process and understand basic health information and services needed to make appropriate health decisions

Take 3 times a day orally after meals but not with alcohol, dairy or caffeine.

???

GLASBERGEN

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Fostering cultural competence:

– What is Health Literacy?

❑ 30% of adults in the state have only a "basic" or "below basic" level of health literacy

Source: Maryland population sample of the National Assessment of Adult Literacy.

Without clear information and an understanding of the information's importance, people are more likely to skip necessary medical tests, end up in the emergency room more often, and have a harder time managing chronic diseases like diabetes or high blood pressure.

Source: (Rudd, R . E., Anderson, J . E., Oppenheimer, S., & Nath , C. (2007). Health literacy: An update of public health and medical literature. In J. P. Comi ngs, B. Garner, & C. Smith. (E ds.), *Review of adult learning and literacy* (vol . 7) (pp 175–204). Mahwa h, NJ: Lawrence Erlbaum Associates.)

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Fostering cultural competence:

– Importance of Health Literacy

- □ Evidence suggests that disparities in treatment outcomes may be explained partly by differences in the health literacy levels of health consumers.

- □ Differences in health literacy have been consistently linked to:
  - ◻ Increased hospitalizations
  - ◻ Greater emergency care use
  - ◻ Lower use of mammography
  - ◻ Lower receipt of influenza vaccine
  - ◻ Less ability to interpret labels and health messages
  - ◻ Less ability to demonstrate taking medications appropriately
  - ◻ Poorer overall health status and higher mortality among seniors

  These outcomes are associated with higher healthcare costs.

Source: Berkman ND, Sheridan SL, Donahue KE, et al. Health Literacy Interventions and Outcomes: An Updated Systematic Review. Rockville (MD): Agency for Healthcare Research and Quality (US); 2011 Mar. (Evidence Reports/Technology Assessments, No. 199.)

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Fostering cultural competence:

– Interactive Exercise

"The Newest Vital Sign"

http://pilot.train.hrsa.gov/uhc/pdf/modules/02/Module02NewestVitalSignAssessment.pdf

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The Newest Vital Sign Assessment

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.

Fostering cultural competence:
Attributes of Health Literate Organizations

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1. Have leadership that makes health literacy integral to its mission, structure, and operations.

2. Integrate health literacy into planning, evaluation measures, patient safety, and quality improvement.

3. Prepare the workforce to be health literate and monitor progress.

4. Include the service population in the design, implementation, and evaluation of health information and services.

5. Meet the needs of populations with a range of health literacy skills while avoiding stigmatization.

Source: Brach C, Keller D, Hernandez LM, et al. *Ten Attributes of Health Literate Health Care Organizations*. Institute of Medicine, June 2012.

– **Attributes** (cont'd)

6. Use health literacy strategies in interpersonal communications and confirm understanding at all points of contact.

7. Provide easy access to health information and services and navigation assistance.

8. Design and distribute print, audiovisual, and social media content that is easy to understand and take action on.

9. Address health literacy in high-risk situations, including care transitions and communications about medicines.

10. Communicate clearly what services health plans cover and how much individuals will have to pay out-of-pocket.

Fostering cultural competence:
– Discussion

- In what ways do you feel that cultural competence is being fostered?

- Are leaders and staff in all roles and departments encouraged to participate in the described activities?

- What have been facilitators to fostering cultural competence?

- What have been barriers to fostering cultural competence?

- What actions can be taken to overcome the barriers?

- What are additional actions/activities that you would like to undertake to foster cultural competence?

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– Action Steps

☐ [Step 1](). **Identify committed champions of cultural competency within the organization.**

☐ [Step 2](). **Embed a commitment to culturally competent care in the organization's goals, mission, and strategic plan.**

☐ [Step 3](). **Allocate organizational resources to educating senior leadership, staff, and volunteers.**

☐ [Step 4](). **Integrate cultural competency and CLAS into staff evaluations.**

☐ [Step 5](). **Regularly review and update organizational policies and practices to reflect the CLAS Standards.**

Fostering cultural competence:

– Case Example

☐ **Integrating Cultural Competency into Population Health Initiatives** *New York Presbyterian Hospital (NY)*

☐ <u>**Actions:**</u>

  ◻ NYP established a collaborative to improve care coordination and cultural competency.

  ◻ Physicians also receive training with patient-based cross-cultural care, which assists with cultural competency and communication with patients and families.

☐ <u>**Results:**</u> As of May 2011, approximately 600 employees have received cultural competency training. The collaborative has helped decrease the number of emergency department visits for ambulatory care - sensitive conditions by 9.2 percent.

Source: Alliance of Community Health Plans Foundation. *Making the Business Case for Culturally and Linguistically Appropriate Services in Health Care: Case Studies from the Field.* 2007

CLAS Implementation

II. Reflect and Respect Diversity

Reflect and Respect Diversity:
– CLAS Standards

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

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

❑ **CLAS Standard # 14:** Create conflict and grievance resolution processes that are culturally and linguistically appropriate to identify, prevent, and resolve conflicts or complaints.

Reflect and Respect Diversity:
– U.S. Health Workforce

Under-represented Minorities (URMs) in the U.S. Health Workforce

0.7% — Native Americans

0.2% — Native Hawaiians & Other Pacific Islanders

12.3% — Blacks

16.9% — Hispanics

30%

16% Nursing (RN)

