

INTRODUCTION TO THE NATIONAL CLAS STANDARDS

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Maryland Office of Minority Health and Health
Disparities

Updated June 2018



MARYLAND
Department of Health

Overview

- **Introduction to the National CLAS Standards**
- **Making the case for the CLAS Standards**
 - Diversity and Health Disparities in Maryland and Baltimore City
 - The Business, Ethical and Social Case for CLAS
- **CLAS Standards Implementation**
 - Concepts
 - Discussion
 - Action Steps/Strategies
- **Questions and Feedback**
- **Post-Training Questionnaire**
- **Closing**

Purpose of the National CLAS Standards

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

Source:

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

What are the National CLAS Standards?

- The National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care
- First published by the HHS Office of Minority Health in 2000
- Provided a framework for organizations to best serve the nation's diverse communities
- Underwent an Enhancement Initiative from 2010 to 2013
- Launched the enhanced CLAS Standards in April 2013

What are the enhanced National CLAS Standards?

Standard 1

Principal Standard

Standards 2-4

Governance, Leadership & Workforce

Standards 5-8

Communication & Language

Standards 9-15

Engagement, Continuous Improvement & Accountability

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

Video Clip

“What Kind of Asian Are You?”

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

Maryland is One of the Most Racial/Ethnic Diverse States

(all percents are percent of “total total”)

<i>2014 estimates MD Dept of Planning</i>	<u>Total</u>	<u>Not Hispanic</u>	<u>Hispanic</u>
Total	100.0%	90.7%	9.3%
White Alone	60.1%	52.6%	7.4%
Black Alone	30.3%	29.3%	1.0%
Amer Indian / Alaska Native Alone	0.6%	0.2%	0.3%
Asian Alone	6.4%	6.3%	0.1%
Native Hawaiian / Pacific Islander	0.1%	0.1%	0.1%
Two or More Races	2.6%	2.2%	0.4%

Blacks are 64% of the Minority Population, Hispanics are 20% and Asians are 13%

What are Health Disparities?

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

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

In particular, we focus on.....

Avoidable differences in health that result from cumulative social disadvantage.

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

What Causes Health Disparities?

- Inequities in the social determinants of health?
- Environmental risk factors?
- Institutional factors?
- Provider factors?
- Patient factors?

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

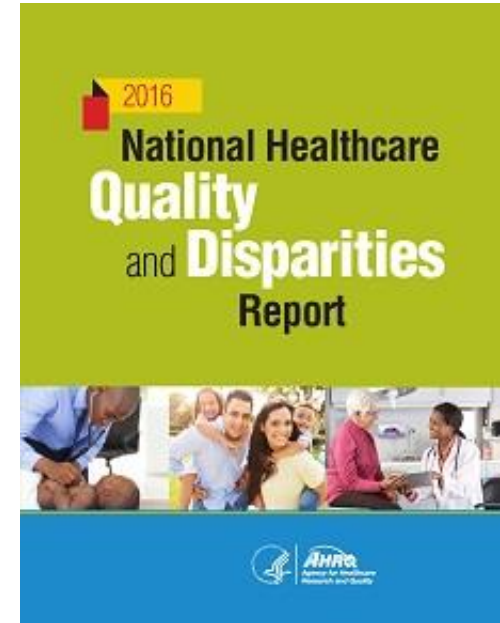
Quality of Care and Health Disparities – Are We Seeing Progress?

According to the latest HHS/AHRQ **National Healthcare Disparities Report** (2016),

- ❖ Blacks experienced worse access to care compared with Whites for 50% of measures.
- ❖ Asians experienced worse access to care compared with Whites for 28% of measures and better access for 44% of measures.
- ❖ Hispanics experienced worse access to care compared with Whites for 75% of measures

Summary:

There were significant disparities for poor and uninsured populations in all priority areas. Some health disparities are getting smaller since 2000-2015, but disparities persist, especially among people in poor and low-income households, uninsured people, Hispanics, and Blacks.



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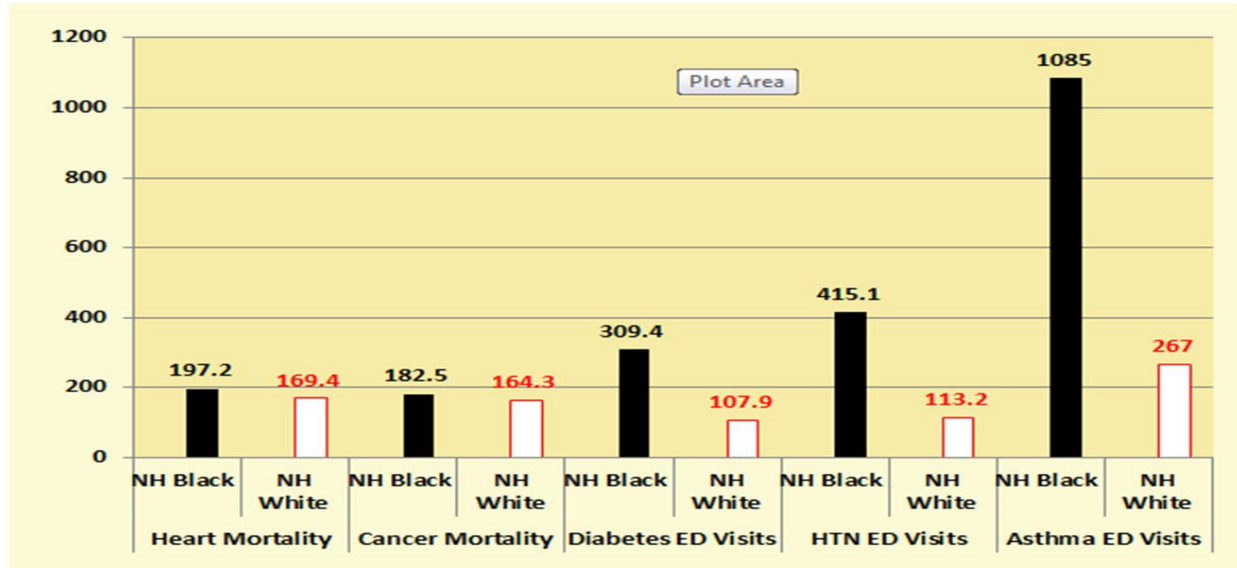
<https://www.ahrq.gov/research/findings/nhqdr/nhqdr16/index.html>

