

Leadership Preparatory Resources

MAKING THE CASE FOR THE CLAS STANDARDS



CLAS Standards Training Project

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

[Insert Date]

Overview

2

- Maryland Population
 - ▣ Racial and Ethnic Diversity
 - ▣ Linguistic Diversity
- Health Disparities in Maryland
- All-Payer Model and Health Disparities
- Linkages: Medicare Waiver, Triple Aim in Health Care, and the CLAS Standards
- Business, Legal and Ethical Case for the CLAS Standards
- Framework for the CLAS Standards Training Project
- Final Thoughts and Next Steps

CLAS Standards Training Project

3

- Maryland's Office of Minority Health and Health Disparities (MHHD) State Partnership Grant with U.S. Department of Health and Human Services Office of Minority Health (2013-2015)
- Goal: To increase the cultural competency of selected health care organizations in Maryland through training and promoting the adoption of the CLAS Standards
- Target organizations: Hospitals, Patient-Centered Medical Homes, Federally Qualified Health Centers, and organizations operating within HEZs

Purpose of the National CLAS Standards



4

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 enhanced National CLAS Standards?

5

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.

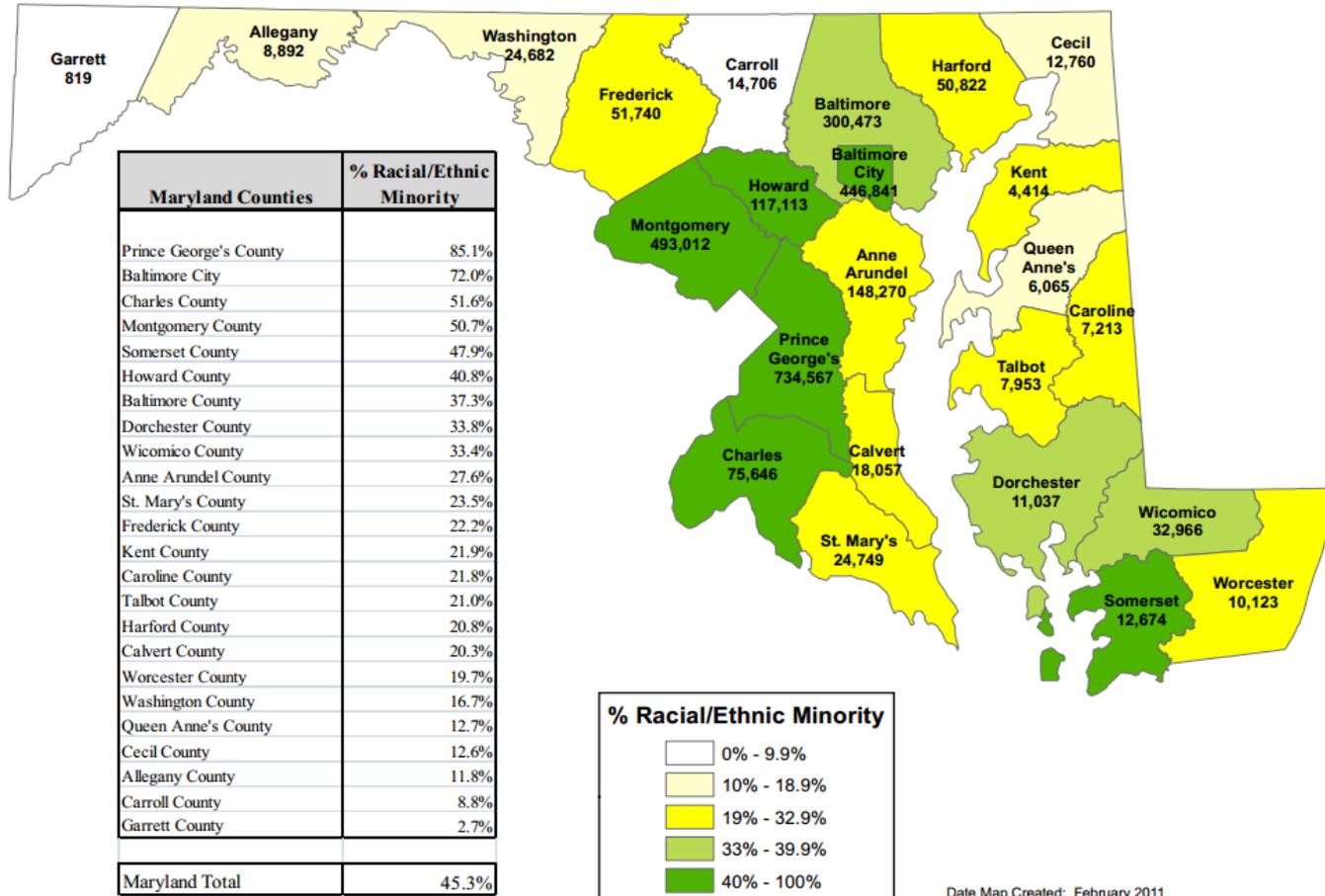
6

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

Maryland is One of the Most Racial/Ethnic Diverse States



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



45% minority

4 jurisdictions > 50% minority

6 jurisdictions > 40% minority

9 jurisdictions > 33% minority

out of 24 jurisdictions

Date Map Created: February 2011

Linguistic Diversity in Maryland & [Insert Jurisdiction]



8

Top Foreign Languages Spoken in Households in Maryland

1. Spanish
2. Chinese
3. Korean
4. African languages (several)
5. Vietnamese
6. French
7. Tagalog

Top Foreign Languages Spoken in Households in [Insert Jurisdiction]

1. >>>

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

Language Access

9

- 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.



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.

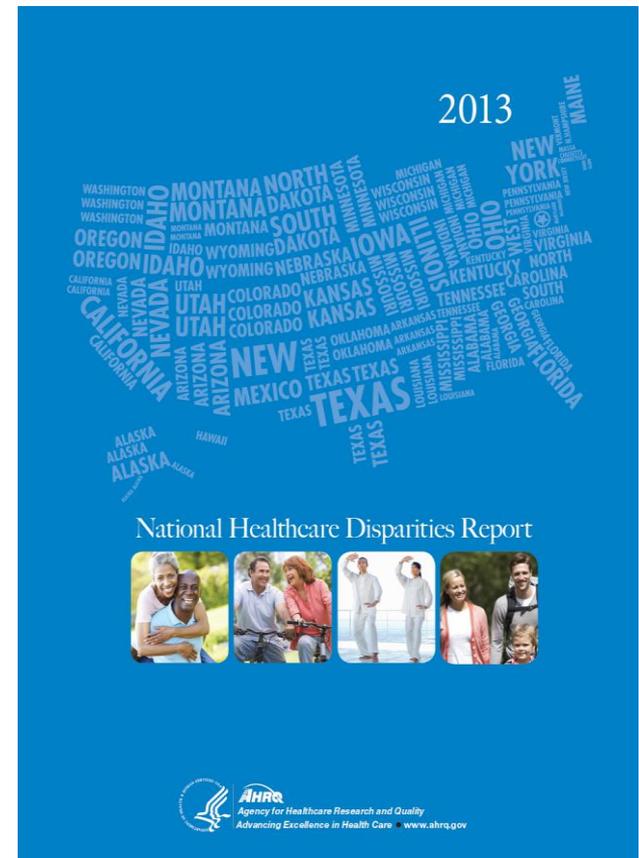
(Adapted from The Connecticut Multicultural Health Partnership. Faces of Disparity. <http://www.ctmhp.org>)

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



11

- According to the latest HHS/AHRQ **National Healthcare Disparities Report (2013)**,
 - 1) Health care quality and access are suboptimal, especially for minority and low-income groups.
 - 2) Overall quality is improving, but disparities are not changing.
 - Only 70% of recommended care is actually received.
 - Minorities and individuals living in poverty have worse quality measures overall.
 - 3) Improvements are lagging most in:
 - Quality of ambulatory care, diabetes care, and maternal and child health care; and,
 - Addressing the increased disparities in cancer screening



Source: HHS/AHRQ. National Healthcare Disparities Report, 2013. Available at: <http://www.ahrq.gov/research/findings/nhqrdr/nhdr/13/2013nhdr.pdf>

