CLAS Standards Training Toolkit

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FACILITATORS' GUIDE for OUTREACH WORKERS

REVISED JUNE 2015

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FACILITATION GUIDELINES

Introduction

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.

Introduction (Cont.)

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 guide is intended to serve as a resource to support the integration of culturally and linguistically appropriate practices and policies into community-based organizations (CBOs). It is to assist them in advocating for adoption of the 2013 US Department of Health and Human Services/Office of Minority Health's Enhanced Culturally and Linguistically Appropriate Services (CLAS) Standards by health and healthcare organizations in their jurisdictions.

These Standards provide a framework for health and health care organizations to ensure that all patients/consumers receive equitable and effective treatment in a culturally and linguistically appropriate manner, thus contributing to the elimination of racial and ethnic health disparities. Prior to their creation, providers had no clear guidance on how to provide culturally and linguistically appropriate services. The CLAS Standards are intended to assist Federal, State and local governments as well as administrative staff and program managers to draft consistent laws, regulations, contracts and policies and procedures. They also allow for accreditation and credentialing agencies to assess and compare organizations who claim that they are providing culturally competent services to diverse consumers.

The guidelines provided in this document extend the cultural competencies spectrum beyond racial and ethnic cultural groups to include language, age, gender, sexual orientation, disability, and religious belief systems and practices. These factors have proven to have significant impact on how individuals and families access and approach health care and health maintenance, and by appropriately addressing them, we can improve the quality of care and ultimate health outcomes.

The History and Purpose of the CLAS Standards

Health inequities in our nation are well documented, and the provision of culturally and linguistically appropriate services (CLAS) is one strategy to help eliminate health inequities. By tailoring services to an individual's culture and language preference, health and health care professionals can help bring about positive health outcomes for diverse populations. The provision of health care services that are respectful of and responsive to the health beliefs, practices and needs of diverse patients can help close the gap in health care outcomes.

In 2001, the Office of Minority Health published the National Standards for Culturally and Linguistically Appropriate Services in Health Care (CLAS Standards), which provided a framework for all health care organizations to best serve the nation's increasingly diverse communities. The original CLAS Standards were a collective set of mandates, guidelines, and recommendations intended to inform, guide, and facilitate required and recommended practices related to culturally and linguistically appropriate health services. The 2001 CLAS Standards provided guidance on improving quality care under three areas in particular: Culturally Competent Care, Language Access Services and Organizational Supports.

After a 3-year process, which called for extensive public comment, an enhanced version of the original CLAS standards was released in 2013 by the U.S. Department of Health and Human Services, Office of Minority Health. The re-launched CLAS Standards signified progress in the state-of-the-art in theory, and practice of cultural competency guidelines for health organizations to address health care disparities and enhance health equity. The overarching theme of the enhanced National CLAS Standards is to present a blueprint for health and health care organizations to "provide, 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". However, the enhanced National CLAS Standards hold significance not only for health care organizations, but also for individual licensed health care professionals in Maryland and around the country.

The History and Purpose of the CLAS Standards (Cont.)

The 2013 Enhanced National CLAS Standards are made up of a principal standard and 14 supporting standards divided into 3 major themes. The principal standard of "providing effective, equitable, understandable and respectful quality care" for all, is considered to have been achieved when the other 14 standards are met. The three subsequent themes are "Governance, Leadership and Workforce", "Communication and Language Assistance" and "Engagement, Continuous improvement, and accountability." (Appendix 1)

"Governance, Leadership, and Workforce," emphasizes that the responsibility for CLAS implementation rests at the highest levels of organizational leadership. The standards under this theme require that organizational boards set cultural-competence goals in their strategic plans and that diversity awareness and training are required for senior leadership, management, staff, and volunteers.

Standards under the second theme, "Communication and Language Assistance," include the recommendation that language assistance should be provided as needed in both verbal interactions and written materials, and that organizations inform clients and patients about the availability of language assistance.

The third theme, "Engagement, Continuous Improvement, and Accountability," underscores the importance of quality improvement, community engagement, and evaluation. Organizations can assess whether their CLAS activities meet their community's needs and communicate implementation progress to interested parties. For example, in its resource manual for stakeholders, "Making CLAS Happen," the Massachusetts Department of Public Health recommends using "cultural brokers," such as community health workers or promotores de salud,as bridges to people of various cultural backgrounds.

CLAS Standards for Outreach Workers

While the CLAS standards were designed for use by health and health care organizations, many of the recommendations can be adopted by community-based groups as well. Community organizations should adopt the goal of providing effective, equitable, understandable, respectful quality services, with the use of adapting CLAS standards to reach that goal. The following suggested steps for community organizations are broken down into the areas of action first identified by the Massachusetts Department of Health in their document "Making CLAS Happen". These steps are not the only steps that can be used, but give a general guide for CLAS adoption. Steps can be followed in any order, as some steps require more time and resources than others.

Foster Cultural Competency

- Identify committed champions of cultural competency within the organization. These individuals are responsible for making sure that the organization is continually working towards providing more culturally and linguistically appropriate services.
- Embed a commitment to culturally competent care in the organization's goals, mission, and strategic plan. This step shows the organizations commitment to making the changes necessary to adopt the CLAS standards.
- Allocate organizational resources to educating senior leadership, staff, and volunteers. Regular education on CLAS for all employees and volunteers is important in ensuring that clients receive culturally competent services at every point of contact with an organization.
- Integrate cultural competency and CLAS into staff evaluations. When staff is aware that they will be evaluated on their ability to provide culturally and linguistically appropriate services, they are more likely to do so.
- Regularly review and update organizational policies and practices to reflect the CLAS Standards. Organizations policies and practices evolve with changing community needs, and regular review ensures that the CLAS standards are being met.

* 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

Reflect and Respect Diversity

- Implement recruitment, retention, and promotion policies for a workforce (staff and leadership) that reflects the diversity of the community being served. A workforce that reflects the diversity of a community can better understand its needs and relate to those it serves.
- Establish a conflict and grievance resolution process to respond to concerns from both clients and staff and make sure that clients and staff understand how to file grievances. This step ensures that an organization continues to provide the best services for their community.
- Provide cross-cultural communication and conflict resolution training. Provide the training needed to successfully communicate with clients and implement a conflict resolution plan.

Ensure Language Access

- Assess the language needs and services within the community. In order to successfully address the needs of a community it is important to understand what those needs are, and to remember that needs change with time. Assessments should be done periodically.
- Develop a Communication and Language Assistance Plan. Planning is important to ensure that services fully address the needs of the community.
- Develop a standardized process for identifying and documenting clients' preferred language. Clients appreciate the courtesy of having staff anticipate their needs before each encounter.
- Provide training for staff in the use of interpreters.
- Notify patients of availability of communication and language assistance services.
- Issue guidance to staff on use of "plain language". Plain language refers to language that is clear, concise, at no higher than a fifth grade reading and comprehension level and free of jargon.

Collect Diversity Data

- Collaborate with community in data collection, analysis, review, and reporting. Not all community groups collect this type of data on clients, but work with the community to understand what level of data collection is necessary and appropriate.
- Standardize data collection process for self-reported demographic information. Make sure collection methods are culturally and linguistically competent. Train staff on how to collect data in this way.
- Collect demographic data on organization's staff, managers, and senior executives; and monitor trends. This allows an organization to assess whether the staff reflects the diversity of the community.

Benchmark, Plan and Evaluate

- Conduct an organizational assessment and ongoing re-assessments. Refer to this document and other CLAS sources (see resource section) to assess the level of CLAS adoption in the organization.
- Integrate CLAS into organizational strategic planning and set benchmarks. Prioritize the need for delivery of culturally and linguistically appropriate services.
- Ensure sufficient fiscal and human resources to support implementation of CLAS. The resources needed will depend on the size of the organization, the demographics of the community and services offered.
- Involve community/patients in monitoring organization's progress on implementation of CLAS. Involving the community in evaluation of CLAS implementation can keep an organization on target to achieving their CLAS goals.

Advocating for CLAS

The 2013 CLAS Standards, as with its predecessor the 2000 Standards, require strong leadership and organizational commitment to successfully implement, but they also represent an opportunity to improve health for many people in the United States and to do so in an organized, effective way.

To ensure that the CLAS standards are implemented in health and healthcare organizations in your jurisdiction, one can use the following guidelines and checklists to find out whether organizations are adopting the standards and find out where they are in the process. Offer to partner with health and healthcare organizations to bring about CLAS adoption for all clients and patients in the state. A manual for effective CLAS advocacy can be found in Appendix 2.