Progress in Elimination of Health Disparities in Maryland

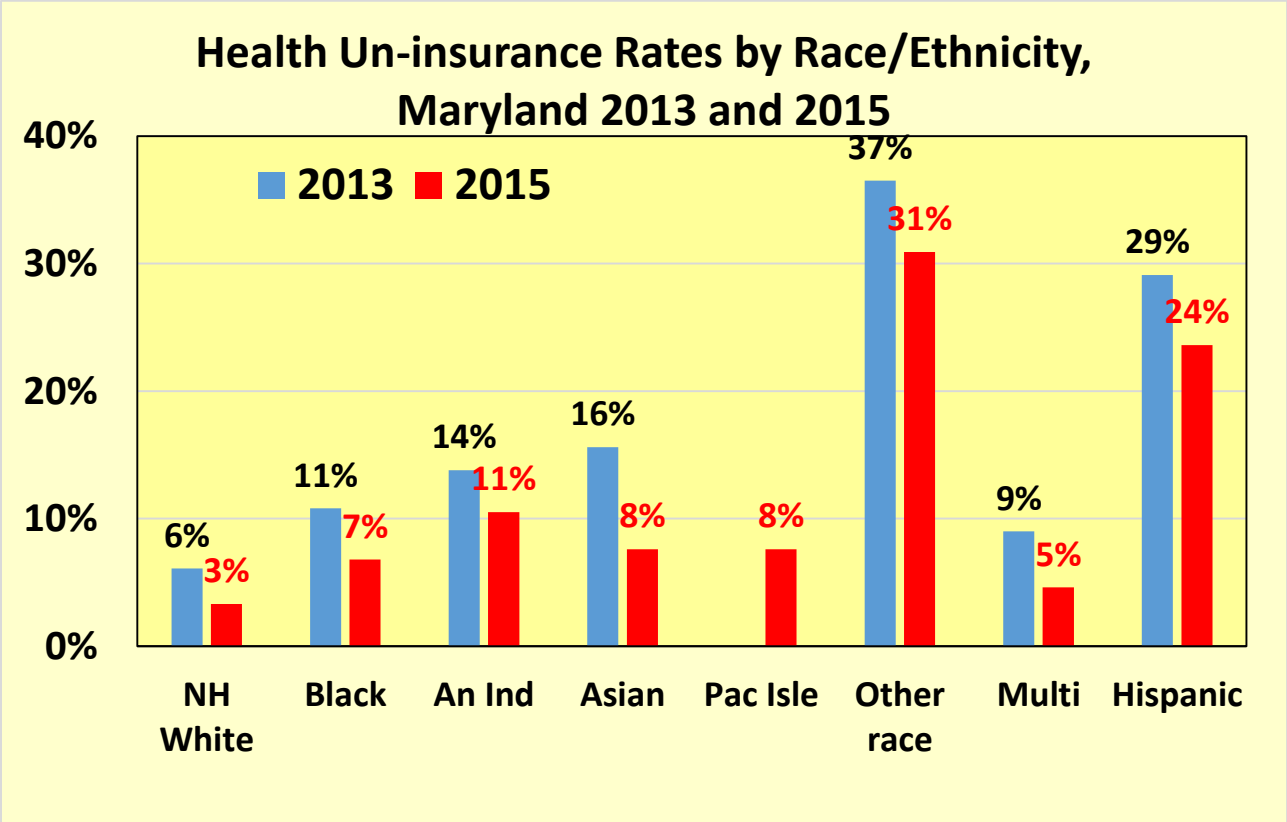
- Between 2007 and 2016 **the gaps** between the Black and White age-adjusted death rates (Black rate minus White rate) **were reduced** as follows: (*Maryland Vital Statistics Annual Report data*)
- For All-cause Mortality, the gap was reduced by **65.9%**
 - For Cancer Mortality, the gap was reduced by **8.3%**
 - For Heart Disease Mortality, the gap was reduced by **20%**
 - For Stroke Mortality, the gap was reduced by **0.8%**
 - For Diabetes Mortality, the gap was reduced by **4.1%**
 - For HIV/AIDS Mortality, the gap was reduced by **14.7%**