Progress in Elimination of Health Disparities in Maryland



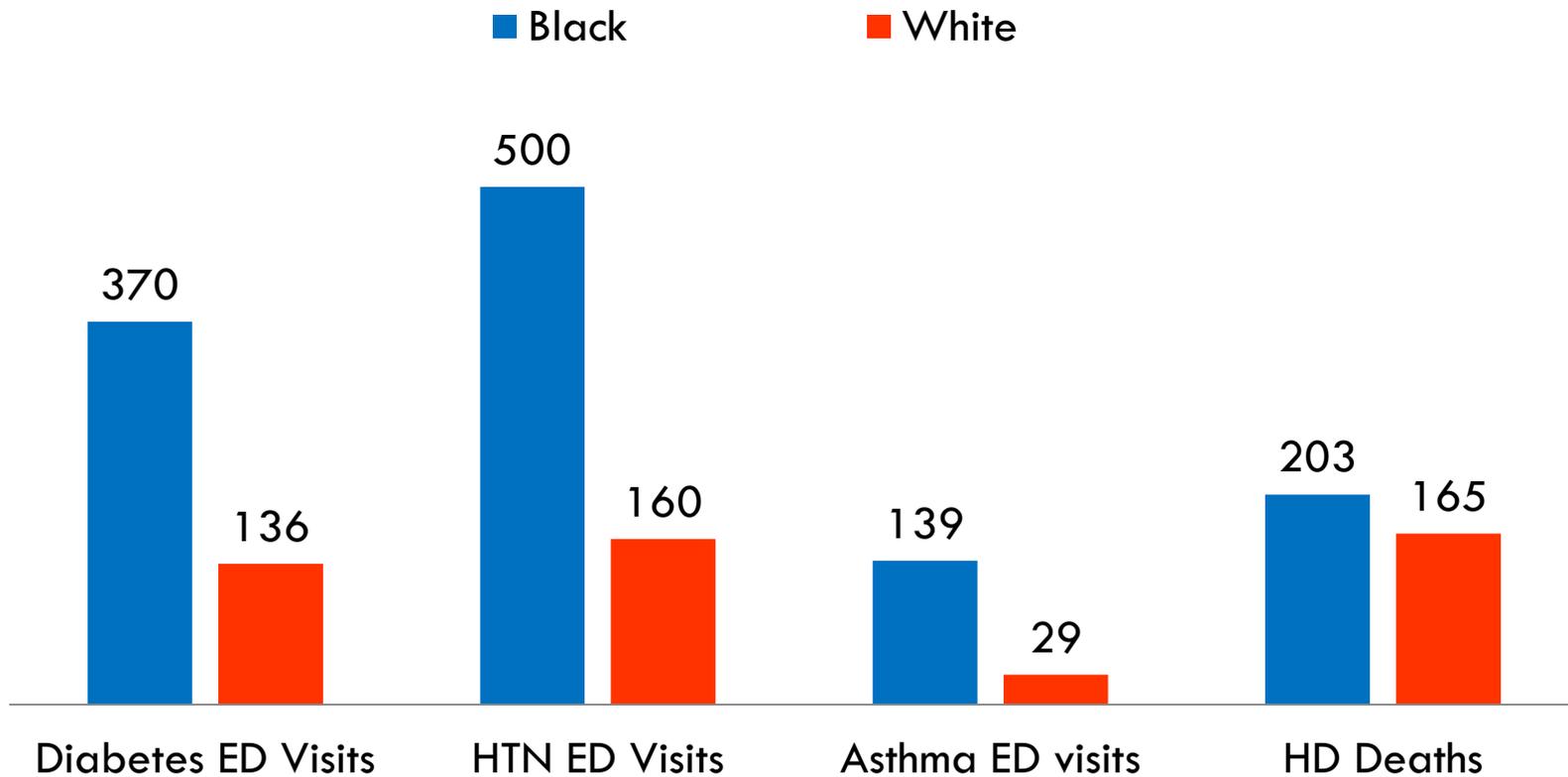
12

- Between 2000 and 2012 **the gaps** between the Black and White age-adjusted death rates (Black rate minus White rate) **were reduced** as follows: *(Maryland Vital Statistics Annual Report data)*
 - For All-cause Mortality, the gap was reduced by **56%**
 - For Cancer Mortality, the gap was reduced by **58%**
 - For Heart Disease Mortality, the gap was reduced by **33%**
 - For Stroke Mortality, the gap was reduced by **64%**
 - For Diabetes Mortality, the gap was reduced by **52%**
 - For HIV/AIDS Mortality, the gap was reduced by **66%**