13% Medicine

11% Pharmacy

10% Dentistry
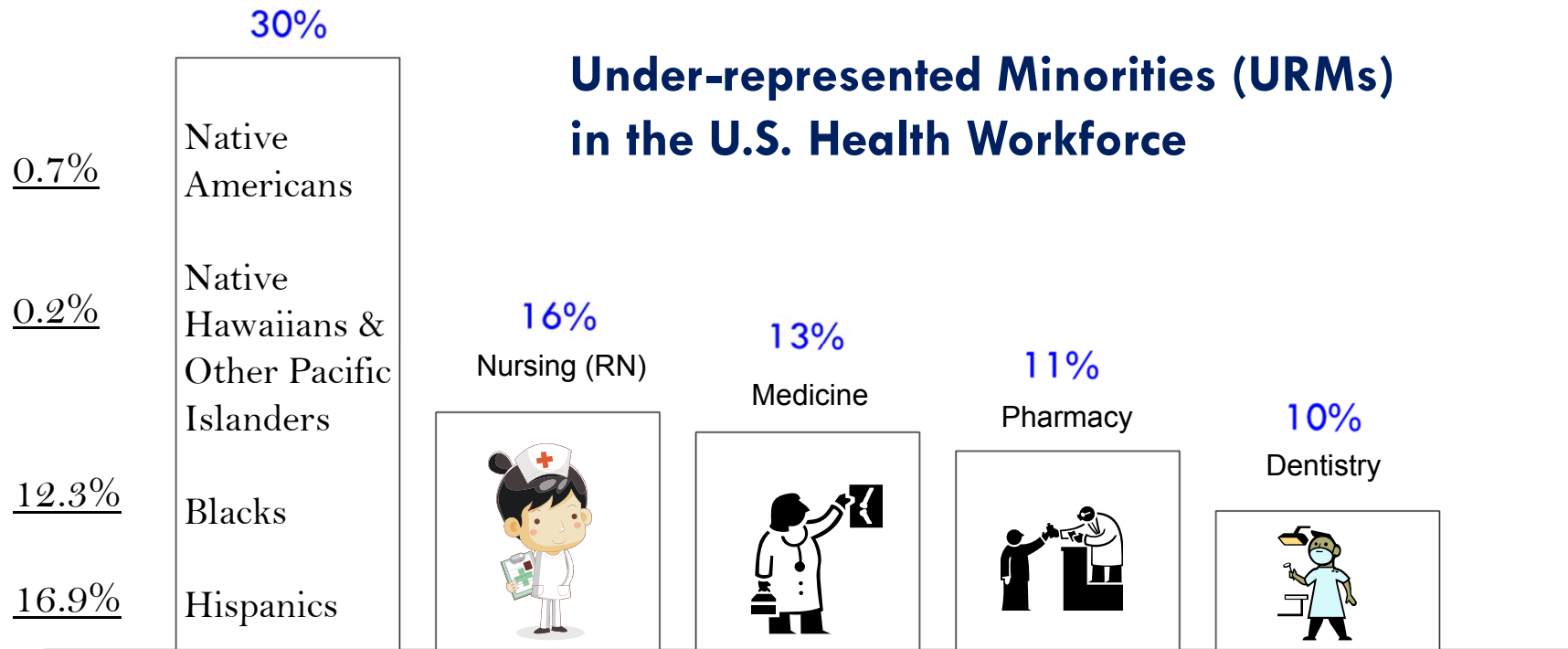
URMs in the General Population
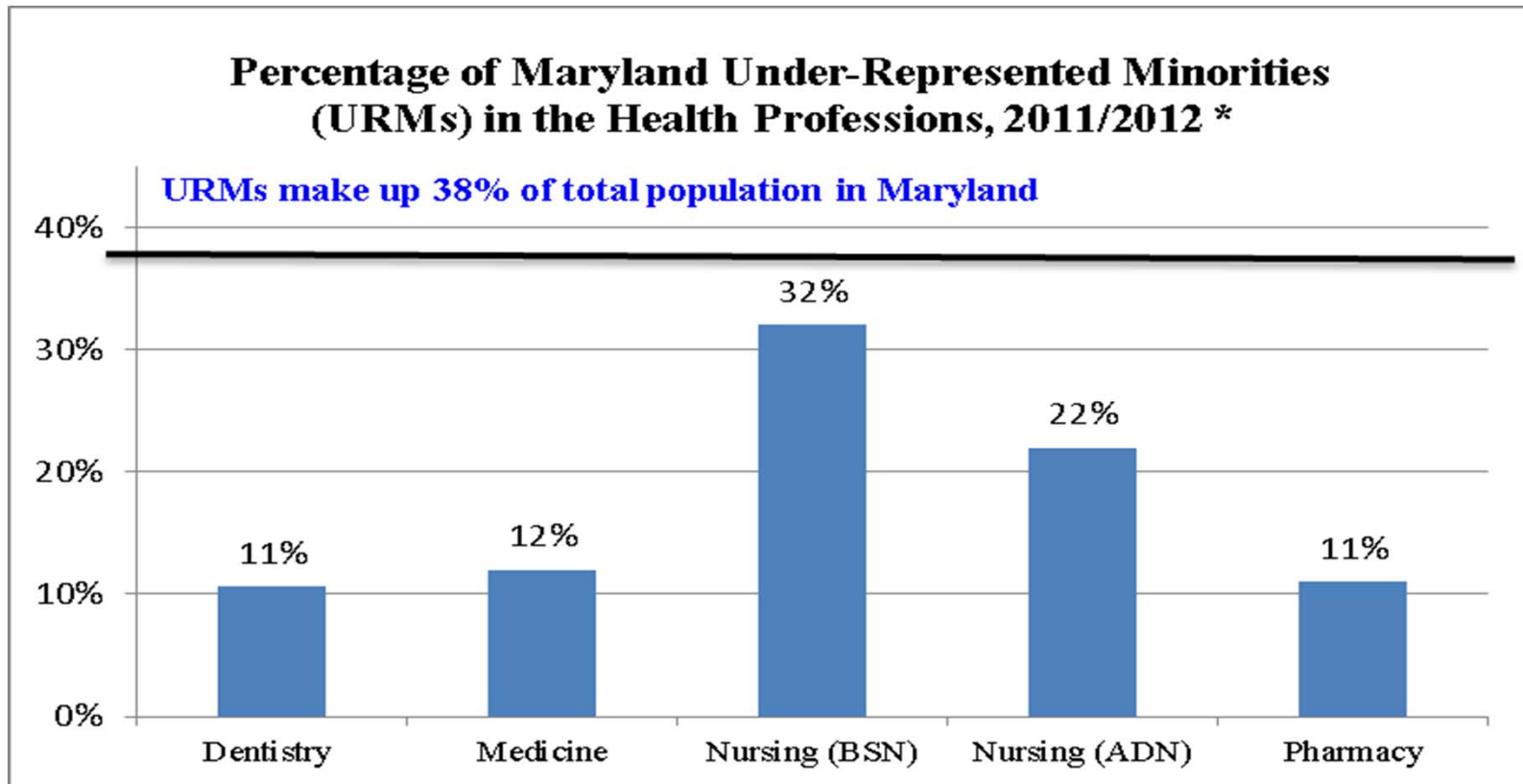
URMs in the Health Professions