Steps to an Effective CLAS Standards Training Program

Community-based organizations can successfully train health and healthcare organizations about the CLAS standards and the importance of their adoption. There are numerous resources available (see resources section) to help design a CLAS standards training program, with most programs containing 5 major steps.

The first step is engaging the leadership of an organization and obtaining their critical buy-in for the process. The second step is an organizational assessment, which involves surveying key organizational personnel on their current level of CLAS adherence. This assessment helps the facilitators to customize the curriculum to the participants. The third step involves identification and assessment of individuals who will participate in the training program. Step four involves holding the CLAS training program, and step 5 is an evaluation of that training both for comprehension and adoption.

Step 1. Engaging the leadership of an organization

Implementation of the CLAS standards requires commitment from an organization's top leadership. It is therefore important to obtain leadership buy-in from the state. 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 who can 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 reinforcing their commitment to systems change and CLAS implementation. That introduction gives leaders an opportunity to articulate their own perspectives about culturally and linguistically competent services, thereby clarifying what they expect from their staff.

Step 2. Organizational Assessment

An initial CLAS assessment of an organization is completed by individuals identified by the top leadership. Those involved in the assessment may include human resources, client/patient relations, and planning personnel as well as chief executive officers. A number of assessment tools are available which vary depending on the type of healthcare organization (hospitals, FQHCs, physician practices etc.) and the amount of time and effort that an organization is willing to expend on the assessment. One such tool developed by our office is the Organizational CLAS Pre-training Assessment, an example of which can be found Appendix 3. A list of other available instruments and their links can be found in Appendix 4.

Step 3. Participant Identification and Assessment

The ideal participants for the workshop/training should:

- Have interest in diversity and cultural competence.
- Be a mix of middle to senior managers and supervisory personnel.
- Be committed to designing and implementing a project incorporating CLAS standards into the service.
- Be able to work collaboratively in small group settings.
- Be available and willing to participate in the full program of training and follow-up.
- Work with one or more of the following areas:
  - Direct patient services.
  - Human resources
  - Quality Improvement
  - Language and community outreach services

As the workshops/training will involve a number of small group activities, it is important to carefully select participants to optimize the group dynamics. Ideally there should be a mixture of those who have already been exposed to, and are on board with the cultural and linguistic competency in healthcare (champions) along with more resistant or skeptical individuals. Where possible, include individuals who have successfully worked well in group settings in the past. In addition, cultural diversity, gender, ethnic, age, sexual orientation and other sociocultural diversity within each group will promote richer discussion when participants explore issues of cultural competence, language, and health disparities.

On the day of the training, the chosen participants should be given the Participant Pre-training survey which can be found in the toolkit. The answer key can be found in Appendix 5. The purpose of the survey is to assess participant attitudes, skills, and knowledge about the CLAS standards, and the degree to which they are aware of CLAS-oriented programs in their organization.

Step 4 Deliver Training to Participants

Elements:

- Introduction to the CLAS Standards The participants will be introduced to the CLAS standards, the reasons why CLAS was developed and later enhanced, and the impact of health disparities on the quality of care for patients. The importance of CLAS adherence from the point of service providers, clients and organizations will be discussed.
- Quality of services for culturally diverse clients The participants will examine the difficulties of obtaining quality services from the perspective of individual clients. Themes will include unconscious bias, and the impact of issues such as communication, decision-making, racism, and socioeconomics on quality of services. The participants also will identify systems and organizational factors that mitigate the impact of these issues.
- System Change and CLAS. The participants will be introduced to various examples of best practices in CLAS implementation. They will then discuss how CLAS standards can be applied to their service and to the organization as a whole, and how they can collaborate with colleagues in different departments and pool resources to implement CLAS.

By the completion of the training, trainees should have acquired the knowledge to:

1. Describe the CLAS standards and why they were developed;
2. Examine your own service in the context of CLAS standards;
3. Describe the impact of culture on client and staff decision making;
4. Describe the impact of language barriers on services;
5. Describe the potential impact of the CLAS standards on attainment of improvements in quality of care services for these communities;
6. Describe the relevancy of these standards to your department;
7. Describe how CLAS standards can be applied to your service and the organization as a whole;

Step 4 Deliver Training to Participants (Cont.)

You should have acquired the skill to:
1. Assess whether and how your department responds to the CLAS standards;
2. Compare and contrast the various approaches taken to implement CLAS standards;
3. Assess the readiness of your service for the CLAS standards;
4. Acknowledge that these standards can be adopted in numerous effective and practical ways;
5. Commit to improving quality of service through the CLAS standards;
6. Recognize the role that you and others have to collaboratively implement the CLAS standards.

A sample presentation can be found in Appendix 6.

Step 5. Evaluation and Follow-up

The evaluation process is designed to measure both the participant comprehension of subject matter and the organization's adoption of the CLAS standards. Immediately after the training session, participants will be asked to complete the Participant Post-training Survey, an example of which is found in Appendix 6. This instrument should contain many of the same questions found in the pre-training survey and is designed to ascertain the impact of the curriculum on the participants through self-assessment of their knowledge, skills, and attitudes around various components of the CLAS standards.

Three to six months after the CLAS training session, the organizational leadership should be asked to complete an Post-training Organizational CLAS Assessment Survey, In addition to the questions asked in the pre-training organizational survey, the leadership will be asked to identify any changes that have been implemented since training.

For more information or technical assistance, please contact::

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This training facilitation guide and materials were prepared by staff of the Maryland Department of Health and Mental Hygiene, Office of Minority Health and Health Disparities. Funding support was provided by the U.S. Department of Health and Human Services, Office of Minority Health under State Partnership Grant # 1 STTMP 131091-01-00.

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

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

Principal Standard:

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

Governance, Leadership, and Workforce:

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

Communication and Language Assistance:

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

Engagement, Continuous Improvement, and Accountability:

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

The Case for the Enhanced National CLAS Standards

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

Health equity is the attainment of the highest level of health for all people (U.S. Department of Health and Human Services [HHS] Office of Minority Health, 2011). Currently, individuals across the United States from various cultural backgrounds are unable to attain their highest level of health for several reasons, including the social determinants of health, or those conditions in which individuals are born, grow, live, work, and age (World Health Organization, 2012), such as socioeconomic status, education level, and the availability of health services (HHS Office of Disease Prevention and Health Promotion, 2010). Though health inequities are directly related to the existence of historical and current discrimination and social injustice, one of the most modifiable factors is the lack of culturally and linguistically appropriate services, broadly defined as care and services that are respectful of and responsive to the cultural and linguistic needs of all individuals.

Health inequities result in disparities that directly affect the quality of life for all individuals. Health disparities adversely affect neighborhoods, communities, and the broader society, thus making the issue not only an individual concern but also a public health concern. In the United States, it has been estimated that the combined cost of health disparities and subsequent deaths due to inadequate and/or inequitable care is $1.24 trillion (LaVeist, Gaskin, & Richard, 2009). Culturally and linguistically appropriate services are increasingly recognized as effective in improving the quality of care and services (Beach et al., 2004; Goode, Dunne, & Bronheim, 2006). By providing a structure to implement culturally and linguistically appropriate services, the enhanced National CLAS Standards will improve an organization's ability to address health care disparities.

The enhanced National CLAS Standards align with the HHS Action Plan to Reduce Racial and Ethnic Health Disparities (HHS, 2011) and the National Stakeholder Strategy for Achieving Health Equity (HHS National Partnership for Action to End Health Disparities, 2011), which aim to promote health equity through providing clear plans and strategies to guide collaborative efforts that address racial and ethnic health disparities across the country. Similar to these initiatives, the enhanced National CLAS Standards are intended to advance health equity, improve quality, and help eliminate health care disparities by providing a blueprint for individuals and health and health care organizations to implement culturally and linguistically appropriate services. Adoption of these Standards will help advance better health and health care in the United States.

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Advocating for CLAS

Recognizing CLAS Compliance in Health and Health Care Organizations

The 2013 CLAS Standards, as with its predecessor 2000 Standards, require strong leadership and organizational commitment to successfully implement, but they also represent an opportunity to improve health for many people in the United States and to do so in an organized, effective way. To ensure that the CLAS standards are implemented in health and healthcare organizations in your jurisdiction, one can use the following guidelines and checklists to find out whether organizations are adopting the standards and find out where they are in the process. Offer to partner with health and healthcare organizations to bring about CLAS adoption for all clients and patients in the state.

PRINCIPAL STANDARD

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.