Health Outcome Disparities Black v. White in Maryland

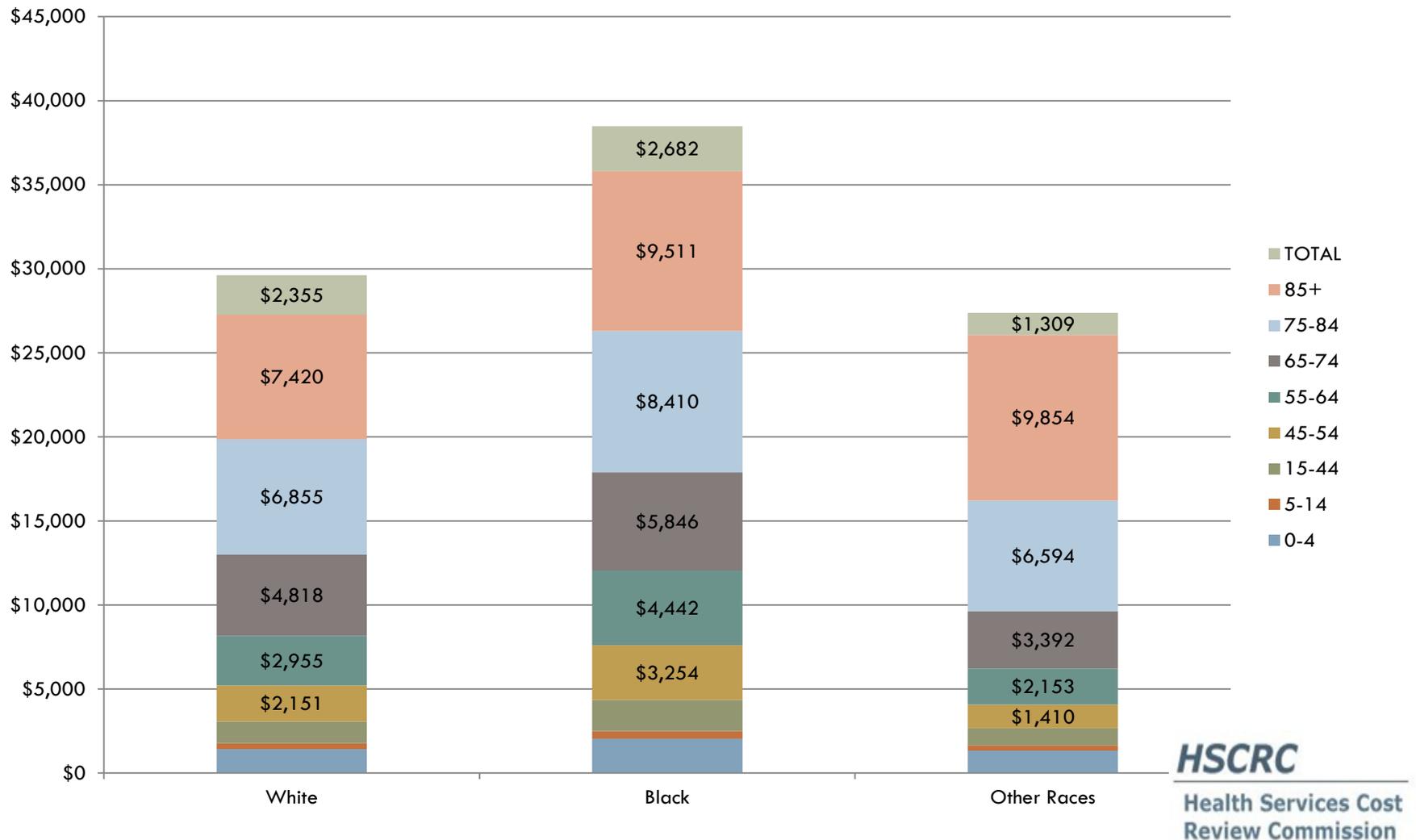
13

Rate per 100,000

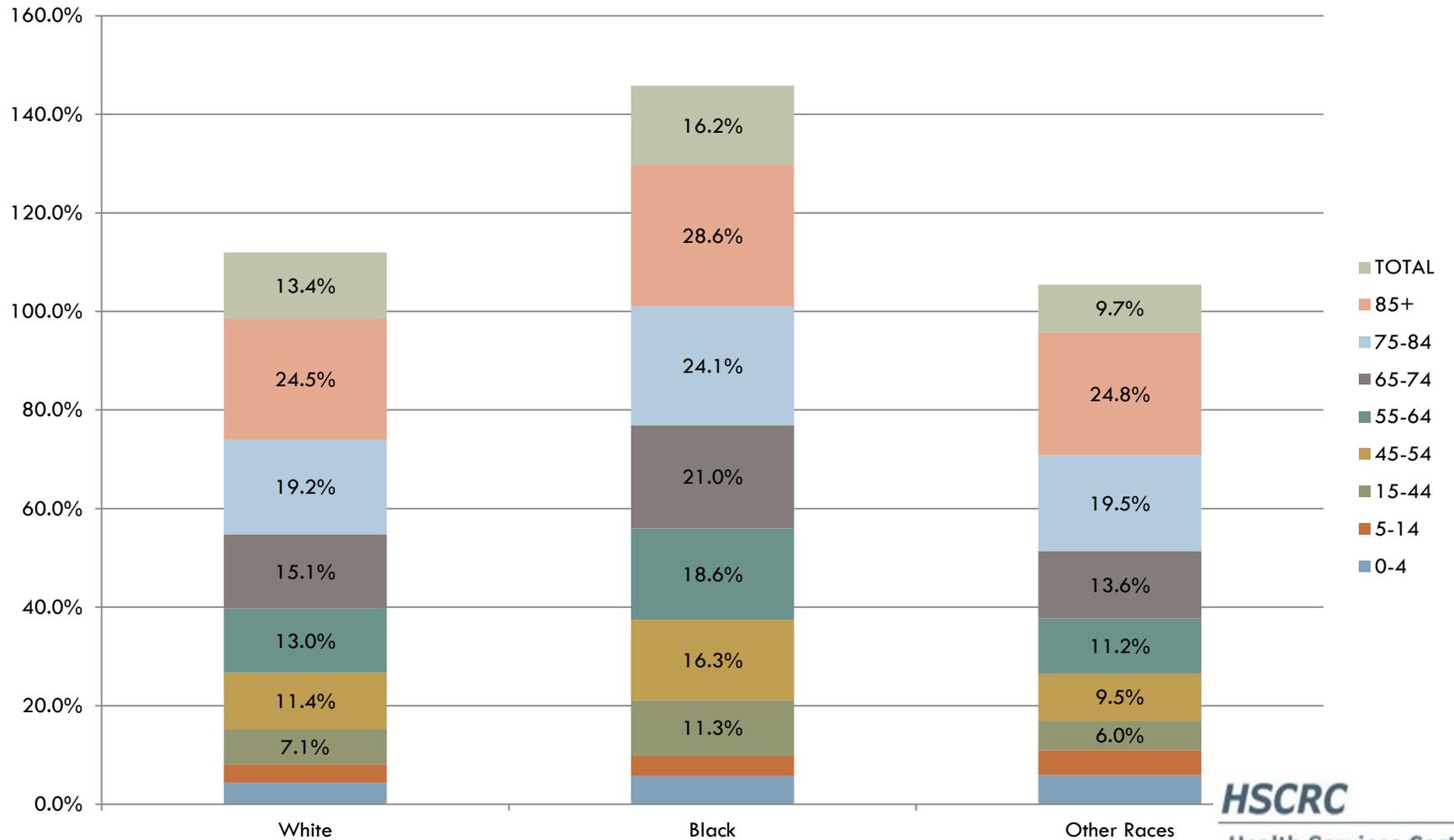


Importance of Disparities - Per Capita Total Hospital Cost by Race (FY 2013)

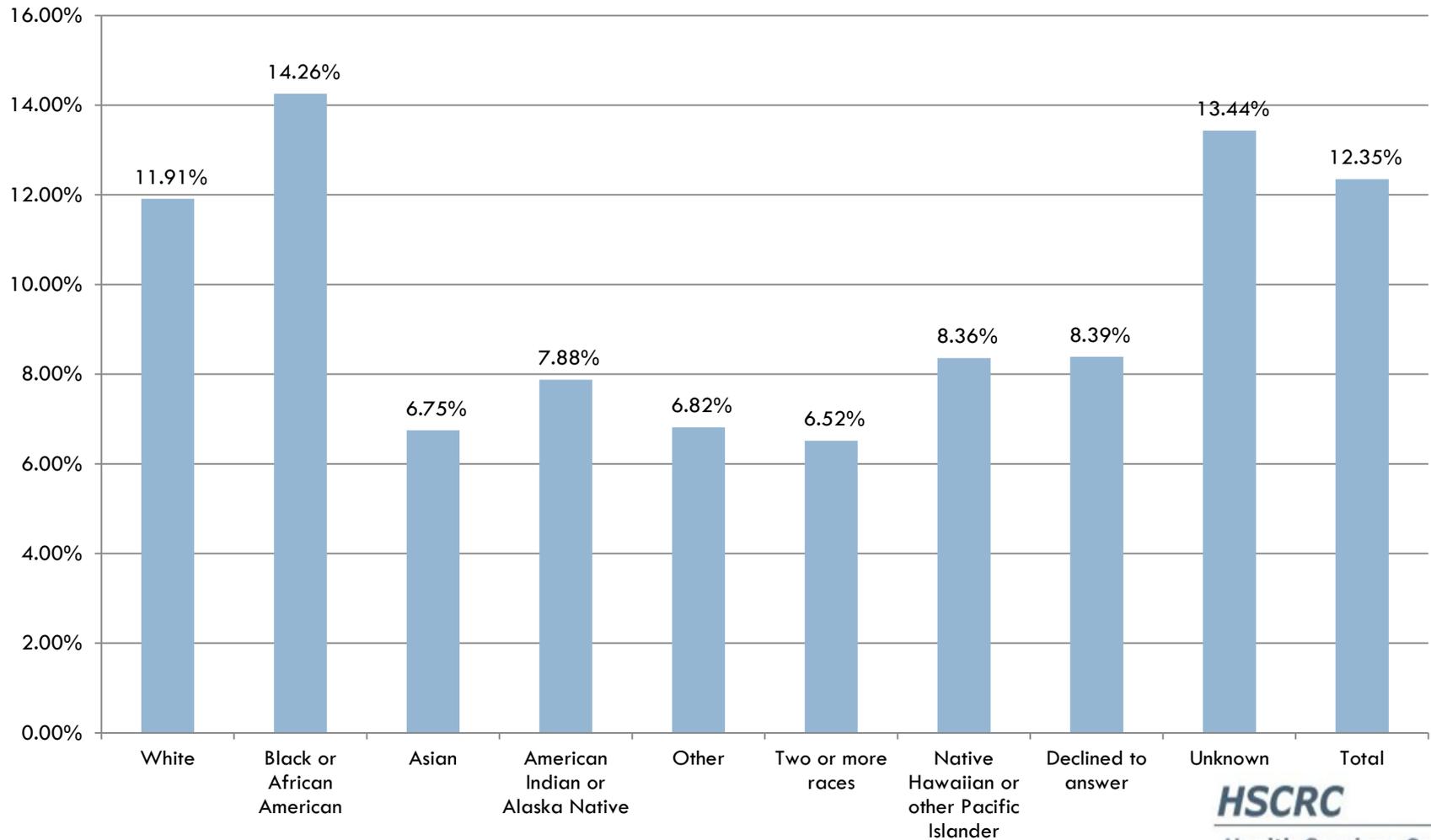
14



Potentially Avoidable Utilization by Race (FY 2013)



Readmission Rates by Race (FY 2014)



Cost of Disparities in Maryland



17

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

- **In 2011, excess charges in Maryland from Black/White hospitalization disparities alone were \$814 Million.**
 - ▣ ***These excess charges are just the hospital charges, NOT including physician fees for hospital care, emergency department charges, or any outpatient costs.***

Source: Estimated from The Economic Burden Of Health Inequalities in the United States, Thomas A. LaVeist, Ph.D., Darrel J. Gaskin, Ph.D., and Patrick Richard, Ph.D. which was funded by the Joint Center for Political and Economic Studies.