Sources:
U.S. Bureau of Census, American Community Survey, 2012
HHS/HRSA, U.S. Health Workforce Chartbook, 2013

Reflect and Respect Diversity:
– Maryland Health Profession Grads

Percentage of Maryland Under-Represented Minorities (URMs) in the Health Professions, 2011/2012 *

URMs make up 38% of total population in Maryland

Source: Office of Minority Health and Health Disparities. Diversity in the Health Professions Fact Sheet. Maryland Department of Health and Mental Hygiene. Baltimore, MD. August 2013.

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Reflect and Respect Diversity:
– Discussion

- Are there structured opportunities available for staff to have discussions about culture, language, and other factors involved in meeting the needs of diverse populations?

- How well does your workforce reflect the community?

- What strategies are in place to ensure that the community is also reflected at governance and leadership levels?

- In what ways is the diversity of the staff being utilized to provide culturally and linguistically competent care?

- What other things are done to help patients feel welcome?

- What processes are in place to resolve conflicts or grievances from patients and/or staff?

- What methods are used to obtain and process feedback from staff?

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Reflect and Respect Diversity:
– Action Steps

- **Step 1**. Implement recruitment, retention, and promotion policies for a workforce (staff and leadership) that reflects the diversity of the community being served.

- **Step 2**. Establish a conflict and grievance resolution process to respond to concerns from both patients and staff.

- **Step 3**. Provide cross-cultural communication and conflict resolution training.

- **Step 4**. Provide notice about the right to file grievances or to provide feedback.

- **Step 5**. Establish formal and informal methods to obtain and process feedback from patients and staff.

- Case Example

- **Establishing a Process to Increase Diversity in Recruitment Initiatives** *Greenville Hospital System University Medical Center, Greenville, South Carolina*

- <u>Actions:</u>
  - The leadership search and selection process was overhauled, and a new method of hiring employees at the director level and above was put in place.
  - GHS worked with Furman University, also in Greenville, to send key leaders at GHS through a five-month educational program designed to train existing local leaders in diversity and its importance to an organization.

- <u>Results:</u>

  The first year after implementation of the new process, 70 percent of leadership team appointments were from underrepresented groups, and 50 percent were racial and ethnic minorities.

CLAS Implementation

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III. Ensure Language Access

Ensure Language Access:
– CLAS Standards

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

- **CLAS Standard #6:** Inform all individuals of the availability of language assistance services clearly and in their preferred language, verbally and in writing.

- **CLAS Standard #7:** Ensure the competence of individuals providing language assistance, recognizing that the use of untrained individuals and/or minors as interpreters should be avoided.

- **CLAS Standard #8:** Provide easy-to-understand print and multimedia materials and signage in the languages commonly used by the populations in the service area.

Ensure Language Access:

- Video Clip

"Can Someone Help Me?"

http://www.youtube.com/watch?v=q5ZJzEeJbe0

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Language Access

❑ Nearly 15% of Marylanders age 5 and older speak a language other than English at home

Source: U.S. Census Bureau, 2010.

❑ 20% of Marylanders report that they speak English "not well" or "not at all"

Source: U.S. Census Bureau, 2010.

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Linguistic Diversity in Maryland & [INSERT JURISDICTION]

Top Foreign Languages Spoken in Households in Maryland	Top Foreign Languages Spoken in Households in [IJURISDICTION]
1. Spanish	1. >>>
2. Chinese	
3. Korean	
4. African languages (several)	
5. Vietnamese	
6. French	
7. Tagalog	

Source: Migration Policy Institute tabulations from the U.S. Census Bureau pooled from 2009 – 2011 American Community Survey.

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Ensure Language Access:
– Discussion

- ☐ How are the language needs of the patient population monitored?

- ☐ How are patients notified of the availability of communication and language assistance services?

- ☐ What do you currently do to ensure language access?

- ☐ What processes are in place to assess the quality of language assistance services?

- ☐ What methods are used to familiarize staff about communication and language assistance services?

- ☐ How well are bilingual staff being utilized?

- ☐ What opportunities exist in the community to help strengthen language access?

- ☐ What else could be done to improve accessibility of language services?

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Ensure Language Access:

- Action Steps

- **Step 1**. Assess the language needs and services within the community.

- **Step 2**. Develop a Communication and Language Assistance Plan.

- **Step 3**. Develop a standardized process for identifying and documenting patients' preferred language.

- **Step 4**. Provide training for staff (language services and medical interpreter training).

- **Step 5**. Notify patients of availability of communication and language assistance services.

- **Step 6**. Issue guidance to staff on use of "plain language".

CLAS Implementation

IV. Build Community Partnerships

Build Community Partnerships:
– CLAS Standards

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

- **CLAS Standard #15:** Communicate the organization's progress in implementing and sustaining CLAS to all stakeholders, constituents, and the general public.

Build Community Partnerships:

- Interactive Exercise

Working with hard-to-reach communities:

☐ How do you make contact?

☐ How do you determine need?

☐ How do you develop culturally and linguistically appropriate services?

☐ How do you determine whether the services are meeting the needs of the population?

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Build Community Partnerships:
– Discussion

☐ What methods are being used to help develop sustainable links with the community?

☐ How are community liaisons identified and engaged?

☐ In what ways is the community involved in the design, implementation, and/or evaluation of policies, practices and services at your site?

☐ How are the organization's CLAS-related activities being communicated to the community?

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Build Community Partnerships:
- Action Steps

- ❑ **Step 1**. Partner with community organizations.

- ❑ **Step 2**. Engage community stakeholders and patients in planning, developing, and implementing services.