GUIDLINE

Health and health care organizations should ensure that clients receive effective, understandable and respectful care provided in a manner compatible with their own cultural health beliefs, practices and preferred language. This standard is met when the remaining 14 CLAS standards are addressed.

CHECKLIST

- The culturally specific health beliefs and health practices of those served by the organization is known by staff and management
- The organization is able to respond to these beliefs and practices in service provision
- The language preferences of clients is noted in their charts
- Standards exist for staff conduct and performance monitoring that promotes cultural competence through cultural competence training for new and existing staff
- There is regular, ongoing cross-training within the organization to promote an environment of multicultural understanding across professional sectors
- Staff is encouraged to share with one another their own cultural perspectives and practice of cultural humility in meetings and other organizational forums
- Clients/consumers are surveyed to determine whether they have received culturally and linguistically competent services

Adapted from the Community Alliance for Culturally and Linguistically Appropriate Services "CLAS GUIDELINES FOR THE ALCOHOL AND OTHER DRUG FIELD IN CALIFORNIA" found at http://allianceforclas.org/wp-content/uploads/2011/05/CA-AOD-CLAS-Standards-and-Recommendations-7.pdf

GOVERNANCE, LEADERSHIP AND WORKFORCE:

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

GUIDELINE

Health and health care organizations should adopt the CLAS standards through governance and leadership, and design policies and practices that ensure provision of culturally and linguistically appropriate services for clients and patients at every point of contact.

CHECKLIST

- Boards and advisory committees are representative of groups served by the organization.
- Board members participate in ongoing education on cultural competence.
- Cultural competence is included in policies on:
  - personnel recruitment and retention
  - training and staff development
  - language access and communication
  - management of grievances and complaints
  - community and client input and participation

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.

GUIDELINE

Health and health care organizations should develop and implement strategies to recruit, retain and promote diverse staff and leadership within the organization. An organization's staff and leadership reflect the characteristics of the community they serve.

CHECKLIST

- The cultural and linguistic characteristics of your organization's service community is known
- There are regular agency self-assessment s to determine the current level of cultural and linguistic diversity within the organization at all levels of staffing and leadership
- There is active recruitment of staff and leadership who have the cultural and linguistic skill sets needed by your service community
- Employees who have cultural and linguistic competencies are compensated for their proficiency
- Cultural and linguistic competencies are included in decisions about promotions
- Organizational policies and procedures regarding cultural competence are regularly reviewed

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

GUIDELINE

Health and health care organizations should ensure that education and training in cultural and linguistically appropriate service delivery are ongoing and effective for all staff, at all levels, and across all disciplines.

CHECKLIST

- Clear definitions of cultural and linguistic competence are provided that includes milestones and levels of proficiency, and make sure all staff are familiar with them
- There is awareness of the ways personal history influences perceptions of other cultures
- There is knowledge of the ability of staff to engage in effective cross cultural communication
- There is knowledge of the institutional barriers that impact the ability of people in your community to access services
- There is awareness of the how levels of acculturation affect client's ability/willingness to participate in a prescribed healthcare regimen
- There is an Organizational Diversity Subcommittee or Diversity Council with the endorsement of the Executive Director and/or Board of Directors
- Employee participation in cultural competence trainings is tracked, and use this information is used as part of performance reviews

COMMUNICATION AND LANGUAGE ASSISTANCE:

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.

GUIDELINE

Health and health care organizations must offer and provide language and communication assistance to clients/consumers with limited English proficiency (LEP) or disability-related language/communication needs.

Adherence to the communication and language standards is required of recipients of federal financial assistance under Title VI of the Civil Rights Act and Executive Order No. 13166 issued by President Clinton in 2000. The activities necessary to comply with these legal requirements may vary from provider to provider, or individual to individual, but some measure of compliance is nevertheless mandatory.

CHECKLIST

- Language and communication assistance are offered at all points of service contact, including all levels of care (e.g. crisis, outpatient, residential) and with all levels of staff (e.g. administrative, clinical)
- Language and communication assistance are offered in a timely manner during all hours of operation
- Language assistance services are offered at no cost to each client
- Policies and procedures prioritize the use of bi/multilingual staff over interpreters, and the use of in-person interpreters over phone interpretation services
- Staff understand the pros and cons of different types of interpretation methods
- Staff are trained to use the language access system, including how to ask about language preference, and how to work with interpreters
- Data is collected on how long it takes to access language services, how proficient these services are, and how well clients/consumers are satisfied with them

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

GUIDELINE

Health and health care organizations must provide to clients/consumers in their preferred language or disability-related communication mode both verbal offers and written notices informing them of their right to receive language/communication assistance services.

CHECKLIST

- Policies and procedures are in place to ask the preferred language/communication of all clients/consumers
- Staff are trained to inform all clients/consumers of their right to language/communication assistance
- There is visible signage offering language/communication assistance in all local threshold languages
- Staff are provided with ongoing training for staff in the legal rights of LEP and disabled clients
- Staff offer clients information about how to receive services in their preferred languages
- There is systematic recording of the preferred language of all clients/consumers

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.

GUIDELINE

Health and health care organizations must assure the competence of language/communication assistance provided to limited English proficient or disabled clients/consumers by interpreters and bilingual staff.

CHECKLIST

- Family and friends are not used to provide interpretation services (except on request by the client/consumer and after being informed of the risks of this choice, and that a trained, confidential interpreter can be provided without cost)
- Interpreters are qualified to work in the health industry and have no conflicts of interest with the client/consumer
- Providers can educate and counsel clients/consumers on when and how to use an interpreter
- Providers can educate and counsel clients/consumers on confidentiality issues and reassure clients/consumers who are not comfortable with interpreters
- Staff receive regular trainings on how to effectively use an interpreter
- Bilingual clinicians and staff are tested to determine if they have a command of English and the target language
- There are tools in place for measuring interpreter skills and qualifications
- Interpreters skills are evaluated using English and target language
- Interpreters are trained and tested in techniques, ethics, and cross-cultural issues.
- Family, friends, or others are evaluated if they are encouraged to interpret
- Interpreter use is documented

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.

GUIDELINE

Health and health care organizations must make available easily understood patient-related written and audio materials and post signage in the languages of the commonly encountered groups represented in the service area (threshold languages).

CHECKLIST

- There is organizational knowledge of the local threshold languages
- Materials and signage are available and accessible in local threshold languages s and are compliant with ADA regulations
- Age appropriateness and literacy are considered in the development of written materials
- Vital documents have been translated into threshold languages

- There are internal and external resources available for the translation of documents
- There is an ability to deliver oral translation of written materials in uncommon languages
- Translated materials are kept in stock and are accessible to client/consumers
- Staff understand issues related to health literacy and can ensure all materials are appropriate for intended audience
- Staff are trained to use health literacy assessment tools with clients/consumers and respond appropriately when literacy levels are low

ENGAGEMENT, CONTINUOUS IMPROVEMENT, AND ACCOUNTABILITY:

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

GUIDELINE

Health and health care organizations should develop and implement a strategic plan that sets clear goals and measurable objectives for ensuring culturally and linguistically appropriate services. The plan also builds in accountability mechanisms to ensure its implementation.

CHECKLIST

- The agency's Board of Directors oversees a strategic planning process at least every 3-5 years
- The strategic planning process includes input from diverse consumers, community members and staff
- Data gathered in the planning process informs and refines the plan's goals and objectives
- A designated member of the agency's management team is responsible for the implementation of the strategic plan's CLAS related goals and objectives
- The agency's Board of Directors and management team oversee accountability measures that ensure the strategic plan's CLAS related goals and objectives are met.
- Mechanisms for ensuring culturally appropriate and linguistically accessible services are integrated into the agency's program and personnel policies and procedures and quality improvement activities
- Mechanisms are in place to ensure the agency remains aware of and responsive to changing client cultural and linguistic needs

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.

GUIDELINE

Health and health care organizations should evaluate their organization's ability to provide culturally and linguistically competent services on a regular basis. If possible, agencies achieve this through agency

self-evaluations, client satisfaction surveys, and tracking client success rates by cultural and linguistic group.

CHECKLIST

- A dedicated management level person is responsible for integrating CLAS evaluation activities into existing activities, or developing them for use, as needed.
- Agency self-evaluation done annually
- Client satisfaction surveys include questions about whether the client feels that the services were culturally and linguistically appropriate
- Intake and exit interviews include the collection of the client's cultural groups and preferred spoken and written dialect and language.
- Yearly all-staff meeting to review findings of these activities
- Evaluation, survey, and program completion results used to plan program improvements

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.