Health Outcome Disparities Black v. White in Maryland

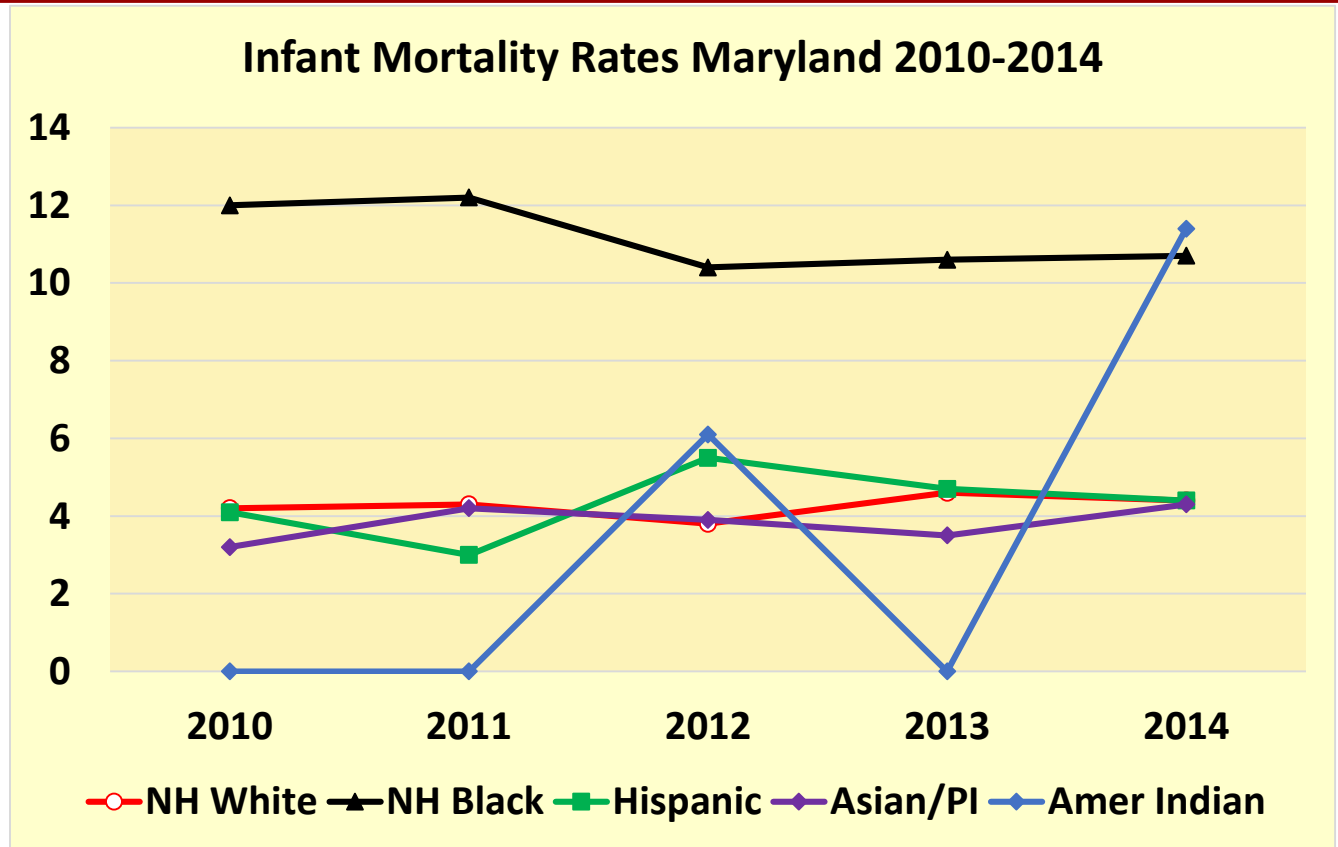
Events (Deaths or ED visits) per 100,000,
Maryland, 2012-14 (deaths) or 2014 (ED)



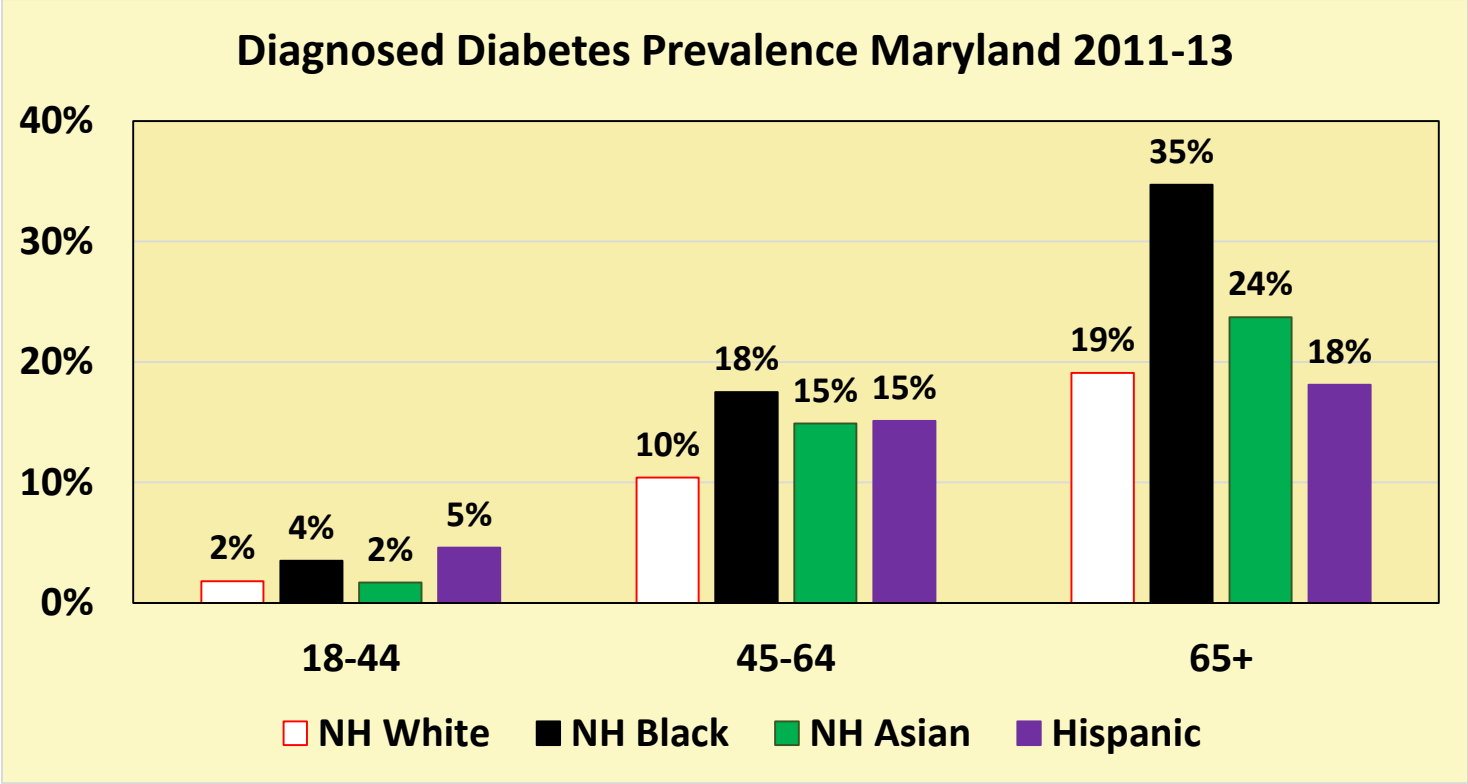
Health Un-insurance by Race and Ethnicity, Maryland 2013 and 2015



Infant Mortality Rates by Race and Ethnicity, Maryland 2010 to 2014



Diabetes Prevalence by Race and Ethnicity



Cost of Disparities in Maryland

Minority Health Disparities cost Maryland between
1 and 2 Billion Dollars per year *of direct medical
costs.*

The Case for Culturally and Linguistically Appropriate Services

Changing Demographics

In Maryland, the population is 58% non-Hispanic White; 8% Hispanic; 29% Black; 5% Asian American; 0.1% Native Hawaiian and Pacific Islander; and 0.4% American Indian/Alaska Native. By 2018, the White and non-White population in MD will be of equal size.