- ❑ **Step 3**. Develop opportunities for community capacity-building and empowerment.

- ❑ **Step 4**. Employ community health workers/ promotores de salud.

- ❑ **Step 5**. Share news of the organization's CLAS and cultural competency efforts.

CLAS Implementation

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V. Collect Diversity Data

Collect Diversity Data:
– CLAS Standards

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

- **CLAS Standard #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.

Collect Diversity Data:

– Interactive Exercise

"Sorting People"

http://www.pbs.org/race/002_SortingPeople/002_00-home.htm

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Collect Diversity Data:

- Demographic Categories

❑ What categories of demographic data do you currently collect?

❑ What other categories should you collect?

Collect Diversity Data:

Sample Categories for Data Collection

Client Data

- Race
- Ethnicity
- Nationality
- Preferred spoken / written language
- Age
- Gender
- Sexual orientation / gender identity
- Income
- Education
- Informed of right to interpreter services
- Use of interpreter services
- Treatment history
- Medical history
- Client satisfaction
- Outcome data (service type, utilization, length of stay)

Staff Data

- Race
- Ethnicity
- Nationality
- Primary/preferred language
- Gender
- Records of cultural competency training participation and evaluations

Collect Diversity Data:
- Discussion

□ What methods are used to familiarize frontline staff with data collection protocols?

□ How is the community engaged in the data collection process?

□ What types of community data might it be useful to link with patient data?

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Collect Diversity Data:

- Action Steps

- ☐ **Step 1. Collaborate with community in data collection, analysis, review, and reporting.**

- ☐ **Step 2. Standardize data collection process for self-reported demographic information.**

- ☐ **Step 3. Provide ongoing REL (race, ethnicity, language) data collection training for staff.**

- ☐ **Step 4. Conduct a community services assessment.**

- ☐ **Step 5. Link patient data with other types of community data.**

- ☐ **Step 6. Collect demographic data on organization's staff, managers, and senior executives; and monitor trends.**

CLAS Implementation

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VI. Benchmark, Plan and Evaluate

– CLAS Standards

☐ **CLAS Standard #9:** Establish culturally and linguistically appropriate goals, policies, and management accountability, and infuse them throughout the organization's planning and operations.

☐ **CLAS Standard #10:** Conduct ongoing assessments of the organization's CLAS-related activities and integrate CLAS-related measures into measurement and continuous quality improvement activities.

Benchmark, Plan and Evaluate:

– Action Steps

- **Step 1**. Identify "champions" and appoint a Cultural Competence Committee.

- **Step 2**. Conduct an organizational assessment and ongoing re-assessments.

- **Step 3**. Integrate CLAS into organizational strategic planning and set benchmarks.

- **Step 4**. Ensure sufficient fiscal and human resources to support implementation of CLAS.

- **Step 5**. Involve community/patients in monitoring organization's progress on implementation of CLAS.

Benchmark, Plan and Evaluate:
CLAS Planning Worksheet

GOALS					
Foster Cultural Competence	Build Community Partnerships	Collect Diversity Data	Benchmark: Plan and Evaluate	Reflect and Respect Diversity	Ensure Language Access

OBJECTIVES					
1. **Understand** the need for cultural competence. 2. **Develop** cultural competence. 3. **Deliver** culturally competent services. 4. **Train** staff on cultural competence.	1. **Partner** with community organizations. 2. **Involve** the community. 3. **Engage** client participation. 4. **Share** cultural competence knowledge.	1. **Identify** key populations. 2. **Standardize** REL data collection. 3. **Integrate** data collection into frameworks. 4. **Assess** needs and areas for improvement. 5. **Share** relevant data with the community.	1. **Appoint** a cultural competence committee. 2. **Assess** cultural competence. 3. **Frame** CLAS within vision and goals. 4. **Plan.** 5. **Evaluate** progress. 6. **Benchmark.**	1. **Reflect** diversity. 2. **Recruit** diverse employees. 3. **Retain** and promote diverse employees. 4. **Respond** to concerns through culturally competent process. 5. **Resolve** and prevent cross cultural conflicts.	1. **Identify** LEP clients. 2. **Assess** services and language needs. 3. **Plan.** 4. **Deliver** effective language access services. 5. **Adapt** LEP programs regularly.

From "Making CLAS Happen", Massachusetts Department of Health
http://www.mass.gov/eohhs/gov/departments/dph/programs/admin/health-equity/clas/making-clas-happen.html

Benchmark, Plan and Evaluate:

- Interactive Exercise

❑ Based on your table assignments, for each "Area of Action" let's brainstorm –

  ❑ Specific action steps

  ❑ Resources needed

  ❑ People/departments responsible

  ❑ Indicators of progress

❑ Also consider:

  ❑ Stakeholders

  ❑ Policy changes

  ❑ Potential challenges

  ❑ Strategies to overcome challenges and barriers

Benchmark, Plan and Evaluate:
- Discussion

- In what ways are CLAS-related goals, policies, and accountability currently infused into the organization's strategic planning and operations?

- What might be ways that CLAS can be better integrated into organizational policies, practices, and resource allocation decisions?

- How are CLAS-related performance measures integrated into organizational assessments and continuous quality improvement activities?

- What methods are used to obtain and process feedback from patients and the community?

- What methods are used to monitor the impact of CLAS-oriented feedback from patients and the community on the organization's service design and delivery?