GUIDELINE

Health and health care organizations should collect all information relevant to the cultural and linguistic needs of all clients or participants. This information will be placed in each file or record. As trust builds with the person, this information needs to be updated. Important information includes:

- Race
- Ethnicity
- Spoken and Written language(s) they use and are proficient in
- Sexual Identity (Lesbian, Gay, Bisexual, Queer, Questioning , Undetermined)
- Sex or Gender (Male, Female, Female to Male Transgendered, Male to Female Transgendered,
- Undetermined, Intersex)
- Religion/Spiritual Practice
- Abilities and Challenges (i.e. physical, cognitive)
- Military Service
- Circumstance of migration (forced, refugee, economic, suppression of Freedom, asylee)
- Homeless
- Formerly Incarcerated

It is common knowledge that poor data collection has limited the ability to analyze some health disparities and therefore to devise proper remedies for them. Enhancement of data collection is consequently an important piece of the effort to eliminate health disparities.

CHECKLIST

- Intake data form includes demographic identifiers
- Client charts are reviewed to verify/confirm that current data is included in the chart.
- Demographic identifiers are included on exit form
- Training is provided to staff collecting this information to ensure that they do so in a culturally and linguistically appropriate and accessible manner
- Staff informs clients that the information collected will remain confidential and will not have a negative effect on the quality of care they receive – and that this data is being collected to ensure a high quality of service for everyone

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.

GUIDELINE

Health and health care organizations should collect demographic, cultural and epidemiological information for their service community. Organizations conduct ongoing needs assessments of their community and use this information to put in place services that meet the cultural and linguistic needs of their clients/participants.

Community organizations can be of assistance in the assessment process. In general, community groups have a better knowledge of both the needs of residents and the assets available to them. Offering your knowledge can be indispensable.

CHECKLIST

- Data on the service community's demographic profile is accessible
- Data on the service community's cultural profile is accessible
- Data on the service community's epidemiological profile is accessible
- Someone on staff is designated to collect and interpret community level data, including an assessment of utilization rates based on client-level demographic, cultural and epidemiological data.
- Community needs and assets assessments are performed regularly
- Data received through community needs and assets assessments should be reviewed by stakeholders of the community assessed and used to implement changes as needed within the program**.**

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

GUIDELINE

Health and health care organizations should maintain participatory, collaborative partnerships with the communities they serve. Organizations make sure that both the community and the clients/participants are involved in designing and implementing CLAS-related activities.

Utilizing this Standard helps to ensure that the services being offered are guided by the needs, interest and expertise of the community that is being served. And, importantly, it also can serve to empower members of the community so that they become active participants in the health care process.

CHECKLIST

- Client/consumer satisfaction surveys about the cultural and linguistic competence of services are collected
- A staff person is designated to analyze and publicize client satisfaction data within the organization
- There are relationships with the key community based and/or faith based organizations in the community Feedback from community based and/or faith based organizations in incorporated in the design and implementation of services
- Community feedback is sought about the language and interpreters services that the organization provides to clients/consumers
- Feedback from both community and clients/consumers is sought about the signage and materials displayed within the office to ensure that everyone feels welcomed and included, such as posters, pamphlets, magazines, and resource listings
- Representatives from the service community participate in the organization's advisory board

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

GUIDELINE

Health and health care organizations should evaluate their organization's processes for identifying and resolving cross-cultural conflicts and/or complaints by clients and staff. These organizations also ensure that the grievance resolution processes are culturally and linguistically appropriate.

If implemented in a meaningful way, such a process could be used not only for the important purpose of resolving differences, but also for the organization to learn how to improve its practices so that it continues to enhance its cultural and linguistic initiatives.

CHECKLIST

- The grievance or complaint process is made known to all clients and staff.
- Grievances and complaints are reviewed to determine if there is a cultural component

• New client/patient packets and new staff hire paperwork emphasize the open and welcoming nature of the program to all, regardless of race, ethnicity, sexual or gender minority status, except in cases where the program has a specific, clearly stated mission (i.e. Native American, pregnant women, etc.)
• A grievance review committee is convened that consists of members who represent staff and client ethnic diversity, to identify and address potential conflicts. The committee includes at least one staff person at the management level to add weight/credibility to its findings
• Annual trainings and staff development include information on treatment issues for minority populations, with the goal of increasing sensitivity and knowledge of such populations and issues
• A policy is implemented to treat cross-cultural conflicts and grievances in a comparable manner as "incident reports" with a statement of the problem, the steps towards resolution, and the outcome. These forms are maintained and documented for quality assurance and policy changes
• All staff members are trained to recognize and prevent cross cultural related conflicts and grievances
• Notice is given in the client's and staff's language about the right and instructions to file a complaint or grievance

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

GUIDELINE

Health and health care organizations should make information about their progress on the CLAS standards available to the public. Organizations should make sure that the public knows this information is available.

CHECKLIST

- A person in the organization is responsible for tracking progress on the 14 CLAS standards
- Information about the organization's progress on the CLAS standards is regularly reviewed and compiled into a report that is written in easily accessible language
- This report is translated into the threshold languages of the community
- Signage is posted in the organization's public areas informing the public that this information is available
- Information about the organization's progress on the CLAS standards is posted on the organization's website

APPENDIX 3

Maryland PCMH CLAS Assessment Survey

1. **What strategies are currently used to ensure that the range and capacity of services at the practice site reflect the needs of the community?**
    - Community health needs assessment which include data on the race, ethnicity and language of the community
    - Cultural competence organizational assessment
    - Other internal assessments on the utilization and success of services
    - We do not currently have any strategies to ensure that the range and capacity of services at the practice site reflect the needs of the community
    - Other (please describe)

2. **In what ways are patients and/or the community encouraged to provide feedback on the array and delivery of services?**
    - Members of the community give input via surveys and questionnaires
    - Staff hold focus groups with members of the community
    - PCMH leadership meets periodically with key leaders of the community and faith-based organizations
    - Community members serve on a patient and family advisory council/committee
    - The community does not currently participate in determining the array of services and the manner in which services are delivered and evaluated
    - Other (please describe)

3. **What strategies are used to <u>identify</u> potential barriers to service access and treatment adherence that may result from the effect of cultural, linguistic, and social determinant of health characteristics within the community (i.e. cultural differences in treatment seeking, limited health and behavioral literacy, limited English proficiency, transportation limitations)?**
    - Patient surveys
    - Internal assessment of patient service utilization
    - Internal assessment of patient visits due to lack of compliance with instructions
    - Assessment of patient no-show and cancellation rates
    - We do not currently have strategies to identify potential barriers to service access and treatment adherence
    - Other (please describe)

4. **What strategies are used to <u>address</u> the identified barriers to service access and treatment adherence?**
    - Training and differential pay to Qualified Bilingual Staff
    - Interpreter skills training for all staff
    - Cultural competency training for all staff
    - Development of a strategic plan that addresses identified barriers
    - Case management services
    - Use of community health workers
    - Use of care transition teams
    - Involvement of community members in planning and evaluating services
    - We do not currently have strategies to address potential barriers to service access and treatment adherence
    - Other (please describe)

5. **What strategies are used to assess patient health literacy?**
    - Formal health literacy tests (e.g., The Newest Vital Sign)
    - Patients are asked to repeat physician instructions in their own words
    - Medication reconciliation with the patient
    - We do not have strategies at this time for assessing a patient's health literacy.
    - Other (please describe)

6. **What tools do staff and/or clinicians use to help address health literacy needs?**
    - Patients are offered help in completing forms
    - All forms are simplified in easy-to-read formats, using clear language and non-medical terms when possible
    - All written instructions and health education materials are at a 5^{th}-grade reading level or lower
    - Forms and health education materials are translated into the languages of the patient population
    - Instructions are reviewed with patients and checked to be sure that patients understand the information (i.e., teach-back method)
    - Members of the community are invited to serve on a patient and family education committee
    - We do not have tools to address health literacy needs at this time
    - Other (please describe)

7. **What strategies are used to ensure that the provision of services, verbal and written information (including signage), and educational materials are in the language(s) of the community being served?**
    - A language needs assessment is conducted in the community
    - Signage is posted in the major languages present in the community
    - Educational materials are available in the major languages present in the community
    - Patients are informed of their right to treatment in the language they are most proficient.
    - Interpreter services are available and patients are encouraged to ask for these services
    - A formal language services policy is in place
    - We do not currently have strategies to ensure materials are available in the language(s) of the community being served
    - Other (please describe)

8. **What methods are used to provide language interpretation to limited English proficient patients?**
    - Chart flagging is used to identify patients that need interpreter services.
    - Staff members have the capacity to provide services in the respective languages of our patients
    - Contracts are established with onsite or telephonic interpreter service vendors
    - Staff are trained in the use of interpreter services.
    - Our telephone messaging service offers information in the respective languages of our patients
    - We do not currently provide language services to our patients.
    - Other (Please describe)

9. **Does your PCMH provide formal training in medical interpretation for staff with bilingual skills?**
    - Yes
    - No
    - Not sure

10. What policies are in place to ensure the <u>quality</u> of language interpretation to limited English proficient patients?