Cost of Health and Health Care Disparities

Minority health disparities cost Maryland between \$1 Billion and \$2 Billion per year of direct medical costs. In 2011, excess charges in Maryland from Black/White hospitalization disparities alone were \$814 Million. (Source: Maryland Office of Minority Health and Health Disparities)

Medicare Waiver

Financial Tests and Quality Targets make it necessary for hospitals to know their patients and develop tailored strategies to keep patients out of the hospital and to help manage the health of the community.

Industry Standards

Joint Commission Hospital Accreditation Standards; National Committee on Quality Assurance (NCQA) Patient-Centered Medical Home Standards

Federal Statutes and Regulations

Affordable Care Act (2010); Plain Writing Act of 2010, Americans with Disabilities Act (1990); Section 504 of the Rehabilitation Act of 1973; Title VI of the Civil Rights Act of 1964; Executive Order 13166 of August 2000: Improving Access to Services for Persons with Limited English Proficiency; Federal and State community benefit reporting and needs assessments

The Case for Culturally and Linguistically Appropriate Services

Medical Errors

Limited English proficient (LEP) patients who may not be able to communicate effectively with their health care providers are at greater risk for medical errors. (Source: Agency for Healthcare Research and Quality. (2012). *Improving Patient Safety Systems for Patients with Limited English Proficiency*. Rockville: U.S. HHS Agency for Healthcare Research and Quality.)

Readmissions

Racial and ethnic minorities are more likely to be readmitted for certain chronic conditions than their non-Hispanic White counterparts. (Source: Agency for Healthcare Research and Quality. *Improving Patient Safety Systems for Patients with Limited English Proficiency*. Rockville: U.S. HHS Agency for Healthcare Research and Quality, 2012.)

Length of Stay

Length of a hospital stay for LEP patients was significantly longer when professional interpreters were not used during both admission and discharge. (Source: Lindholm M, et al. *Professional Language Interpretation and Inpatient Length of Stay and Readmission Rates*. *J Gen Intern Med*, Oct 2012; 27(10):1294-9.)

Treatment Adherence

Effective patient-provider communication can increase treatment adherence, reduce unnecessary diagnostic services, and improve health outcomes. (Source: American Medical Association, Ethical Force Program. *The AMA Ethical Force Program Toolkit: Improving Communication – Improving Care*. 2008.)

More on the Business Case ...

Potential for the following benefits:

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

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

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

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

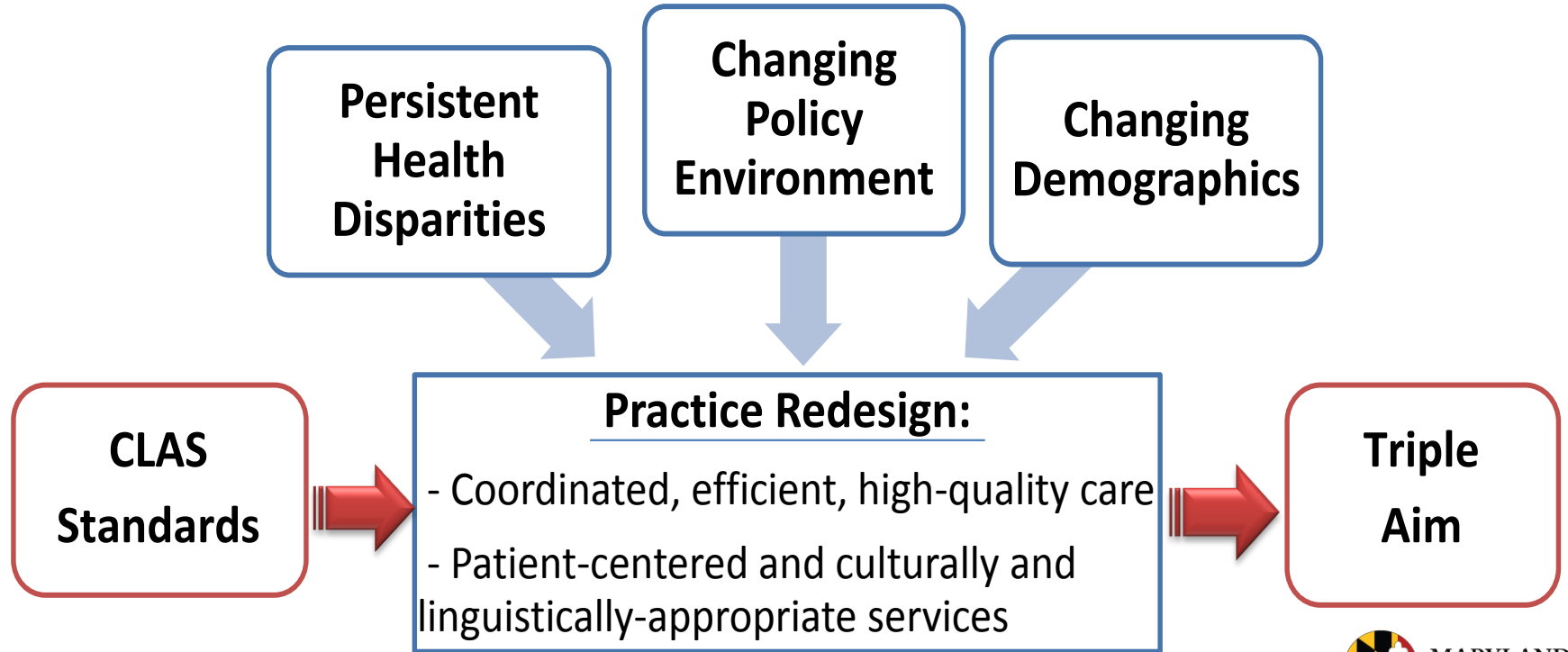
Ethical & Social Case

Potential for the following benefits:

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

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


Bottom Line



Implementation Framework: Six Areas for Action



I. Fostering Cultural Competence

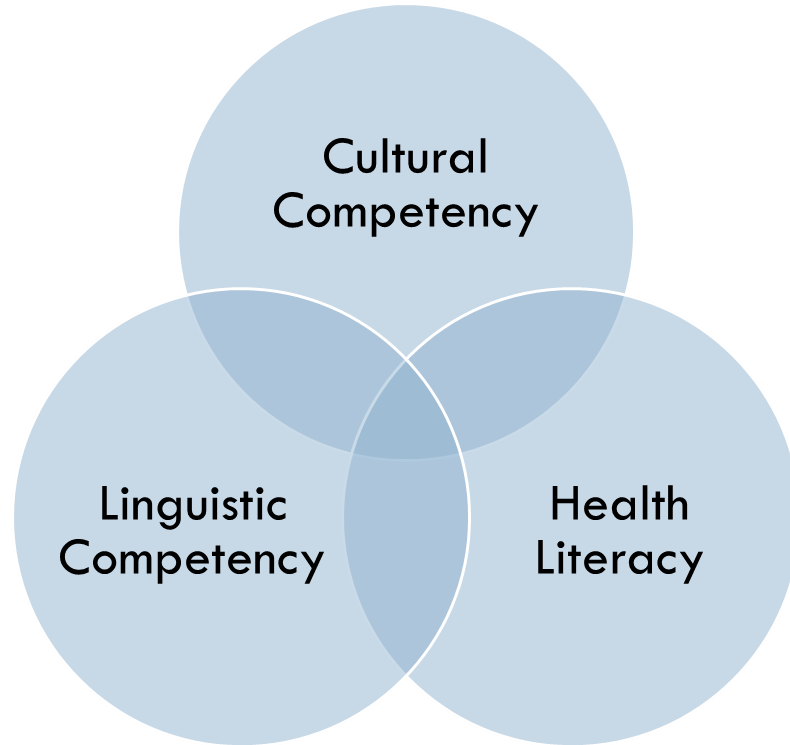
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Fostering cultural competence:

CLAS Standards

- **CLAS Standard #1:** Provide effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs.
- **CLAS Standard #4:** Educate and train governance, leadership, and workforce in culturally and linguistically appropriate policies and practices on an ongoing basis.

Fostering cultural competence: Complementary Concepts



Fostering cultural competence:

What is cultural competency?

- A set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among professionals that enables effective work in cross-cultural situations

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

- Cultural competency can be described as the ability of health organizations and professionals to:
 - Recognize the cultural beliefs, values, attitudes, traditions, language preferences, and health practices of diverse populations
 - Understand how these cultural factors interact with the biological, social, economic, and physical environment of an individual client or patient
 - Apply this knowledge to produce a positive health outcome

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

Fostering cultural competence:

We all have health beliefs ...

Group Exercise:

- Let's break into small groups to discuss what we learned from family and friends during childhood/adulthood about two common conditions:
- What causes you to catch a cold?
- What things should a woman not do when pregnant?

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

Source: National Center for Cultural Competence. Georgetown University, Center for Child and Human Development.

<http://nccc.georgetown.edu/projects/sids/dvd/health%20beliefs.pdf>

Fostering cultural competence: Health beliefs may influence ...

- ❑ When care is sought.
- ❑ Expectations about care.
- ❑ Reactions to illness.
- ❑ Adherence to recommendations.
- ❑ Adoption of healthy behaviors.

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

Fostering cultural competence:

Unconscious Bias

- 'Our implicit people preferences, formed by our socialization, our experiences, and by our exposure to others' views about other groups of people'
 - They cause us to have feelings and attitudes about other people based on characteristics such as race, ethnicity, age, and appearance.
 - They are **pervasive**. Everyone possesses them, even people with avowed commitments to impartiality.
 - They are **malleable**. Our brains are incredibly complex, and the implicit associations that we have formed can be gradually unlearned.

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

Fostering cultural competence:

Recognizing Your Biases

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

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

Fostering cultural competence:

What is linguistic competency?

- ❑ The capacity to communicate effectively, and convey information in a manner that is easily understood by diverse audiences including persons of limited English proficiency, those who have low literacy skills or are not literate, individuals with disabilities, and those who are deaf or hard of hearing
- ❑ Linguistic competency requires:
 - Organizational and provider capacity to respond effectively to the health and mental health literacy needs of populations served.
 - Organizational policies, structures, practices, procedures, and dedicated resources to support this capacity.



Fostering cultural competence:

Importance of Cultural & Linguistic Competence

- Health care services that are respectful of and responsive to the health beliefs, practices and cultural and linguistic needs of diverse patients can help bring about positive health outcomes.
- The increasing population growth of racial and ethnic communities and linguistic groups, each with its own cultural traits and health profiles, presents a challenge to the health care delivery service industry in this country.
- The provider and the patient each bring their individual learned patterns of language and culture to the health care experience, which must be transcended to achieve equal access and quality health care.

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

Fostering cultural competence:

What is Health Literacy

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



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. Comings, B. Garner, & C. Smith. (Eds.), *Review of adult learning and literacy* (vol. 7) (pp 175–204). Mahwah, 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:

Attributes of Health Literate Organizations



1. Have leadership that makes health literacy integral to its mission, structure, and operations.
2. Integrate health literacy into planning, evaluation measures, patient safety, and quality improvement.
3. Prepare the workforce to be health literate and monitor progress.
4. Include the service population in the design, implementation, and evaluation of health information and services.
5. Meet the needs of populations with a range of health literacy skills while avoiding stigmatization.