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82 Final Thoughts

QUESTIONS

Feedback & Closing

❑ Post-Training Assessment

❑ Session Evaluation

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Additional Resources

- American Hospital Association. Equity Resources Webpage. Available at: http://www.hpoe.org/resources?topic=85

- Health Research and Educational Trust. Quality/Cost/Disparities Webpage. Available at: http://www.hret.org/quality/index.shtml

- Joint Commission. *A Crosswalk of the National CLAS Standards to the Joint Commission Hospital Accreditation Standards*. Available at: http://www.jointcommission.org/assets/1/6/Crosswalk-_CLAS_-20140718.pdf

- Joint Commission. *Advancing Effective Communication, Cultural Competence, and Patient- and Family-Centered Communication*. Available at: http://www.jointcommission.org/Advancing_Effective_Communication/

- Maryland Department of Health and Mental Hygiene. Office of Minority Health and Health Disparities Webpage. Available at: http://dhmh.maryland.gov/mhhd/SitePages/Home.aspx

- Smedly BD et al. "Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care." Institute of Medicine (2002). http://www.iom.edu/Reports/2002/Unequal-Treatment-Confronting-Racial-and-Ethnic-Disparities-in-Health-Care.aspx

- U.S. Department of Health & Human Services, Office of Minority Health Webpage. Available at: http://minorityhealth.hhs.gov/

- U.S. Department of Health & Human Services, Office of Minority Health. *The National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care*. Available at: https://www.thinkculturalhealth.hhs.gov/pdfs/NationalCLASStandardsFactSheet.pdf

Additional Resources (cont'd)

- **Maryland Office of Minority Health and Health Disparities, Cultural Competency Initiative**
  - Web: http://dhmh.maryland.gov/mhhd/SitePages/Cultural%20And%20Linguistic%20Competency.aspx

- **Maryland Cultural Competency Technical Assistance Resource Kit** (listing of local consultants)
  - Web: http://dhmh.maryland.gov/mhhd/SitePages/cultural-competency-trainings.aspx

- **The Cultural Competency and Health Literacy Primer**
  - Web: http://dhmh.maryland.gov/mhhd/CCHLP

- **The Herschel S. Horowitz Center for Health Literacy, University of Maryland**
  - Web: http://www.healthliteracy.umd.edu/

Contacts

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and Mental Hygiene

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Website: www.dhmh.maryland.gov/mhhd
Facebook: https://www.facebook.com/MarylandMHHD
Twitter: @MarylandDHMH
MHHD E-Newsletter: http://bit.ly/12ECsOL

CLAS Standards Training:
Sample Discussion Questions

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Fostering Cultural Competence

- o In what ways do you feel that cultural competence is being fostered?

- o Are leaders and staff in all roles and departments encouraged to participate in the described activities?

- o What have been facilitators to fostering cultural competence?

- o What have been barriers to fostering cultural competence?

- o What actions can be taken to overcome the barriers?

- o What are additional actions/activities that you would like to undertake to foster cultural competence?

Reflect and Respect Diversity

- o Are there structured opportunities available for staff to have discussions about culture, language and other factors involved in meeting the needs of diverse populations?

- o How well does your workforce reflect the community?

- o What strategies are in place to ensure that the community is also reflected at governance and leadership levels?

- o In what ways is the diversity of the staff being utilized to provide culturally and linguistically competent care?

- o What other things are done to help patients feel welcome?

- o What processes are in place to resolve conflicts or grievances from patients and/or staff?

- o What methods are used to obtain and process feedback from staff?

Ensure Language Access

- How are the language needs of the patient population monitored?

- How are patients notified of the availability of communication and language assistance services?

- What do you currently do to ensure language access?
    - Written materials??
    - Translation??
    - Signage??

- What processes are in place to assess the quality of language assistance services?

- What methods are used to familiarize staff about communication and language assistance services?

- How well are bilingual staff being utilized?

- What opportunities exist in the community to help strengthen language access?

- What else could be done to improve accessibility of language services?

Build Community Partnerships

- What methods are being used to help develop sustainable links with the community?

- How are community liaisons identified and engaged?

- In what ways is the community involved in the design, implementation, and/or evaluation of policies, practices and services at your site?

- How are the organization's CLAS-related activities being communicated to the community?

- Working with hard-to-reach communities:
    - How do you make contact?
    - How do you determine need?
    - How do you develop culturally and linguistically   appropriate services?
    - How do you determine whether the services are meeting the needs of the population?

Collect Diversity Data

- o What categories of demographic data do you currently collect?

- o What methods are used to familiarize frontline staff with data collection protocols?

- o How is the community engaged in the data collection process?

- o What types of community data might be useful to link with patient data?

Benchmark, Plan and Evaluate

- o In what ways are CLAS-related goals, policies, and accountability currently infused into the organization's strategic planning and operations?

- o What are possible ways that CLAS can be better integrated into organizational policies, practices, and resource allocation decisions?

- o How are CLAS-related performance measures integrated into organizational assessments and continuous quality improvement activities?

- o What methods are used to obtain and process feedback from patients and the community?

- o What methods are used to monitor the impact of CLAS-oriented feedback (from both patients and the community) on the organization's service design and delivery?

CLAS Standards Training

Interactive Exercises and Group Activities
_____

The following collection of activities are included in the CLAS Standards Training template:

☐ **What Kind of Asian Are You?** (Slide #8)
   http://www.youtube.com/watch?v=DWynJkN5HbQ

   A short video clip that illustrates assumptions about race and ethnicity.

☐ **We All Have Health Beliefs** (Slide #33)

   An exercise that illustrates differences in the health beliefs of different cultures.

   Assign the participants to small groups to discuss what they learned from family and friends during childhood/adulthood about two common conditions:
   - What causes one to catch a cold?
   - What things should a woman <u>not do</u> when pregnant?

   Allow groups to discuss for about 10 minutes, and then ask the small groups to report back and share their "findings" with the larger training group. For some suggested discussion guidelines please visit the following website:
   http://nccc.georgetown.edu/projects/sids/dvd/health%20beliefs.pdf

☐ **Recognizing Your Biases** (Slide #37)

   Ask the participants to write down on a sheet of paper the first thing that comes to mind when they see the following terms:

   - An older person
   - A Muslim
   - A fundamentalist Christian

   - An atheist
   - A black person
   - A 50 year-old white male

- A person in a wheelchair
- A person from Vietnam

- A gay man
- A female engineer

Explain that although everyone has biases of some type, these biases are not acceptable due to the impact they have on our care and treatment of patients and clients. It is possible for us to eliminate our biases or modify our behavior in response to our biases—but we must all put in the work to make these changes happen. The first step is to become more aware of our own particular biases.