<http://jointcenter.org/sites/default/files/Economic%20Burden%20of%20Health%20Inequalities%20Fact%20Sheet.pdf>

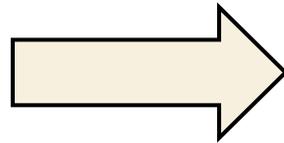
18

What Are the Implications of Disparities Costs Under Maryland's All-Payer Model?

Aim of Maryland's All-Payer Model

19

Maryland's All
Payer Model



- Enhance Patient Experience
- Better Population Health
- Lower Total Cost of Care

Hypothesis: An all-payer system that is accountable for the total cost of care on a per capita basis is an effective model for establishing policies and incentives to drive system progress toward achieving the Three Part Aim.

HSCRC

Health Services Cost
Review Commission

Approved Model at a Glance

20

- All-Payer total hospital **per capita revenue growth ceiling** of 3.58% annual growth
- **Medicare payment savings** of \$330 million in savings over 5 years.
- **Patient and population centered-measures** and targets to promote care improvement
 - ▣ Medicare readmission reductions to national average
 - ▣ 30% reduction in preventable conditions under Maryland's Hospital Acquired Condition program (**MHAC**) over a 5 year period
 - ▣ Other quality improvement targets

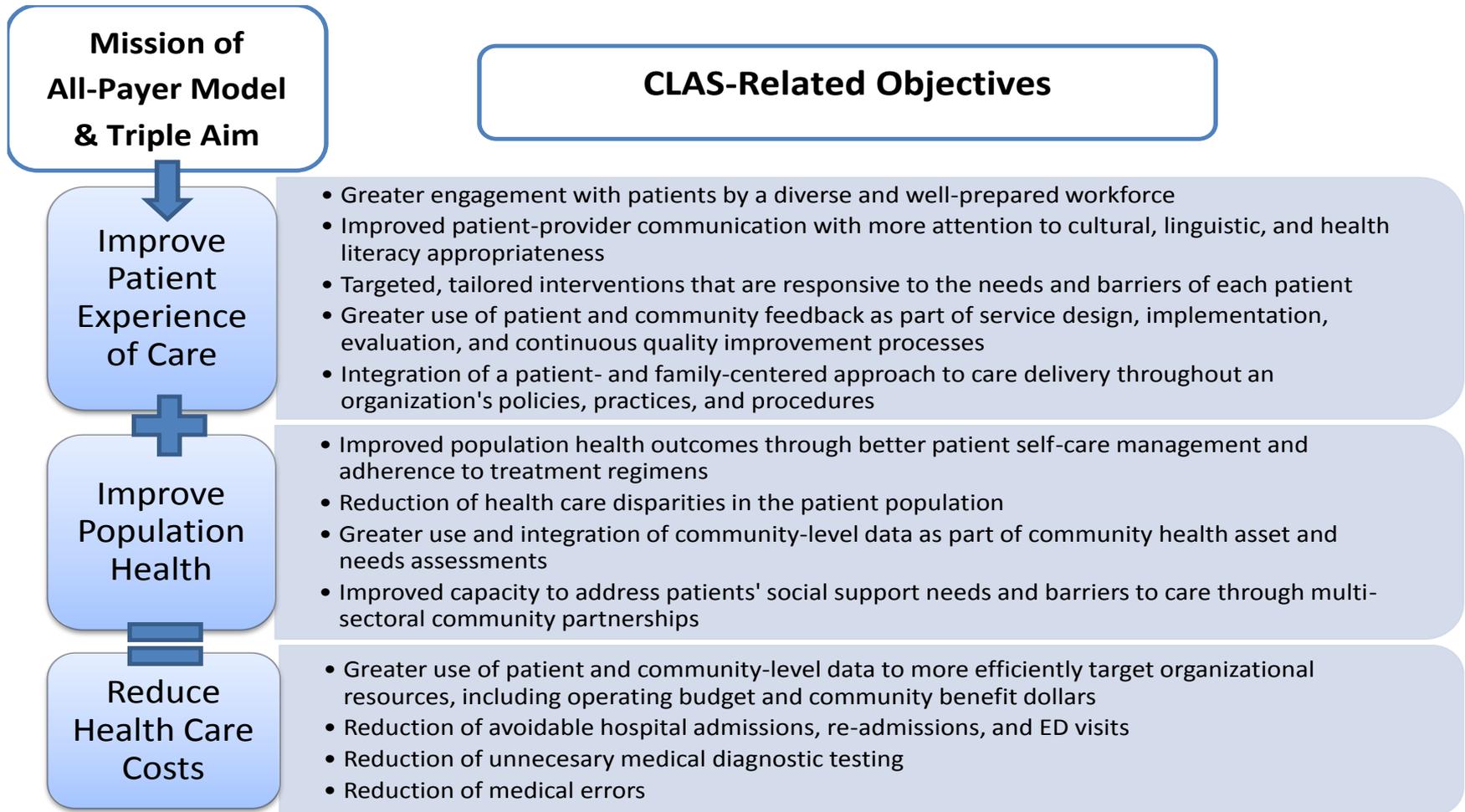
21

How do the CLAS Standards Relate to the Goals of the All-Payer Model?

Linkages: the CLAS Standards, the All-Payer Model, and the Triple Aim



22



The Case for Culturally and Linguistically Appropriate Services



23

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.

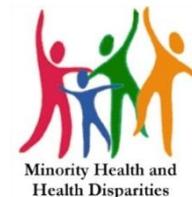
Industry Standards

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 1974; 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

The Case for Culturally and Linguistically Appropriate Services



24

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 ...

25

Potential for the following benefits:

- Reduces preventable service utilizations
- Reduces avoidable 30-day hospital readmissions
- Improves patient safety
- Improves patient compliance
- 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)

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

A Little More on the Business Case ...



26

Potential for the following benefits:

- Improves quality of patient data collection
- Improves patients' satisfaction and self-reported quality of care measures
- Promotes positive public perception of organization
- Increases provider productivity and satisfaction
- Incorporates a diversity of perspectives, ideas and strategies into the decision-making process

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

Potential for the following benefits:

- ❑ Improves risk management
 - Reduces risk of medical liability
 - Reduces care disparities in the patient population and subsequent legal action
 - Improves patient safety and reduces number of medical errors

- ❑ Reduces risk of sanctions and penalties
 - Facilitates fulfillment of legal and regulatory guidelines
 - Improves compliance with:
 - Title VI of Civil Rights Act of 1964
 - Americans with Disabilities Act
 - Rehabilitation Act of 1973
 - Patient Protection and Affordable Care Act of 2010
 - State and Federal community benefit reporting and needs assessments

Ethical & Social Case



28

Potential for the following benefits:

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

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

CLAS-Related Policy Environment in Maryland



29

Legislation:

- Maryland Health Improvement and Disparities Reduction Act of 2012
 - Establishes 5 Health Enterprise Zones (HEZs)
 - Promotes Cultural Competency
 - Maryland Health Care Commission to track efforts by health plans to provide culturally appropriate educational materials for members
 - Maryland Health Quality & Cost Council to make recommendations on cultural competency and health literacy training
 - Encourages Reporting and Analysis of Health Disparities Data
 - Hospital Community Benefit Reports (health disparities-reduction activities)
 - Race/ethnicity data performance tracking (hospitals and health plans)
- House Bill 756 (2009): The statute strongly encourages development of cultural competency training programs for health professionals.
- House Bill 942 (2008) and House Bill 679 (2012): The two statutes require cultural competency training reports from institutions of higher education.