Fostering cultural competence:

Attributes (cont'd)

6. Use health literacy strategies in interpersonal communications and confirm understanding at all points of contact.
7. Provide easy access to health information and services and navigation assistance.
8. Design and distribute print, audiovisual, and social media content that is easy to understand and take action on.
9. Address health literacy in high-risk situations, including care transitions and communications about medicines.
10. Communicate clearly what services health plans cover and how much individuals will have to pay out-of-pocket.

Fostering cultural competence:

Discussion

- In what ways do you feel that cultural competence is being fostered?
- Are leaders and staff in all roles and departments encouraged to participate in the described activities?
- What have been facilitators to fostering cultural competence?
- What have been barriers to fostering cultural competence?
- What actions can be taken to overcome the barriers?
- What are additional actions/activities that you would like to undertake to foster cultural competence?

Fostering cultural competence:

Action Steps

- **Step 1.** Identify committed champions of cultural competency within the organization.
- **Step 2.** Embed a commitment to culturally competent care in the organization's goals, mission, and strategic plan.
- **Step 3.** Allocate organizational resources to educating senior leadership, staff, and volunteers.
- **Step 4.** Integrate cultural competency and CLAS into staff evaluations.
- **Step 5.** Regularly review and update organizational policies and practices to reflect the CLAS Standards.

Fostering cultural competence:

Case Example

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

- **Actions:**
 - ▣ NYP established a collaborative to improve care coordination and cultural competency.
 - ▣ Physicians also receive training with patient-based cross-cultural care, which assists with cultural competency and communication with patients and families.

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

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

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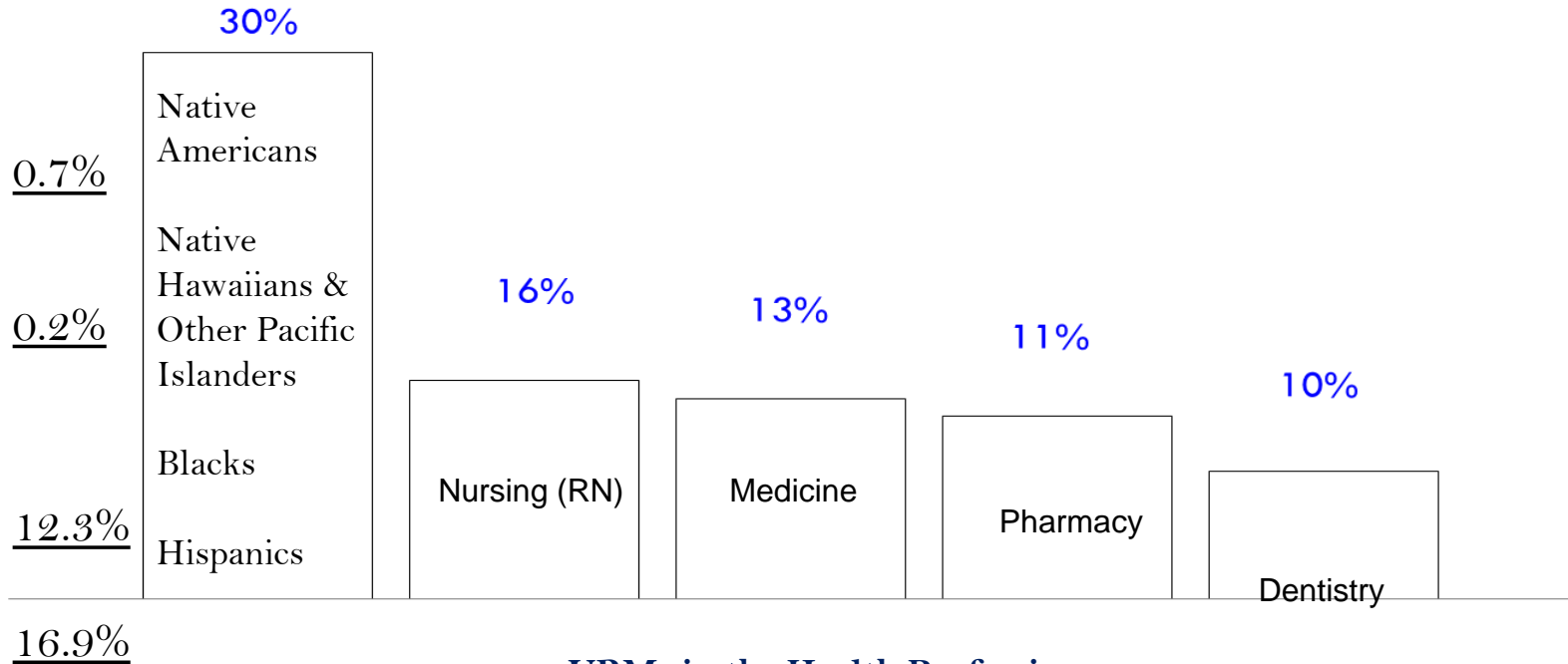
II. Reflect and Respect Diversity

Reflect and Respect Diversity:

CLAS Standards

- **CLAS Standard #2:** Advance and sustain organizational governance and leadership that promotes CLAS and health equity through policy, practices, and allocated resources.
- **CLAS Standard #3:** Recruit, promote, and support a culturally and linguistically diverse governance, leadership, and workforce that are responsive to the population in the service area.
- **CLAS Standard # 14:** Create conflict and grievance resolution processes that are culturally and linguistically appropriate to identify, prevent, and resolve conflicts or complaints.