☐ **The Newest Vital Sign** (Slides #43-44)
http://pilot.train.hrsa.gov/uhc/pdf/modules/02/Module02NewestVitalSignAssessment.pdf

This exercise demonstrates use of a tool to help identify patients and clients who may have low health literacy. If possible assign participants in pairs and have one person read the questions to the other participant who will then respond based on information provided on the food label. The correct responses and scoring chart are provided on the same sheet as the questions.

If it is not possible to pair up the participants, then a separate handout will need to be created that just has the questions (without the answer key). Each participant would receive a question sheet and would need to refer to the food label on Slide #44 to answer the questions.

In both scenarios, once everyone has completed the questions, the training facilitator should review the questions and answers and provide an opportunity for discussion about potential use of the tool with patients/clients. Additional guidance is provided at the website listed above.

☐ **Can Someone Help Me?** (Slide #59)
http://www.youtube.com/watch?v=q5ZJzEeJbe0

Brief video clip featuring an English-speaking mother who encounters a language barrier while seeking care for her infant in an emergency department in a foreign country. Esperanto is the foreign language used in the film so that scene depicted is not specific to any particular country. The clip intends to emphasize the importance of professional medical interpreters and illustrates that the

responsibility for addressing language barrier issues is not just about individuals who do not speak English.

☐ **Sorting People** (Slide #71)
http://www.pbs.org/race/002_SortingPeople/002_00-home.htm

The Web-based exercise demonstrates what happens when we try our hand at "sorting" people into racial groups based on appearances and seeing if our assumptions match with how people think of themselves. Instructions for conducting the exercise are found on the website listed above.

☐ **CLAS Planning Worksheet** (Slides #79-80)

A group exercise that can be helpful in drafting an organizational plan for addressing each of the CLAS Standards. Please refer to the CLAS Planning Worksheet found in the "Implementation Resources" section (appendix) of the CLAS Standards Training Toolkit.

This exercise should be allotted at least 40 minutes (longer if possible). Depending on the size of the group, participants can be divided into 6 smaller groups that match the areas of action on the worksheet:
- Foster Cultural Competence
- Reflect and Respect Diversity
- Ensure Language Access
- Build Community Partnerships
- Collect Diversity Data
- Benchmark, Plan, and Evaluate

These smaller groups could spend 20-25 minutes brainstorming specific action steps, resources needed, people/departments responsible, indicators of progress, stakeholders, potential challenges, and strategies to overcome challenges for their assigned area of action. The participants would recall from the training presentation slides examples of action steps to include on the Planning Worksheet. Following the brainstorming session, the groups would spend some time reporting back their ideas to the larger group. The purpose of the exercise is that by its conclusion at least a rudimentary plan for addressing all

of the CLAS Standards is outlined for continued development following the training session.

Examples of alternative options for interactive exercises:

☐ **Diversity Profile** (Action Area: Reflect and Respect Diversity)
http://www.sourcecon.com/media/2012/04/Screen-shot-2012-04-18-at-2.35.49-PM.png [Tool was developed by the Stockton University, College Committee for Diversity, Equity, and Affirmative Action.]

This matrix can be used by individual training participants to conduct a brief inventory of either the breadth or the limitations of their usual cross-cultural encounters. After allowing the participants a few minutes to complete the profile, the training facilitator could engage the participants in a discussion about ways in which they might further diversify their cultural interactions. Our environment has an effect on our belief systems; and immersing ourselves in more multicultural environments would help to reduce our biases and increase our receptivity to other perspectives of thought regarding health beliefs and health behaviors.

☐ **Hospital Community Partnership SWOT Analysis** (Action Area: Build Community Partnerships)

Prior to conducting this activity, participants will need to familiarize themselves with the hospital's most recent community health needs assessment report and implementation strategy. The training facilitator would engage participants in the process of identifying the strengths, weaknesses, opportunities, and threats pertaining to the hospital's overall partnership efforts in the community. The purpose of the activity is to uncover some potentially unique and beneficial community partnerships that have not yet been explored by the organization.

☐ **Case Studies and Scenarios** (Multiple Action Areas)

There are DVD and Web-based case studies available that may serve as a starting point for discussions about the action areas in the CLAS Standards Implementation Framework [see the training presentation slides for the list of action areas]. For examples of available resources, you may find the "Cultural

Competency and Health Literacy Primer" helpful—the Primer is available at the following website:
http://dhmh.maryland.gov/mhhd/CCHLP/SitePages/Home.aspx

☐ **Who Am I?** (Action Area: Foster Cultural Competency)

Ask participants to take 5 minutes to complete 5 sentences starting with the phrase "I am …" The sentences should reflect participants' feelings of belonging, affiliations, hobbies and other involvements which are relevant to their identity. Afterward request volunteers to share one or two of their sentences to begin to discuss what defines culture.

Resources for additional activities:

☐ Critical Multicultural Pavilion: "Awareness Activities". Website:
http://www.edchange.org/multicultural/activityarch.html

☐ Bowling Green State University: "Diversity Activities Resource Guide". Website:
http://lir.bgsu.wikispaces.net/file/view/Diversity+Activities+Resource+Guide.pdf

☐ Stonehill College, Office of Intercultural Affairs: "Practicing Inclusion: Icebreakers and Team Builders for Diversity". Website:
http://www.stonehill.edu/files/resources/talusandiversityteambuilders.pdf

☐ Stockton University, College Committee for Diversity, Equity, and Affirmative Action: "A Booklet of Interactive Exercises to Explore Our Differences". Website:
http://intraweb.stockton.edu/eyos/affirmative_action/content/docs/Interactive%20Diversity%20Booklet%2010-14-2011.pdf

Participant Pre-Training Survey

_____

Adapted from the California Department of Public Health and Department of Health Care Services, Office of Multicultural Health, "Providing Quality Health Care with CLAS: A Curriculum for Developing Culturally and Linguistically Appropriate Services".