CLAS-Related Policy Environment in Maryland (cont'd)



30

Recent Actions:

- Cultural Competency Workgroups
 - ▣ Maryland Health Disparities Collaborative
 - ▣ Maryland Health Quality and Cost Council

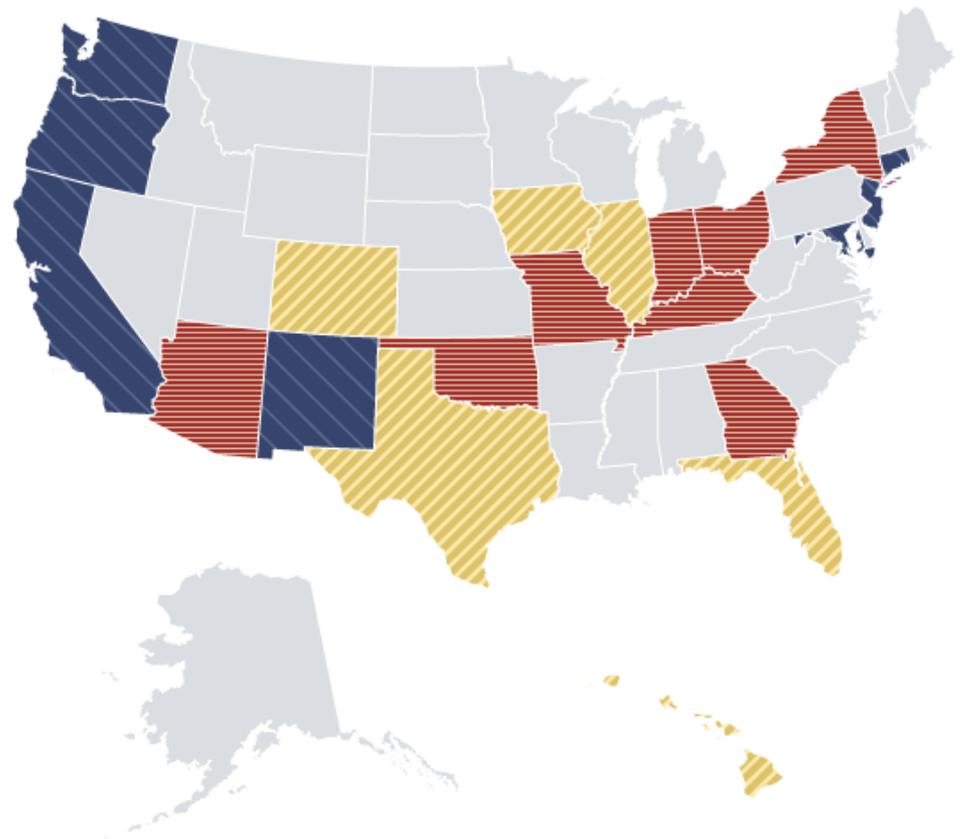
- Data Collection and Assessment
 - ▣ Maryland Health Services Cost Review Commission – Convened a Hospital Race and Ethnicity Disparities Workgroup and Regional Data Collection Training (2012/2013)
 - ▣ MHA/Adventist Center for Health Disparities – Held statewide training session on accurate, consistent, data collection (December 12, 2012) and supported Regional Training Sessions (Summer 2013)
 - ▣ Maryland Health Care Commission – Developed the RELICC assessment tool for health benefit plans (RELICC: Race, Ethnicity, Language, Interpreters, Cultural Competency)

- Medicare Waiver and All-Payer Model
 - ▣ Financial Tests and Quality Targets require hospitals to know our patients and tailor strategies to:
 - Keep patients out of the hospital
 - Manage health of the community

U.S. Map of CLAS Legislation

31

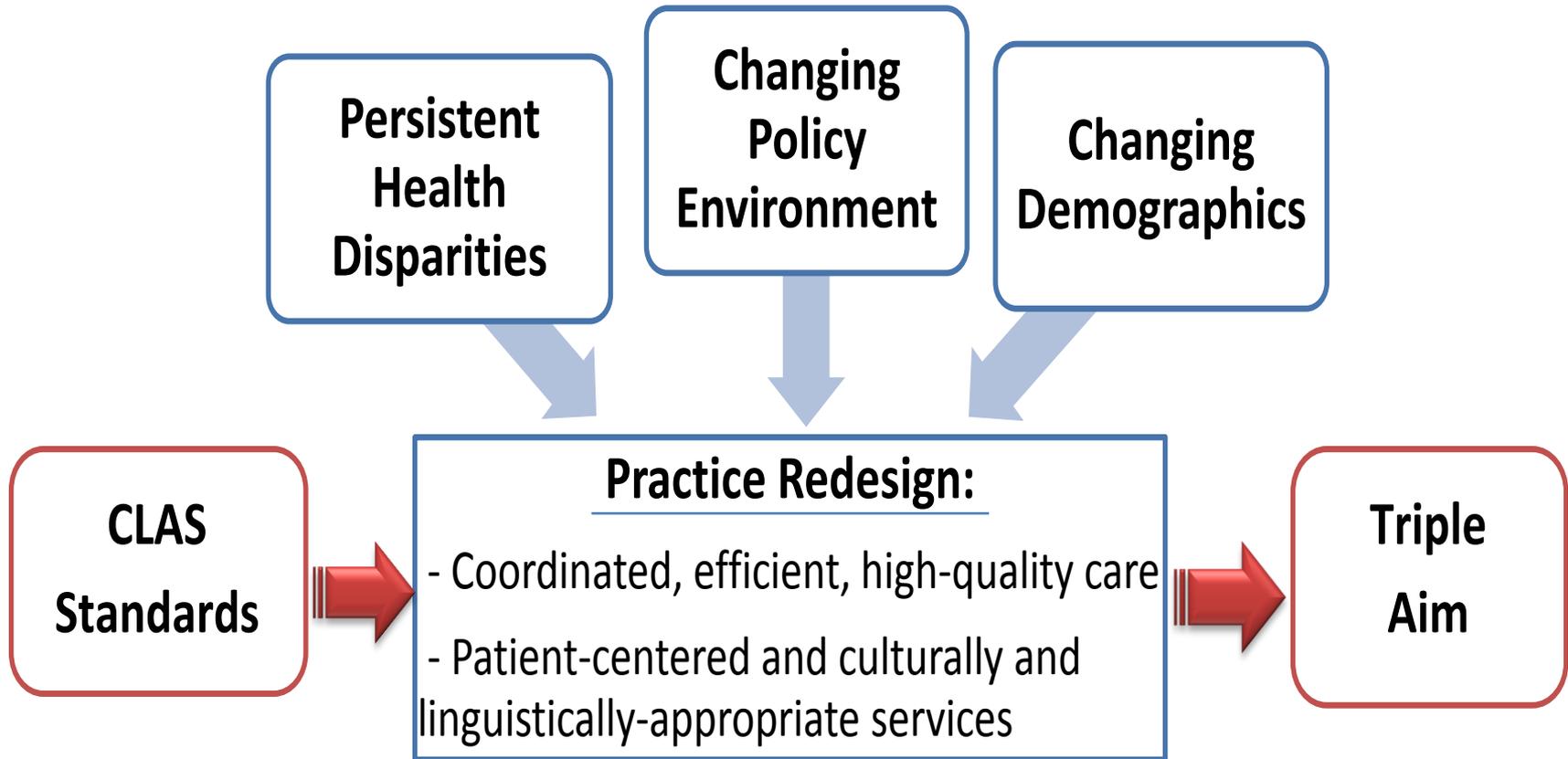
-  Denotes legislation that was signed into law requiring (CA, CT, NJ, NM, OR, WA) or strongly recommending (MD) cultural competence training.
-  Denotes legislation that was referred to committee and/or is currently under consideration.
-  Denotes legislation that died in committee or was vetoed.



Bottom Line



32



33

How Will the CLAS Standards Training Project Be Conducted?

Training: Fall 2014/Winter 2015

34

One half-day session will be scheduled on site at each of 4 hospitals. Sessions will include presentations, group activities and discussions.