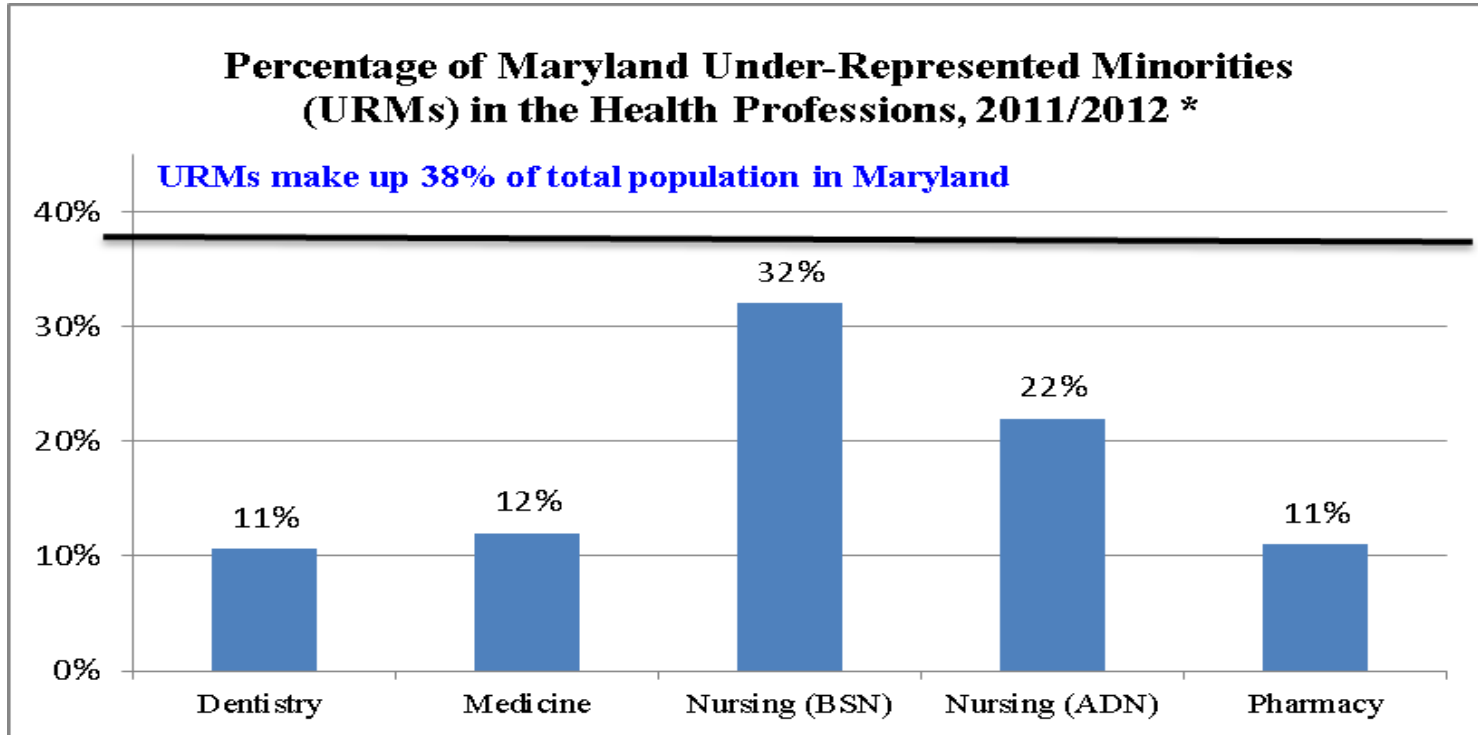
Reflect and Respect Diversity: U.S. Health Workforce



URMs in the Health Professions

URMs in the
General Population

Reflect and Respect Diversity: Maryland Health Profession Grads



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



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Reflect and Respect Diversity: Discussion

- Are there structured opportunities available for staff to have discussions about culture, language, and other factors involved in meeting the needs of diverse populations?
- How well does your workforce reflect the community?
- What strategies are in place to ensure that the community is also reflected at governance and leadership levels?
- In what ways is the diversity of the staff being utilized to provide culturally and linguistically competent care?
- What other things are done to help patients feel welcome?
- What processes are in place to resolve conflicts or grievances from patients and/or staff?
- What methods are used to obtain and process feedback from staff?



III. Ensure Language Access



Reflect and Respect Diversity:

Action Steps

- ❑ **Step 1.** Implement recruitment, retention, and promotion policies for a workforce (staff and leadership) that reflects the diversity of the community being served.
- ❑ **Step 2.** Establish a conflict and grievance resolution process to respond to concerns from both patients and staff.
- ❑ **Step 3.** Provide cross-cultural communication and conflict resolution training.
- ❑ **Step 4.** Provide notice about the right to file grievances or to provide feedback.
- ❑ **Step 5.** Establish formal and informal methods to obtain and process feedback from patients and staff.

Reflect and respect diversity:

Case Example

- Establishing a Process to Increase Diversity in Recruitment Initiatives
Greenville Hospital System University Medical Center, Greenville, South Carolina
- Actions:
 - The leadership search and selection process was overhauled, and a new method of hiring employees at the director level and above was put in place.
 - GHS worked with Furman University, also in Greenville, to send key leaders at GHS through a five-month educational program designed to train existing local leaders in diversity and its importance to an organization.

- Results:

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

Ensure Language Access:

CLAS Standards

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

Ensure Language Access:

- Video Clip

“Can Someone Help Me?”

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

Language Access

- Nearly 17.6% of Marylanders age 5 and older speak a language other than English at home
 - Source: U.S Census Bureau, 2012-2016.
- 20% of Marylanders report that they speak English “not well” or “not at all”
 - Source: American Community Survey, 2008-2012.



Linguistic Diversity in Maryland & [INSERT JURISDICTION]

Top Foreign Languages Spoken in Households in Maryland

1. Spanish
2. African Languages
3. Chinese
4. French
5. Korean
6. Tagalog

Top Foreign Languages Spoken in Households in [I JURISDICTION]

1. >>>

Ensure Language Access:

- Discussion

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

Ensure Language Access:

- Action Steps

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

Step 2. Develop a Communication and Language Assistance Plan.

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

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

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

Step 6. Issue guidance to staff on use of “plain language”.

IV. Build Community Partnerships

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Build Community Partnerships:

- CLAS Standards

- CLAS Standard #13:** Partner with the community to design, implement, and evaluate policies, practices, and services to ensure cultural and linguistic appropriateness.
- CLAS Standard #15:** Communicate the organization's progress in implementing and sustaining CLAS to all stakeholders, constituents, and the general public.