Please choose the single best answer for the following questions:

1. The purpose of the CLAS Standards is to:
(Check all that apply)

       [ ] Advance health equity
       [ ] Improve health quality
       [ ] Help eliminate health disparities
       [ ] None of the above

2. How many CLAS standards exist?
       [ ] 4
       [ ] 10
       [ ] 14
       [ ] 15

3. Which agency or organization developed the CLAS standards?
       [ ] Maryland Department of Health and Mental Hygiene
       [ ] U.S. Department of Health and Human Services, Office of Minority Health
       [ ] American Medical Association
       [ ] The Joint Commission

4. Cultural competence can be defined as:
       [ ] Being an expert regarding the particular languages, behaviors and beliefs of diverse communities
       [ ] The ability to speak the same language as the population served
       [ ] A set of knowledge, skills, attitudes, policies, practices, and methods that enable care providers and programs to work effectively with culturally diverse communities
       [ ] Being of the same ethnic background as the population served

5. Individuals who work in which of the following roles should participate in cultural competency training? (Check all that apply)

       [ ] Executive leaders
       [ ] Department managers
       [ ] Clinical staff
       [ ] Patient intake personnel
       [ ] Housekeeping and environmental services staff

6. Language assistance services are intended for which of the following individuals? (<u>Check all that apply</u>)

        [ ] Patients with limited English proficiency
        [ ] Patients who are deaf or hard-of-hearing
        [ ] Patients who are visually impaired
        [ ] Patients who have low health literacy

7. Which <u>two</u> of the following are recommended to provide language assistance when in-person certified medical interpreters are not available?

        [ ] Qualified bilingual staff
        [ ] Clinical staff with conversational skills in the language
        [ ] Bilingual friend or family member of the patient
        [ ] Remote telephone or video interpreter service

8. Community partnerships can be networks for which of the following activities within my organization? (<u>Check all that apply</u>)

        [ ] Recruitment of diverse staff
        [ ] Community needs and asset assessment
        [ ] Data collection
        [ ] Service planning
        [ ] Cultural competency training

Please indicate how strongly you agree or disagree with the following statements:

9. I agree with the rationale for the CLAS standards.

        [ ] Strongly agree   [ ] Agree   [ ] Disagree   [ ] Strongly disagree

10. Evidence has shown that ethnicity, class, religion, spirituality, sexual orientation, racism and other cultural factors influence health care decision making.

        [ ] Strongly agree   [ ] Agree   [ ] Disagree   [ ] Strongly disagree

11. Maintaining current, accurate data regarding patient race, ethnicity, and language preference is necessary to deliver quality health care.

        [ ] Strongly agree   [ ] Agree   [ ] Disagree   [ ] Strongly disagree

12. In order to help overcome health disparities between people of different race, ethnicity and language, materials and assistance must be offered in each patient's preferred language.

        [ ] Strongly agree   [ ] Agree   [ ] Disagree   [ ] Strongly disagree

13. A diverse workforce is important in provision of quality health care.

[ ] Strongly agree   [ ] Agree   [ ] Disagree   [ ] Strongly disagree

14. Quality improvement efforts must include consideration of the CLAS Standards.

[ ] Strongly agree   [ ] Agree   [ ] Disagree   [ ] Strongly disagree

15. Collaboration with community-based organizations and social support agencies is necessary to provide quality health care.

[ ] Strongly agree   [ ] Agree   [ ] Disagree   [ ] Strongly disagree

16. Patients and community members should participate in the design, implementation, and evaluation of my organization's services.

[ ] Strongly agree   [ ] Agree   [ ] Disagree   [ ] Strongly disagree

17. Community health workers (would) serve as important liaisons between my organization and the community.

[ ] Strongly agree   [ ] Agree   [ ] Disagree   [ ] Strongly disagree

18. Institutionalizing the CLAS standards can lead to reduced health care disparities in my organization.

[ ] Strongly agree   [ ] Agree   [ ] Disagree   [ ] Strongly disagree

19. I feel prepared to implement CLAS-based projects relevant to my service area.

[ ] Strongly agree   [ ] Agree   [ ] Disagree   [ ] Strongly disagree

20. I know how to develop a plan to place one or more of the CLAS standards into operation.

[ ] Strongly agree   [ ] Agree   [ ] Disagree   [ ] Strongly disagree

Participant Pre-Training Survey

Answer Key

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4. Cultural competence can be defined as:

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5. Individuals who work in which of the following roles should participate in cultural competency training?

- Executive leaders
- Department managers
- Clinical staff
- Patient intake personnel
- Housekeeping and environmental services staff

6. Language assistance services are intended for which of the following individuals?

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- Patients who are visually impaired
- Patients who have low health literacy

7. Which <u>two</u> of the following are recommended to provide language assistance when in-person certified medical interpreters are not available?

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8. Community partnerships can be networks for which of the following activities within my organization?

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Participant Post-Survey

_____

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(Check all that apply)

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       [ ] Being of the same ethnic background as the population served

5. Individuals who work in which of the following roles should participate in cultural competency training? (Check all that apply)

       [ ] Executive leaders
       [ ] Department managers
       [ ] Clinical staff
       [ ] Patient intake personnel
       [ ] Housekeeping and environmental services staff

6. Language assistance services are intended for which of the following individuals? (<u>Check all that apply</u>)

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19. I feel more prepared to implement CLAS-based projects relevant to my service area.

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20. I know how to develop a plan to place one or more of the CLAS standards into operation.