- Use of interpreters certified by an independent authority (i.e., National Board of Certification for Medical Interpreters; Certification Commission for Healthcare Interpreters; Registry of Interpreters for the Deaf)
- Use of interpreters with local or state interpreter training (including Qualified Bilingual Staff training)
- Use of staff proficient in the primary language of the patient being served
- Use of family members with a higher level of English proficiency
- We do not have policies in place at this time.
- Other (Please describe)

11. What methods are used to inform patients of their right to receive language assistance services at no cost to the patient or family?

- Information is provided verbally at the first contact with the patient
- Information is provided verbally at every meeting with the patient
- Information is provided in writing in the respective language of the patient
- Information is posted at the facility
- Information is disseminated via cultural brokers or community health workers
- We do not currently inform patients of this right.
- Other (Please describe)

12. What strategies are in place for continually assessing and improving patient and family-centered communication?

- Patient surveys
- Internal reviews
- Reviews by a patient and family advisory council/committee
- Reviews by external evaluators
- We do not currently assess patient and family-centered communication
- Other (please describe)

13. What particular strategies are in place to hire staff who reflect the diversity of the community being served (in terms of gender, race, ethnicity and linguistic capabilities)?

- Tracking racial and ethnic data on the population residing in the service area
- Tracking data on the languages spoken by the population in the service area
- Collaborations with local schools and community organizations to identify diverse candidates for vacancies

- Advertisement of employment opportunities at community health fairs and in job boards, publications, and other media that target minority audiences
- We do not currently have strategies in place to hire staff who reflect the diversity of the community
- Other (please describe)

14. Are there any distinct staff recruitment initiatives that focus on hiring and retaining staff at all levels who are from the surrounding community?

- Yes
- No
- Not sure

If yes, please describe.

15. What strategies are in place to help ensure that all staff members (both clinical and non-clinical) have the appropriate knowledge and skills to deliver services in a culturally competent manner?

- Staff are required to complete cultural competency training
- Staff are required to complete linguistic competency training
- We have incentives for staff to complete cultural and linguistic competency training
- Cultural and linguistic competence is a factor in staff evaluations
- We budget money to train staff in cultural competency or to serve as medical interpreters
- We do not currently have strategies in place to help ensure that all staff members have the appropriate knowledge and skills to deliver services in a culturally competent manner.
- Other (Please describe)

16. Are incentives offered to help ensure that staff obtain knowledge and skills related to cultural competency?

- No
- Yes

If yes, Please describe: _____

17. What trainings, practices, protocols and policies have been put in place to support a culturally-competent workplace?

- Cultural competency training
- Diversity training
- Qualified bilingual staff training
- Title VI protocols
- EEOC protocols
- We do not have these trainings, practices, protocols or policies in place at this time
- Other (Please describe)

18. In what ways do the PCMH's goals, policies, operational plans and management accountability mechanisms reflect the need to provide culturally and linguistically appropriate services?

- Cultural competency is written into our practice's mission statement, goals and strategic plan.
- Our practice regularly assesses the cultural and linguistic competency of its staff and its policies
- We provide patients with satisfaction surveys and encourage them to complete the forms.
- Our practice's goals, policies, operational plans and management accountability mechanisms do not currently reflect the need to provide culturally and linguistically appropriate services
- Other (please describe)

19. Has your PCMH previously conducted any organizational cultural competency assessments?

- Yes
- No
- Not sure

If yes, how often are assessments conducted and which organizational cultural competency assessment tool was used?

_____

_____

20. In what ways has the PCMH created a physical environment that is representative of or accommodating to the cultures in the community being served?

- Signage reflects the race, ethnicity and language of the population served
- The physical environment of our practice has taken culture into account when designing and decorating the facility
- Our practice does not currently have a physical environment that is representative of or accommodating to the cultures in the community being served
- Other (Please describe)

21. How accessible is the PCMH to public transportation and to persons with disabilities?

(1 – Inaccessible, 2 - Poorly accessible, 3 – Neither accessible nor inaccessible, 4 - Somewhat accessible, 5 - Easily accessible)

Public Transportation	1	2	3	4	5
Persons with disabilities	1	2	3	4	5

22. What strategies are being used to promote service utilization?

- Appointment reminder calls
- Walk-in appointments
- Expanded service hours
- Transportation assistance
- Service delivery sites in a variety of community-based settings
- Collaborations/partnerships with other service providers in the community
- Case management services
- Outreach at community events
- We do not currently have strategies to promote service utilization
- Other (Please describe)

23. What additional cultural healing traditions and informal community supports are used to enhance the comprehensiveness of services and improve patient satisfaction with the array of services provided?

- Please describe: _____
- Not Applicable

24. Is patient race data collected?

- Yes
- No

- Not sure

25. Is patient race data available to the clinician during the patient encounter?

- Yes
- No
- Not sure

26. Is patient ethnicity data collected (e.g. Hispanic/Latino)?

- Yes
- No
- Not sure

27. If patient ethnicity data is collected, which ethnic categories are included as part of the standardized dataset?

- Please describe: _____
- Not Applicable

28. Is patient ethnicity data available to the clinician during the patient encounter?

- Yes
- No
- Not sure

29. Is patient language data collected?

- Yes
- No
- Not sure

30. Is patient language data available to the clinician during the patient encounter?

- Yes
- No
- Not sure

31. Are clinical performance measures stratified by gender, race, ethnicity, and language?

	Yes	No	Not sure
Gender	□	□	□
Race	□	□	□

Ethnicity	□	□	□
Language	□	□	□

32. Is patient satisfaction or patient experience of care data collected?

- Yes
- No
- Not sure

If yes, which survey instruments or services are used to collect this data?

_____

33. One example of a patient experience of care survey instrument is the CAHPS (Consumer Assessment of Healthcare Providers and Systems) survey. Does your PCMH administer the CAHPS survey?

- Yes
- No
- Not sure

34. If CAHPS data is collected, are the following item sets included in the survey process:

	Yes	No	Not sure
o CAHPS Cultural Competence Item Set	□	□	□
o CAHPS Health Literacy Item Set	□	□	□
o Not Applicable			

35. What processes are used to ensure that a culturally and linguistically appropriate grievance or conflict policy is in place?

- All staff members, volunteers, patients/consumers are informed of the grievance policy and process.
- Training is provided to all new staff members on the grievance policy and process.
- Patient/client and staff input is used to craft the grievance policy and process
- Policies and processes address literacy, English ability, individuals with disabilities, and unfamiliarity or reluctance of some cultural groups to make formal complaints

- Our electronic data system has the capacity to document and track complaints, their status, and resolution for both patients/clients and staff
- A cultural diversity liaison is in place to assist with patient or staff grievances
- No grievance or conflict resolution processes are in place at this time.
- Other (Please describe)

36. How does the PCMH communicate its dedication and progress in implementing and sustaining culturally and linguistically appropriate services to all stakeholders, constituents and the general public?

- Printed materials about your cultural competence mission and services translated into various languages
- A column in the local newspaper
- E-mails with updates, meeting information
- Agency Web site, updated regularly
- Blogs or newsletters
- Presentations at community meetings
- Spreading the word through coalitions
- We do not communicate this information at this time
- Other (Please describe)

References

Maryland Department of Health and Mental Hygiene, Office of Minority Health and Health Disparities. "Report of the Maryland Health Disparities Collaborative, Cultural and Linguistic Competency Workgroup - Part I." June 2012. Available at: http://dhmh.maryland.gov/mhhd/Documents/Format%20of%20Reporting%20by%20Higher%20Education%20Institutions.pdf

National Quality Forum. "Comprehensive Framework and Preferred Practices for Measuring and Reporting Cultural Competence: A Consensus Report". 2009. Available at: http://www.qualityforum.org/Publications/2009/04/A_Comprehensive_Framework_and_Preferred_Practices_for_Measuring_and_Reporting_Cultural_Competency.aspx

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U.S. Department of Health and Human Services, Office of Minority Health. "National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care". April 2013. Available at: http://minorityhealth.hhs.gov/templates/browse.aspx?lvl=2&lvlID=15

Weech-Maldonado R, Dreachslin J, Brown J. et al. "Cultural Competency Assessment Tool for Hospitals (CCATH): Evaluating Hospitals' Adherence to the CLAS Standards". *Health Care Management Review*, 2012, 37(1):54-66.