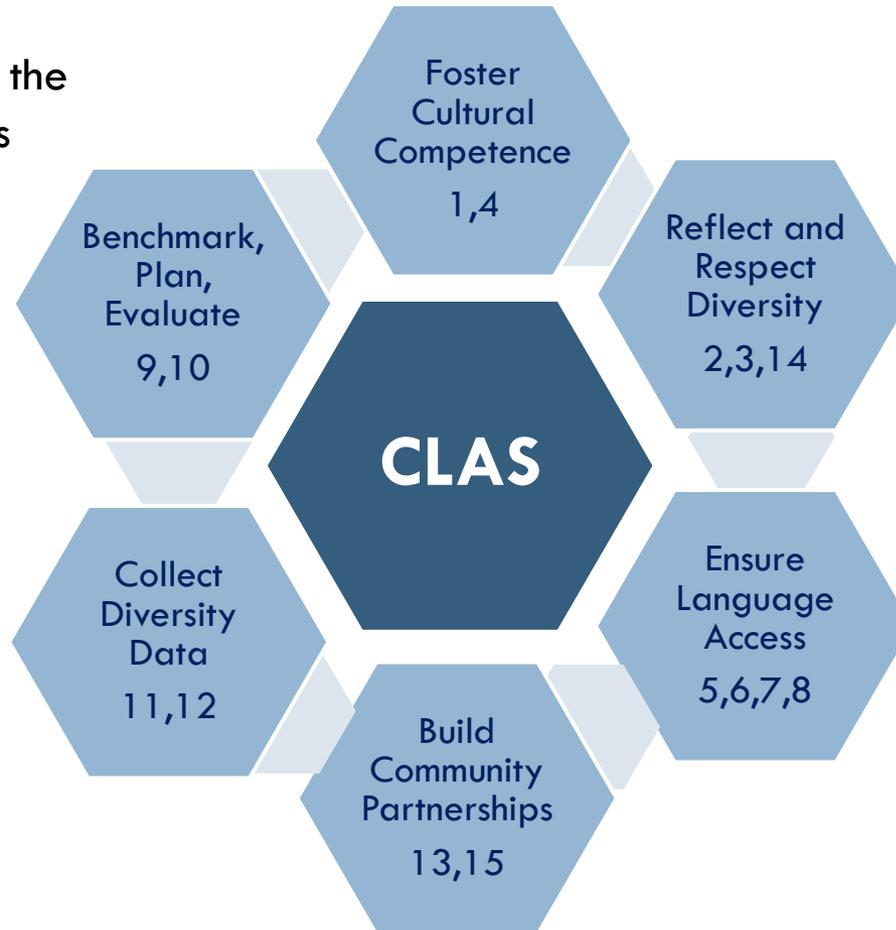
Participants will be chosen by hospital leadership, with a suggestion to include senior personnel (i.e. managers) from each of the following areas:

- ▣ Direct patient services
- ▣ Human resources and professional development
- ▣ Quality Improvement
- ▣ Language and community outreach services

Training Framework: Six Areas for Action

35

Numbers represent the
15 CLAS Standards



Evaluation: Spring/Summer 2015

36

- Evaluation (Pre- and Post-Training Surveys)
 - CLAS Comprehension – Questionnaire administered to all individual participants in the program prior to the training and then again after the training to determine any increase in their knowledge of the CLAS Standards
 - CLAS Adoption – Organizational survey administered prior to the training and then again 6-9 months after the training to identify any increase in the level of adoption of the CLAS Standards at the organizational level

Follow-up and Reporting

37

- Encourage establishment of on-going training and development
- Provide follow-up and technical assistance, as requested
- Share program results with leadership and staff

38

Final Thoughts

Resources

39

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

MHHD Contact



40

Office of Minority Health and Health Disparities Maryland Department of Health and Mental Hygiene

**201 W. Preston Street, Room 500
Baltimore, Maryland 21201
410-767-7117**

Email: dhmh.healthdisparities@maryland.gov

Website: www.dhmh.maryland.gov/mhhd

Facebook: <https://www.facebook.com/MarylandMHHD>

Twitter: [@MarylandDHMH](https://twitter.com/MarylandDHMH)

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

MAKING THE CASE FOR THE CLAS STANDARDS



CLAS Standards Training Project

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

[INSERT DATE]

Overview



2

- Purpose of the CLAS Standards Training Project
- Making the Case for CLAS Standards
 - ▣ Diversity and Health Disparities in Maryland
 - ▣ Linkages to the All-Payer Model and the Triple Aim
 - ▣ Business, Legal, and Ethical Case
 - ▣ CLAS and NCQA-PCMH Recognition
 - ▣ Policy Environment in Maryland
- Implementation of the CLAS Standards Training Project
- Final Thoughts and Next Steps

CLAS Standards Training Project

3

- Maryland's Office of Minority Health and Health Disparities (MHHD) State Partnership Grant with U.S. Department of Health and Human Services Office of Minority Health
- Goal: To increase the cultural competency of selected health care organizations in Maryland through training and promoting the adoption of the CLAS Standards
- Target organizations: Hospitals, Patient-Centered Medical Homes, Federally Qualified Health Centers, and organizations operating within HEZs

Purpose of the National CLAS Standards



4

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 enhanced National CLAS Standards?

5

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.