Build Community Partnerships:

- Interactive Exercise

Working with hard-to-reach communities:

- ❑ How do you make contact?
- ❑ How do you determine need?
- ❑ How do you develop culturally and linguistically appropriate services?
- ❑ How do you determine whether the services are meeting the needs of the population?

Build Community Partnerships:

- Discussion

- What methods are being used to help develop sustainable links with the community?
- How are community liaisons identified and engaged?
- In what ways is the community involved in the design, implementation, and/or evaluation of policies, practices and services at your site?
- How are the organization's CLAS-related activities being communicated to the community?

Build Community Partnerships:

- Action Steps

- **Step 1.** Partner with community organizations.
- **Step 2.** Engage community stakeholders and patients in planning, developing, and implementing services.
- **Step 3.** Develop opportunities for community capacity-building and empowerment.
- **Step 4.** Employ community health workers/ promotores de salud.
- **Step 5.** Share news of the organization's CLAS and cultural competency efforts.

V. Collect Diversity Data



Collect Diversity Data:

- CLAS Standards

- CLAS Standard #11:** Collect and maintain accurate and reliable demographic data to monitor and evaluate the impact of CLAS on health equity and outcomes and to inform service delivery.
- CLAS Standard #12:** Conduct regular assessments of community health assets and needs and use the results to plan and implement services that respond to the cultural and linguistic diversity of populations in the service area.

Collect Diversity Data:

- Interactive Exercise

“Sorting People”

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



Collect Diversity Data:

Sample Categories for Data Collection

Client Data

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

Staff Data

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

Collect Diversity Data:

- Discussion

- What methods are used to familiarize frontline staff with data collection protocols?
- How is the community engaged in the data collection process?
- What types of community data might it be useful to link with patient data?

Collect Diversity Data:

- Action Steps

- **Step 1.** Collaborate with community in data collection, analysis, review, and reporting.
- **Step 2.** Standardize data collection process for self-reported demographic information.
- **Step 3.** Provide ongoing REL (race, ethnicity, language) data collection training for staff.
- **Step 4.** Conduct a community services assessment.
- **Step 5.** Link patient data with other types of community data.
- **Step 6.** Collect demographic data on organization's staff, managers, and senior executives; and monitor trends.

VI. Benchmark, Plan and Evaluate

Benchmark, Plan and Evaluate:

- CLAS Standards

- **CLAS Standard #9:** Establish culturally and linguistically appropriate goals, policies, and management accountability, and infuse them throughout the organization's planning and operations.
- **CLAS Standard #10:** Conduct ongoing assessments of the organization's CLAS-related activities and integrate CLAS-related measures into measurement and continuous quality improvement activities.

Benchmark, Plan and Evaluate:

- Action Steps

- **Step 1.** Identify “champions” and appoint a Cultural Competence Committee.
- **Step 2.** Conduct an organizational assessment and ongoing re-assessments.
- **Step 3.** Integrate CLAS into organizational strategic planning and set benchmarks.
- **Step 4.** Ensure sufficient fiscal and human resources to support implementation of CLAS.
- **Step 5.** Involve community/patients in monitoring organization’s progress on implementation of CLAS.

Benchmark, Plan and Evaluate:

CLAS Planning Worksheet

GOALS					
Foster Cultural Competence	Build Community Partnerships	Collect Diversity Data	Benchmark: Plan and Evaluate	Reflect and Respect Diversity	Ensure Language Access
OBJECTIVES					
<ol style="list-style-type: none"> Understand the need for cultural competence. Develop cultural competence. Deliver culturally competent services. Train staff on cultural competence. 	<ol style="list-style-type: none"> Partner with community organizations. Involve the community. Engage client participation. Share cultural competence knowledge. 	<ol style="list-style-type: none"> Identify key populations. Standardize REL data collection. Integrate data collection into frameworks. Assess needs and areas for improvement. Share relevant data with the community. 	<ol style="list-style-type: none"> Appoint a cultural competence committee. Assess cultural competence. Frame CLAS within vision and goals. Plan. Evaluate progress. Benchmark. 	<ol style="list-style-type: none"> Reflect diversity. Recruit diverse employees. Retain and promote diverse employees. Respond to concerns through culturally competent process. Resolve and prevent cross cultural conflicts. 	<ol style="list-style-type: none"> Identify LEP clients. Assess services and language needs. Plan. Deliver effective language access services. Adapt LEP programs regularly.



Benchmark, Plan and Evaluate:

- Interactive Exercise

- Based on your table assignments, for each “Area of Action” let’s brainstorm –
 - Specific action steps
 - Resources needed
 - People/departments responsible
 - Indicators of progress

- Also consider:
 - Stakeholders
 - Policy changes
 - Potential challenges
 - Strategies to overcome challenges and barriers

Benchmark, Plan and Evaluate:

- Discussion

- In what ways are CLAS-related goals, policies, and accountability currently infused into the organization's strategic planning and operations?
- What might be ways that CLAS can be better integrated into organizational policies, practices, and resource allocation decisions?
- How are CLAS-related performance measures integrated into organizational assessments and continuous quality improvement activities?
- What methods are used to obtain and process feedback from patients and the community?
- What methods are used to monitor the impact of CLAS-oriented feedback from patients and the community on the organization's service design and delivery?



Final Thoughts

Questions?

THANK YOU

Feedback & Closing

- Post-Training Assessment

- Session Evaluation

Additional Resources

- American Hospital Association. Equity Resources Webpage. Available at: <http://www.hpoe.org/resources?topic=85>
- Health Research and Educational Trust. Quality/Cost/Disparities Webpage. Available at: <http://www.hret.org/quality/index.shtml>
- Joint Commission. *Advancing Effective Communication, Cultural Competence, and Patient- and Family-Centered Communication*. Available at: http://www.jointcommission.org/Advancing_Effective_Communication/
- Maryland Department of Health. Office of Minority Health and Health Disparities Webpage. Available at: <https://health.maryland.gov/mhhd/Pages/home.aspx>

**Maryland Department of Health
Office of Minority Health and Health
Disparities**

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