Additional CLAS and Cultural Competency Assessment tools for Organizations

- CAHPS® Cultural Competence Item Set - The Cultural Competence Item Set was developed through funding from the Agency for Healthcare Research and Quality (AHRQ) to the CAHPS Consortium. The items address the following five topic areas: Patient-provider (or doctor) communication; Complementary and alternative medicine; Experiences of discrimination due to race/ethnicity, insurance, or language; Experiences leading to trust or distrust, including level of trust, caring, and truth-telling; and Linguistic competency (Access to language services). Copy of the tool and more information can be retrieved at https://cahps.ahrq.gov/clinician_group/cgsurvey/aboutculturalcompetenceitemset.pdf

- Cultural Competency Assessment Tool for Hospitals (CCATH) - The CCATH, developed by Robert Weech-Maldonado, Janice L. Dreachslin, Julie Brown, Rohit Pradhan, Kelly L. Rubin, Cameron Schiller and Ron D. Hays is an organizational tool to assess adherence to the U.S. national standards for culturally and linguistically appropriate services (CLAS) in health care provide guidelines on policies and practices aimed at developing culturally competent systems of care. A field test provided support for the reliability and validity of the CCATH. See http://www.chime.ucla.edu/Weech-Maldonado-%20Cultural%20competency%20assessment% 20tool%20for %20 hospitals.pdf; https://www.thinkculturalhealth.hhs.gov/pdfs/CCATHFieldTest.pdf

- CLAS Assessment Survey - This survey is based on the Cultural and Linguistically Appropriate Services (CLAS) in health care delivery. This online survey assesses how well your organization provides culturally competent care, assesses patient-provider communication and service delivery. After completing the survey, individuals will receive results and recommended actions to address gaps. The survey is offered at no cost. You have the choice to take the full survey or select each of the sections that interest you. http://culturecareconnection.org/navigating/assessment.html

- Cultural Competency Organizational Assessment - 360 (COA360) - The COA360 is an instrument designed to appraise a healthcare organization's cultural competence. The Office of Minority Health and the Joint Commission have each developed standards for measuring the cultural competency of organizations. The COA360 is designed to assess adherence to both of these sets of standards. http://www.jhsph.edu/research/centers-and-institutes/johns-hopkins-center-for-health-disparities-solutions/Projects/clearview_organizational_assessments_360.html

- Culture and Medicine - The purpose of this tool is to evaluate how well the organization meets national cultural competence guidelines, to learn what actions are needed to become more culturally and linguistically competent, to gain a broad understanding of systems, policies and practices that

contribute to cultural and linguistic competence and to assess needs and determine the level of assistance needed from CLAS experts.
http://www.ct.gov/dph/lib/dph/multicultural_health/assessment_tool.pdf

- The Cultural Competence Awareness Tool (CCAT®) - The CCAT guides health care organizations through an examination of the administrative structures and practices described in the CLAS standards. Through this process, organizations are helped to identify areas that support and those that hinder the delivery of culturally competent health care. With assessment information in hand, the organization can develop a concrete action plan that moves the institution closer to the care outlined in the CLAS standards. http://www.bphc.org/chesj/resources/Documents/Tools/culturalcompentencyassesstool.pdf

- The Cultural and Linguistic Competence Policy Assessment (CLCPA) – The CLCPA was developed by the National Center for Cultural Competence (NCCC) at the request of the Bureau of Primary Health Care (BPHC), Health Resources and Services Administration (HRSA), U.S. Department of Health and Human Service (DHHS) to assist community health centers to advance and sustain cultural and linguistic competence. http://www.clcpa.info/

The Maryland Office of Minority Health and Health Disparities

Participant Pre Curriculum Survey

Adapted from California Endowment "A Curriculum for Developing Culturally and Linguistically Appropriate Services"

Please select the best answer to define the following:

1. Cultural competence

    [ ] 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

2. Patient-centered care

    [ ] Care that integrates the patient's perspectives and promotes greater patient involvement in his or her care
    [ ] Consideration of the patient's limitations when developing care plans
    [ ] Performing learning needs assessments with patients
    [ ] Integration of methods to mitigate barriers to learning

3. Racial and ethnic health care disparities

    [ ] Discrimination resulting in lack of access to necessary health care services
    [ ] Patient preferences, belief systems and/or language barriers resulting in differential outcomes
    [ ] Racial or ethnic differences in the quality of health care that are not due to access-related factors or clinical needs, preferences, and appropriateness of intervention
    [ ] Differential outcomes related to the unique language, culture, spiritual, or other determinants complicating the health care delivery process

4. Culture

    [ ] Groups of people who have a shared racial or ethnic background
    [ ] A set of meanings, norms, beliefs, and values shared by a group of people
    [ ] Groups of people who have the same racial and/or ethnic heritage with shared language and practices
    [ ] Social behaviors related to shared ethnicity, race, spiritual beliefs, and language

5. Health belief

[ ] An individual's concept of illness and health
[ ] The patient's understanding of steps required to regain better health
[ ] Cultural beliefs regarding health shared by members of a group
[ ] All of the above

Please choose the single best answer for questions 6-9

6. How many CLAS standards exist?

[ ] 4
[ ] 10
[ ] 14
[ ] 15

7. Which standard(s) is/are mandated for agencies that receive federal funding?

[ ] #1
[ ] All
[ ] #5, #6, #7, #8
[ ] None

8. Which agency developed the CLAS standards?

[ ] DHMH
[ ] U.S. Department of Health and Human Services, Office of Minority Health
[ ] AMA

9. The CLAS standards are mandated under what authority?

[ ] DHMH
[ ] ACA
[ ] Title VI
[ ] No mandate

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

10. I am aware of CLAS-based projects in my health system.

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

11. 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

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

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

13. In order to 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

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

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

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

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

16. CLAS-based efforts can improve quality of health care and/or services in my organization.

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

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

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

18. I can develop a plan to place one or more of the CLAS standards into operation.

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

The Maryland Office of Minority Health and Health Disparities

Participant Post Curriculum Survey

Adapted from California Endowment "A Curriculum for Developing Culturally and Linguistically Appropriate Services"

Please select the best answer to define the following:

1. Cultural competence

    [ ] 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

2. Patient-centered care

    [ ] Care that integrates the patient's perspectives and promotes greater patient involvement in his or her care
    [ ] Consideration of the patient's limitations when developing care plans
    [ ] Performing learning needs assessments with patients
    [ ] Integration of methods to mitigate barriers to learning

3. Racial and ethnic health care disparities

    [ ] Discrimination resulting in lack of access to necessary health care services
    [ ] Patient preferences, belief systems and/or language barriers resulting in differential outcomes
    [ ] Racial or ethnic differences in the quality of health care that are not due to access-related factors or clinical needs, preferences, and appropriateness of intervention
    [ ] Differential outcomes related to the unique language, culture, spiritual, or other determinants complicating the health care delivery process

4. Culture

    [ ] Groups of people who have a shared racial or ethnic background
    [ ] A set of meanings, norms, beliefs, and values shared by a group of people
    [ ] Groups of people who have the same racial and/or ethnic heritage with shared language and practices
    [ ] Social behaviors related to shared ethnicity, race, spiritual beliefs, and language

5. Health belief

[ ] An individual's concept of illness and health
[ ] The patient's understanding of steps required to regain better health
[ ] Cultural beliefs regarding health shared by members of a group
[ ] All of the above

Please choose the single best answer for questions 6-9

6. How many CLAS standards exist?

[ ] 4
[ ] 10
[ ] 14
[ ] 15

7. Which standard(s) is/are mandated for agencies that receive federal funding?

[ ] #1
[ ] All
[ ] #5, #6, #7, #8
[ ] None

8. Which agency developed the CLAS standards?

[ ] DHMH
[ ] U.S. Department of Health and Human Services, Office of Minority Health
[ ] AMA

9. The CLAS standards are mandated under what authority?

[ ] DHMH
[ ] ACA
[ ] Title VI
[ ] No mandate

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

10. I am aware of CLAS-based projects in my health system.

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

11. 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

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

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

13. In order to 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

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

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

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

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

16. CLAS-based efforts can improve quality of health care and/or services in my organization.

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

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

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

18. I can develop a plan to place one or more of the CLAS standards into operation.

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

The Maryland Office of Minority Health and Health Disparities

Participant Satisfaction Survey

Please rate the following components of the curriculum

	Excellent	Good	Fair	Poor
Degree to which training met the learning objectives				
Power point presentation				
Handouts				
Quality of speakers/facilitators				
Group discussion3				
Exercise 1– ?				
Exercise 2– ?				
Exercise 3– ?				
Overall rating of session				

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

Comments:

INTRODUCTION TO THE NATIONAL CLAS STANDARDS

MARYLAND
Department of Health and Mental Hygiene
Minority Health and Health Disparities

CLAS Standards Training

Session Overview

2

- **Pre-Training Questionnaire**
- **Introduction to the National CLAS Standards**
- **Making the case for the CLAS Standards**
  - Diversity and Health Disparities in Maryland and [local jurisdiction]
  - The Business Case
- **CLAS Standards Implementation**
  - Concepts
  - Discussion
  - Action Steps/Strategies
- **Questions and Feedback**
- **Closing**

Reflect and respect diversity:
- Video Clip

"What Kind of Asian Are You?"