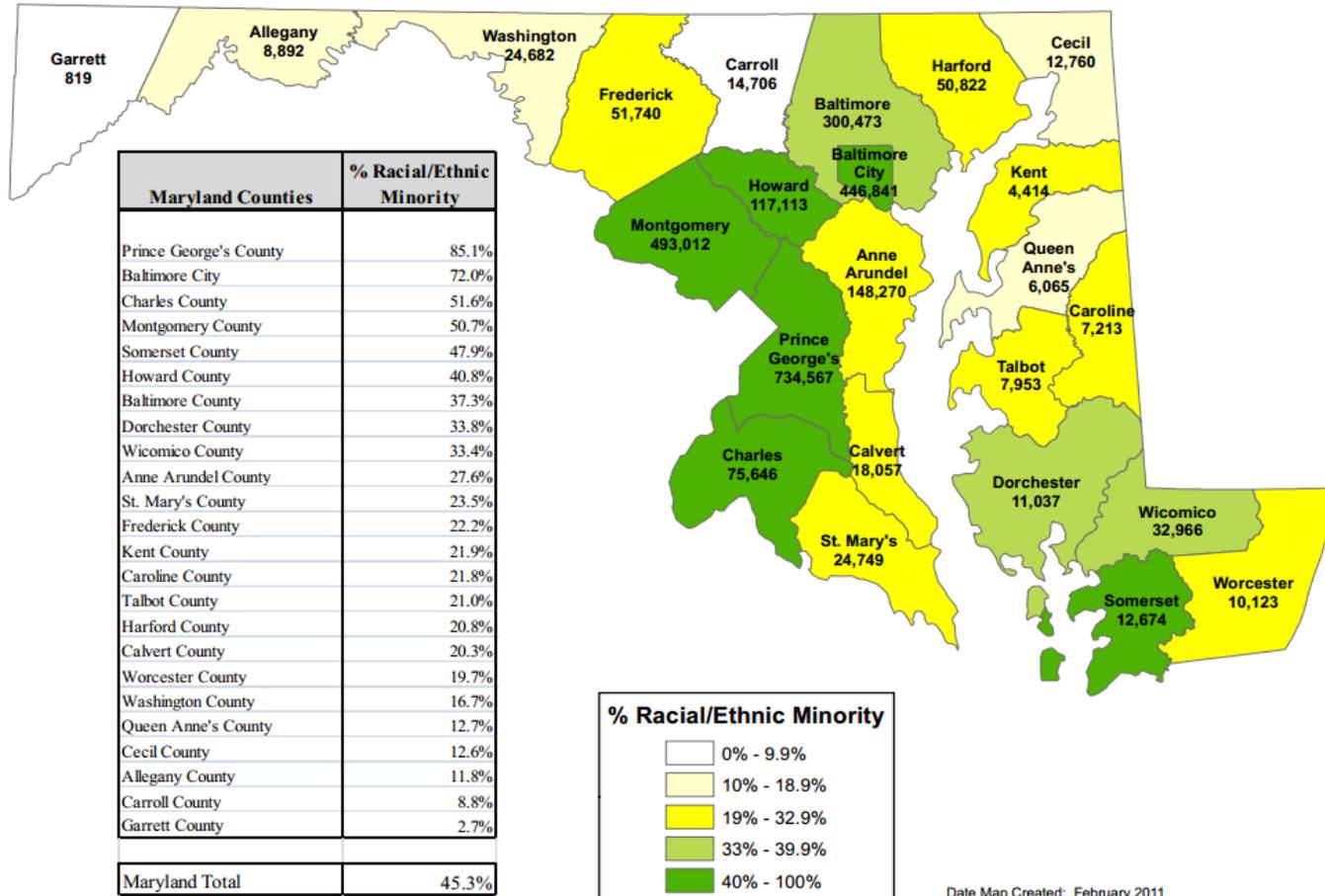
6

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

Maryland is One of the Most Racial/Ethnic Diverse States



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



45% minority

4 jurisdictions > 50% minority

6 jurisdictions > 40% minority

9 jurisdictions > 33% minority

out of 24 jurisdictions

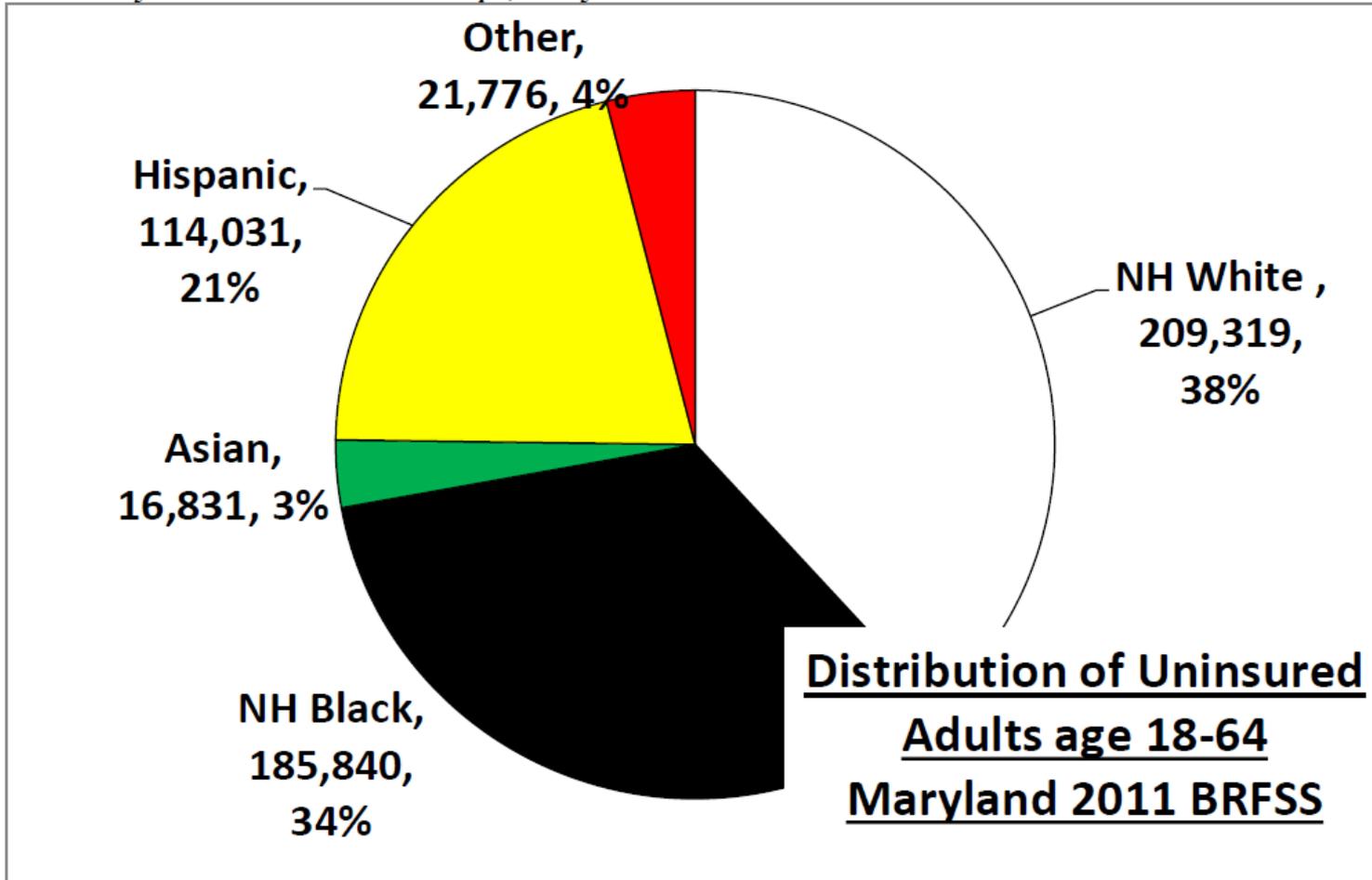
Date Map Created: February 2011

Maryland's Adult Uninsured Age 18-64 by Race/Ethnicity in 2011



8

Percent of all Un-insured, and Number of Adults age 18-64 without Health Insurance, by Racial and Ethnic Groups, Maryland 2011



Source: Maryland Behavioral Risk Factor Surveillance System (BRFSS), 2011.

Maryland Office of Minority Health and Health Disparities

Linguistic Diversity in Maryland & [Insert Jurisdiction]



9

Top Foreign Languages Spoken in Households in Maryland

1. Spanish
2. Chinese
3. Korean
4. African languages (several)
5. Vietnamese
6. French
7. Tagalog

Top Foreign Languages Spoken in Households in [Insert Jurisdiction]

1. >>>

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

Language Access

10

- 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.



What are health disparities?



11

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.

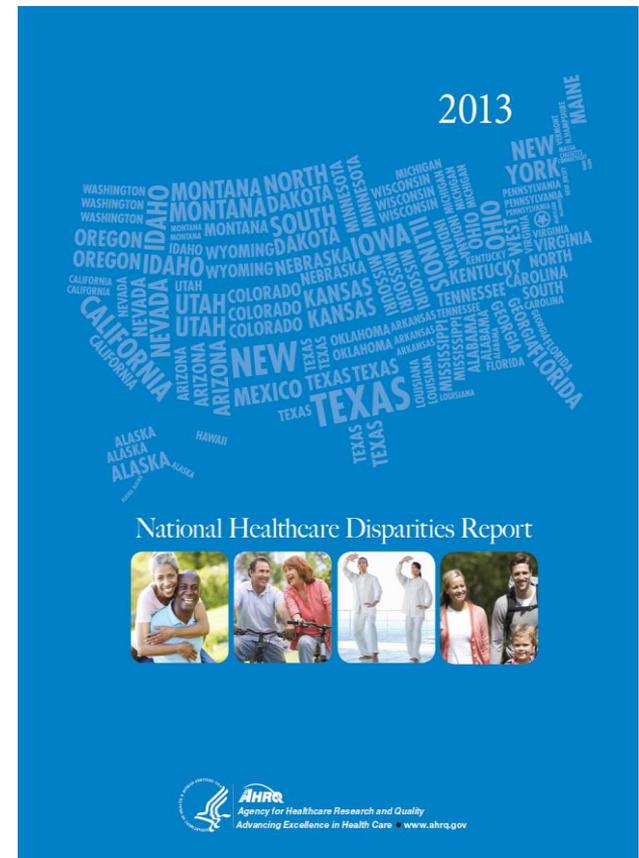
(Adapted from The Connecticut Multicultural Health Partnership. Faces of Disparity. <http://www.ctmhp.org>)

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



12

- According to the latest HHS/AHRQ **National Healthcare Disparities Report (2013)**,
 - 1) Health care quality and access are suboptimal, especially for minority and low-income groups.
 - 2) Overall quality is improving, but disparities are not changing.
 - Only 70% of recommended care is actually received.
 - Minorities and individuals living in poverty have worse quality measures overall.
 - 3) Improvements are lagging most in:
 - Quality of ambulatory care, diabetes care, and maternal and child health care; and,
 - Addressing the increased disparities in cancer screening



Source: HHS/AHRQ. National Healthcare Disparities Report, 2013. Available at: <http://www.ahrq.gov/research/findings/nhqrdr/nhdr/2013nhdr.pdf>