    [ ] Strongly agree   [ ] Agree   [ ] Disagree   [ ] Strongly disagree

21. Today's presentation was valuable for the work that I do.

    [ ] Strongly agree   [ ] Agree   [ ] Disagree   [ ] Strongly disagree

22. I know where to get additional information about the CLAS Standards.

    [ ] Strongly agree   [ ] Agree   [ ] Disagree   [ ] Strongly disagree

23. What type of assistance would be helpful for implementing the CLAS Standards within your practice or service area? *(Feel free to use space on reverse side for additional comments and suggestions.)*
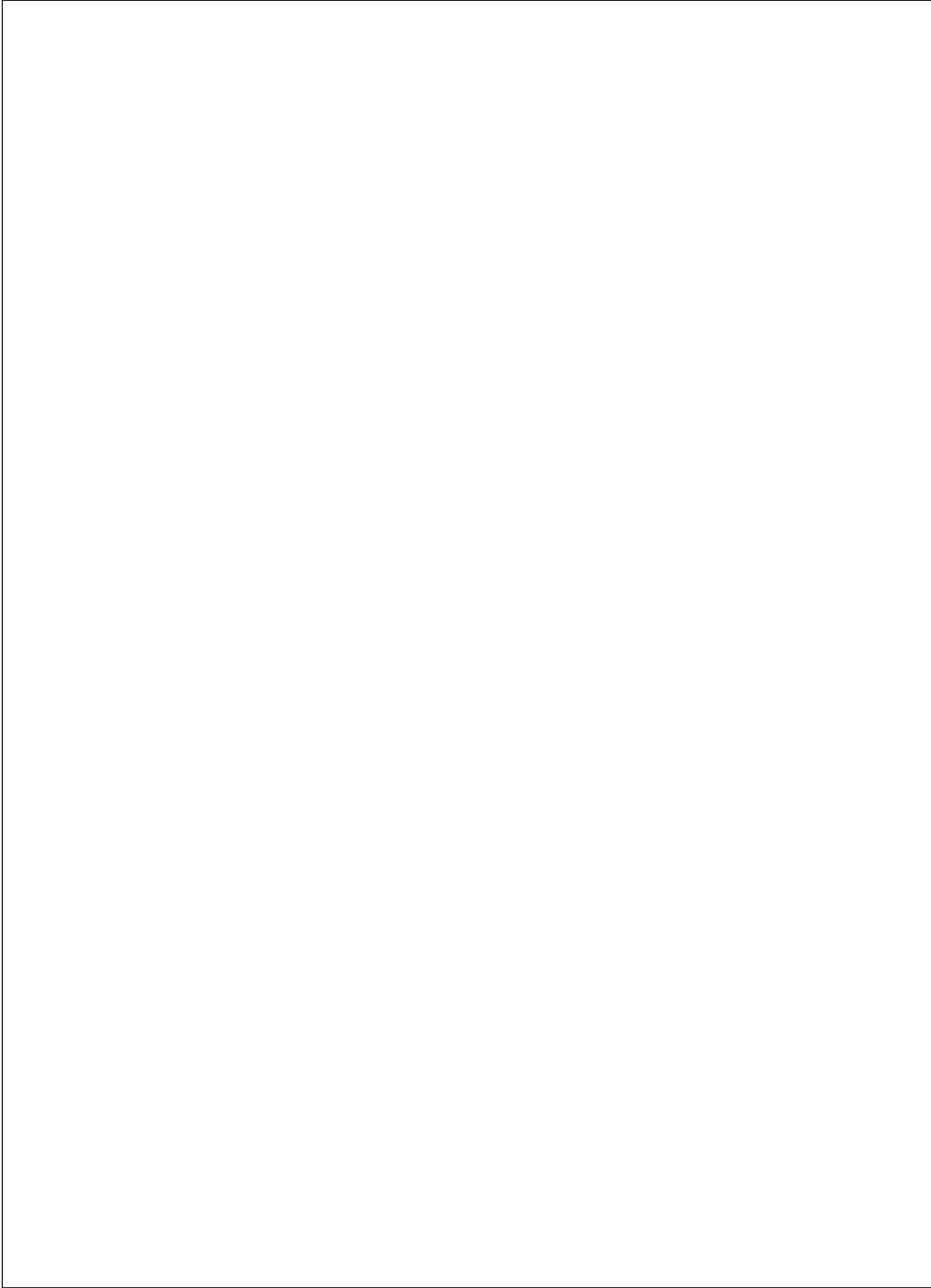
Participant Post-Survey

Answer Key

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- Service planning
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21. Today's presentation was valuable for the work that I do.

- Strongly agree, Agree, Disagree, Strongly disagree

22. I know where to get additional information about the CLAS Standards.

- Strongly agree, Agree, Disagree, Strongly disagree

23. What type of assistance would be helpful for implementing the CLAS Standards within your practice or service area?

- [*Open response*.]

CLAS Standards Training:
[INSERT Sub-Topic]

[Insert Date of Training]

Training Evaluation Form

Please indicate how well the following learning objectives were met.
Scale: 1=Not met 2= Not very well met 3=Somewhat met 4=Well met 5=Very well met

Able to describe the CLAS Standards and why they were developed.	1	2	3	4	5
Able to describe how health disparities affect the quality of care for diverse patients.	1	2	3	4	5
Able to describe the potential impact of the CLAS Standards on reductions in health care disparities and improvements in quality of care.	1	2	3	4	5
Able to identify a role for myself to collaborate with colleagues to put into operation one or more CLAS Standards within my service area or organization-wide.	1	2	3	4	5
Able to identify three or more methods of partnering with the community to improve quality of care for diverse patient populations.	1	2	3	4	5
Able to make recommendations on how to integrate the CLAS Standards into my organization's operational practices, policies, and procedures.	1	2	3	4	5

Please rate the following:
Scale: 1=Very Poor; 2=Poor; 3=Fair; 4=Good; 5=Excellent

Registration Process	1	2	3	4	5
Location	1	2	3	4	5
Quality of the Training Room/Facility	1	2	3	4	5
Quality of Speakers/Facilitators	1	2	3	4	5
Quality of Presentation Slides	1	2	3	4	5
Usefulness of Handouts	1	2	3	4	5
Usefulness or Personal Impact of the Interactive Exercises					
- **"We all have health beliefs" exercise**	1	2	3	4	5
- **"Recognizing your biases" exercise**	1	2	3	4	5
- **"Newest Vital Sign" health literacy exercise**	1	2	3	4	5
- **"Sorting People" exercise**	1	2	3	4	5
- **"CLAS Planning Worksheet" exercise**	1	2	3	4	5
Overall Quality of Training Session	1	2	3	4	5

List ways that the training session can be improved _____
_____
_____
_____
_____

Suggest other topics or themes that you would like to see addressed _____
_____
_____
_____
_____

Additional suggestions/comments _____
_____
_____
_____
_____

Would you recommend this training to colleagues?   [   ] Yes   [   ] No

Please Return Completed Forms to the Training Facilitator(s). Thank you!