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

Introduction to the CLAS Standards

Purpose of the National CLAS Standards

5

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

What are the National CLAS Standards?

6

- 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

What are the enhanced National CLAS Standards?

7

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.

8

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

Maryland is One of the Most Racial/Ethnic Diverse States

9

Maryland/Anne Arundel County Population by Race and Ethnicity – 2013 US Census 5-yr Estimate

Subject	Maryland	Percent	Anne Arundel County	Percent
White (one race)	3,406,243	58.4%	408,715	75.1%
Black/African American (one race)	1,717,582	29.4%	84,230	15.5%
American Indian/Alaska Native (one race)	17,535	0.3%	1,184	0.2%
Asian (one race)	332,620	5.7%	19,326	3.5%
Native Hawaiian/Pacific Islander (one race)	2,570	0.0%	528	0.1%
Some other race	195,644	3.4%	12,614	2.3%
Two or more races	162,105	2.8%	17,829	3.3%
Hispanic or Latino (of any race)	493,310	8.5%	34,854	6.4%

What are health disparities?

10

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)

What causes health disparities??

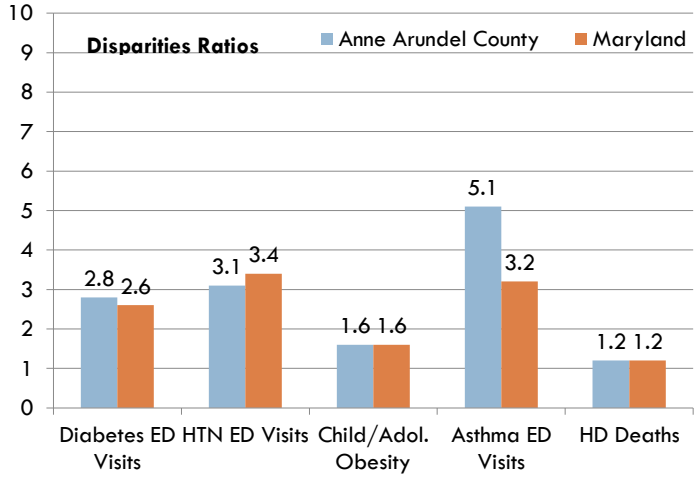
11

- 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

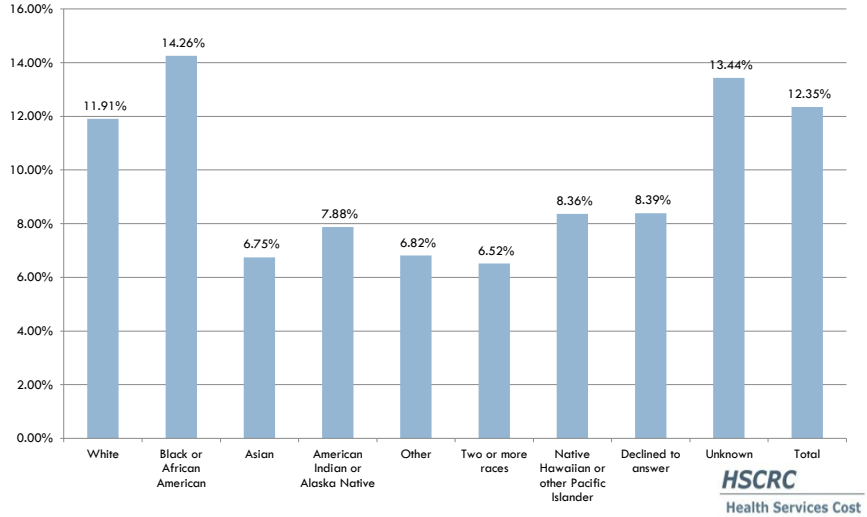
Health Outcome Disparities, Black v. White

12



Readmission Rates by Race (FY 2014)

13



HSCRC
Health Services Cost Review Commission

Cost of Disparities in Maryland

Minority Health and Health Disparities

14

- **Minority Health Disparities cost Maryland between 1 and 2 Billion Dollars per year *of direct medical costs.***
- **In 2011, excess charges in MD from Black/White hospitalization disparities alone were $814 Million.**
- **In [INSERT JURIDICTION], excess charges from Black/White hospitalization disparities were [INSERT $$] (2011).**

These excess charges are just the hospital charges, NOT including physician fees for hospital care, emergency department charges, or any outpatient costs.

Maryland Office of Minority Health and Health Disparities

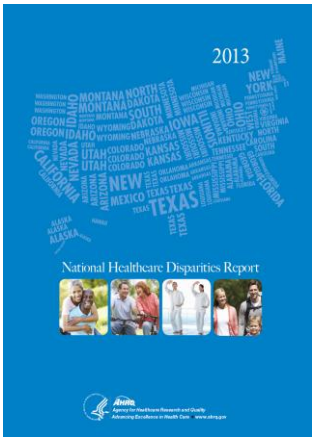
Quality of Care and Health Disparities – Are We Seeing Progress?

15

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

  1) 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.

  2) 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

The Business Case for the CLAS Standards

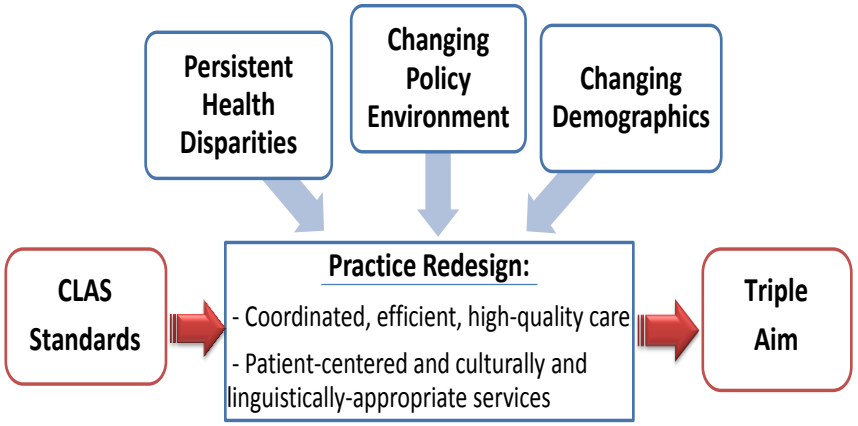
The Case for Culturally and Linguistically Appropriate Services

17

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.
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
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.)
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.)

Bottom Line

18



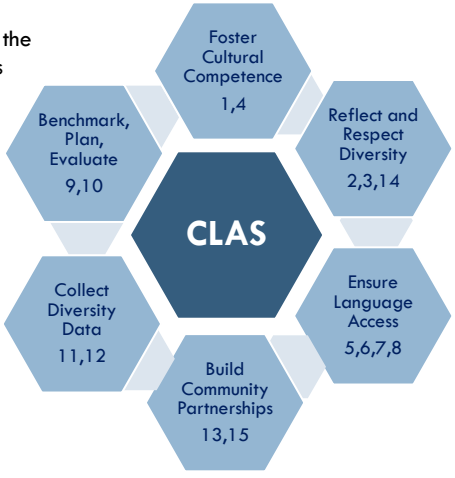
Maryland Office of Minority Health and Health Disparities

CLAS Standards Implementation

Implementation Framework: Six Areas for Action

20

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

I. Fostering Cultural Competence

Fostering cultural competence:

- CLAS Standards

22

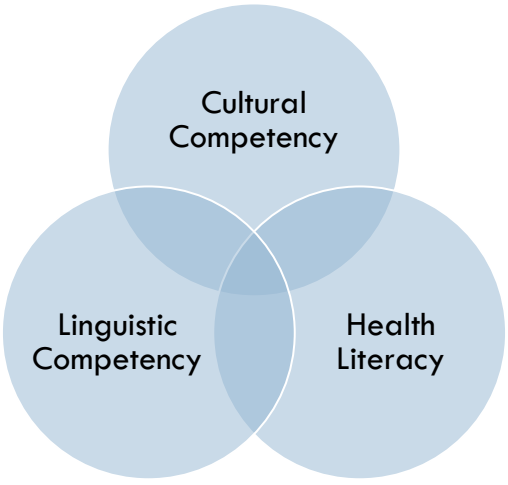
- **CLAS Standard #1:** Provide effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs.

- **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

23



Maryland Office of Minority Health and Health Disparities

Fostering cultural competence:

Defining culture

From the Merriam Webster Dictionary:

The customary beliefs, social forms, and material traits of a racial, religious, or social group; also : the characteristic features of everyday existence (as diversions or a way of life) shared by people in a place or time

Fostering cultural competence:

- What is cultural competency?

25

- 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)

Fostering cultural competence:

- Unconscious Bias

26

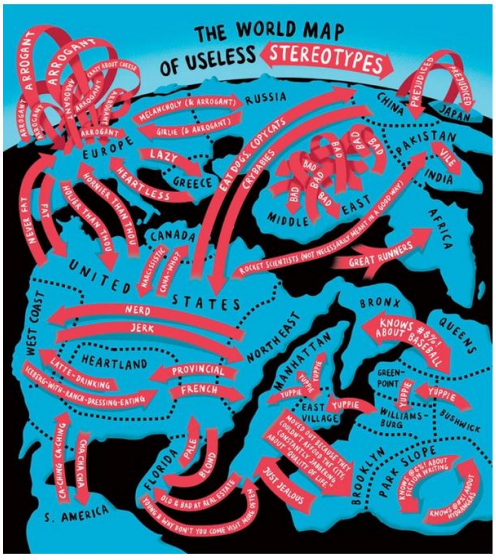
- 'Our implicit people preferences, formed by our socialization, our experiences, and by our exposure to others' views about other groups of people'
  - They cause us to have feelings and attitudes about other people based on characteristics such as race, ethnicity, age, and appearance.
  - They are **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 Our Biases

27



The World Map of Useless Stereotypes by Christoph Niemann

Fostering cultural competence:

Recognizing Our Biases

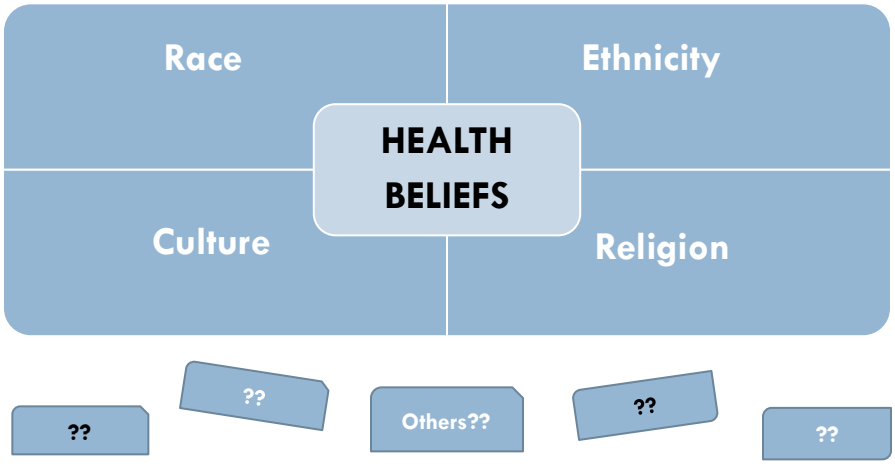
28

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

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

Diverse Intersections of Health

29



We all have health beliefs …

30

- **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.]

Our Health Beliefs May Influence …

31

- 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)

Fostering cultural competence:
- What is linguistic competency?

32

- 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)

Fostering cultural competence:

Importance of Cultural & Linguistic Competence

33

- 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

Fostering cultural competence:

- What is Health Literacy

34

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

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.)

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.)

Fostering cultural competence:
- Interactive Exercise

37

"The Newest Vital Sign"

Fostering cultural competence:
Attributes of Health Literate Organization

38

[See the accompanying handout]

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

Fostering cultural competence:
- Discussion

39

- 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?

Fostering cultural competence:
- Action Steps

40

- **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.**

CLAS Implementation

II. Reflect and Respect Diversity

Reflect and Respect Diversity:

- CLAS Standards

42

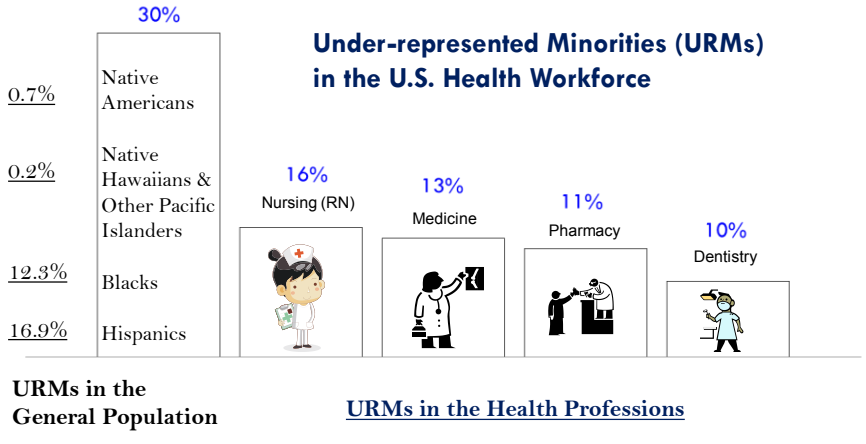
- **CLAS Standard #2:** Advance and sustain organizational governance and leadership that promotes CLAS and health equity through policy, practices, and allocated resources.
- **CLAS Standard #3:** Recruit, promote, and support a culturally and linguistically diverse governance, leadership, and workforce 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:
Activity

"Creating a diversity profile"

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

44



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

Reflect and Respect Diversity:
- Discussion

45

- How well does your workforce reflect the community?
- 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?

Reflect and Respect Diversity:
- Action Steps

46

- **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.**

CLAS Implementation

III. Ensure Language Access

Ensure Language Access:

- CLAS Standards

48

- **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

49

"Can Someone Help Me?"

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

Language Access

50

- 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.

Ensure Language Access:
- Linguistic Diversity in Anne Arundel County

51

Top Foreign Languages Spoken in Households in Maryland	Top Foreign Languages Spoken in Households in Anne Arundel County
1. Spanish	1. Spanish
2. Chinese	2. Korean
3. Korean	3. German
4. African languages (several)	4. French
5. Vietnamese	5. Tagalog
6. French	6. Italian

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

Ensure Language Access:
- Discussion

52

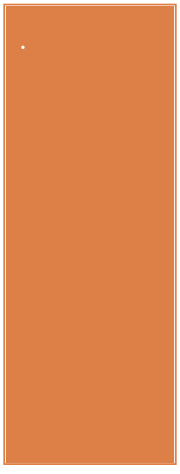
- How are patients notified of the availability of communication and language assistance services?
- What do you currently do to ensure language access?
- What processes are in place to assess the quality of language assistance services?
- What methods are used to familiarize staff about communication and language assistance services?
- How well are bilingual staff being utilized?
- What else could be done to improve accessibility of language services?

Ensure Language Access:
- Action Steps

53

- 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

55

- **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:
- Action Steps

56

- **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

V. Collect Diversity Data

Collect Diversity Data:
- CLAS Standards

58

- **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.

Interactive Exercise

59

"Sorting People"

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

Collect Diversity Data:
- Discussion

60

- What categories of demographic data do you currently collect?
- What methods are used to familiarize frontline staff with data collection protocols?

Collect Diversity Data:
Sample Categories for Data Collection

61

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:
- Action Steps

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- **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

VI. Benchmark, Plan and Evaluate

Benchmark, Plan and Evaluate:

- CLAS Standards

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- **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:
- Discussion

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- 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?

Benchmark, Plan and Evaluate:
- Action Steps

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- **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

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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

Final Thoughts

QUESTIONS

Feedback & Closing

- Post-Training Assessment
- Session Evaluation

Additional Resources

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- 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)

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- **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/

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