Progress in Elimination of Health Disparities in Maryland

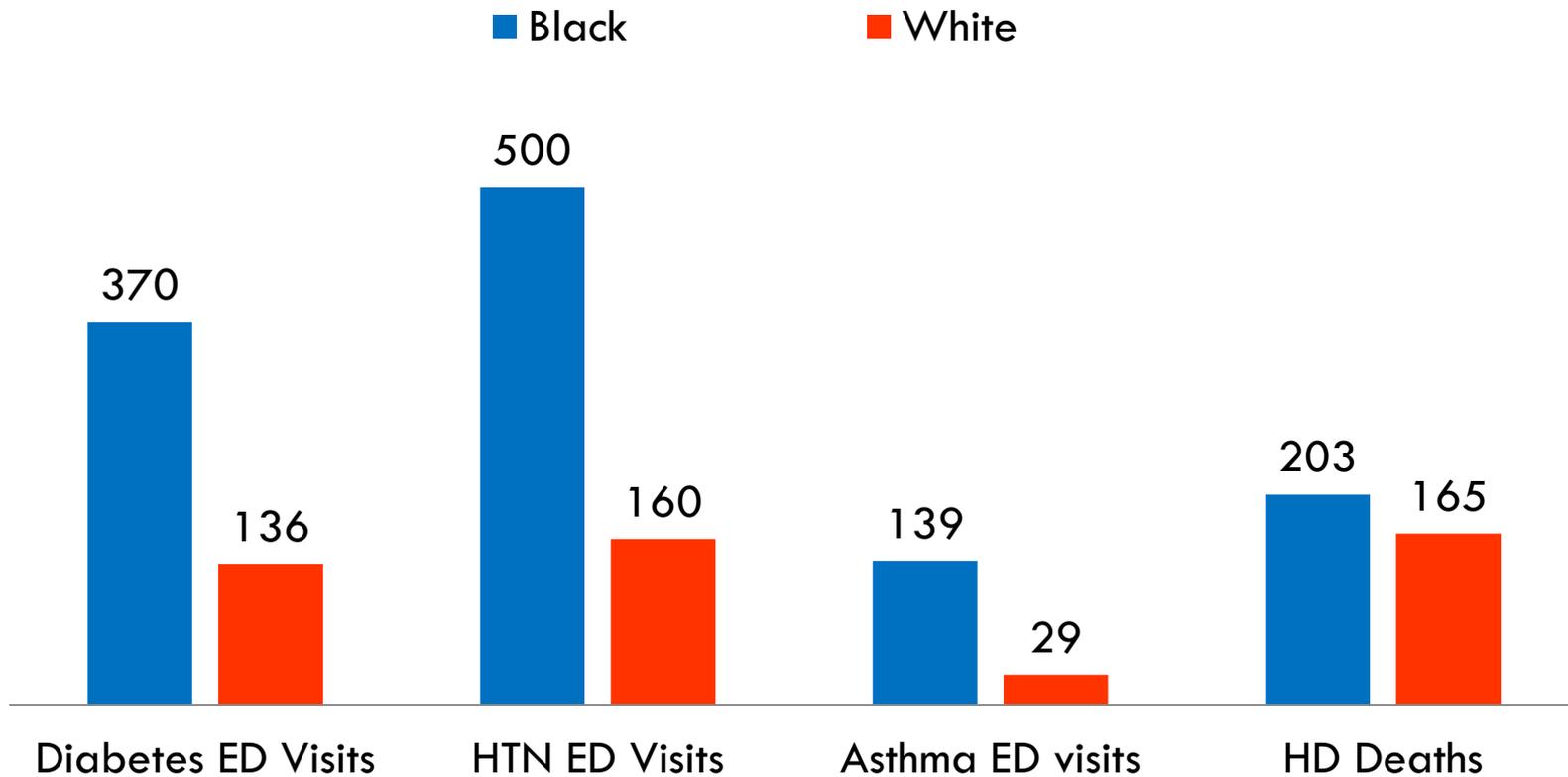


13

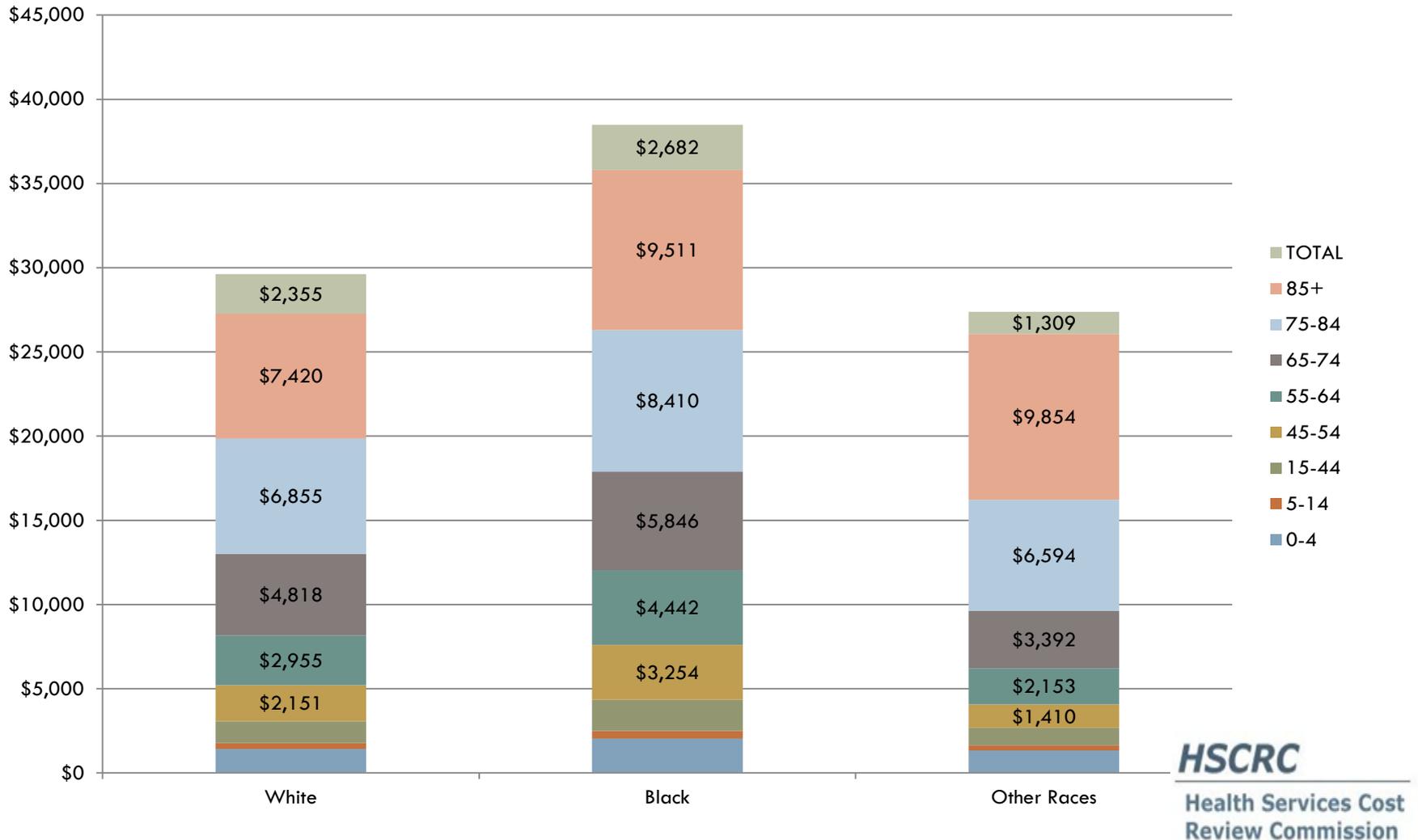
- Between 2000 and 2012 the gaps between the Black and White age-adjusted death rates (Black rate minus White rate) were reduced as follows: (*Maryland Vital Statistics Annual Report data*)
 - For All-cause Mortality, the gap was reduced by **56%**
 - For Cancer Mortality, the gap was reduced by **58%**
 - For Heart Disease Mortality, the gap was reduced by **33%**
 - For Stroke Mortality, the gap was reduced by **64%**
 - For Diabetes Mortality, the gap was reduced by **52%**
 - For HIV/AIDS Mortality, the gap was reduced by **66%**

Health Outcome Disparities Black v. White in Maryland

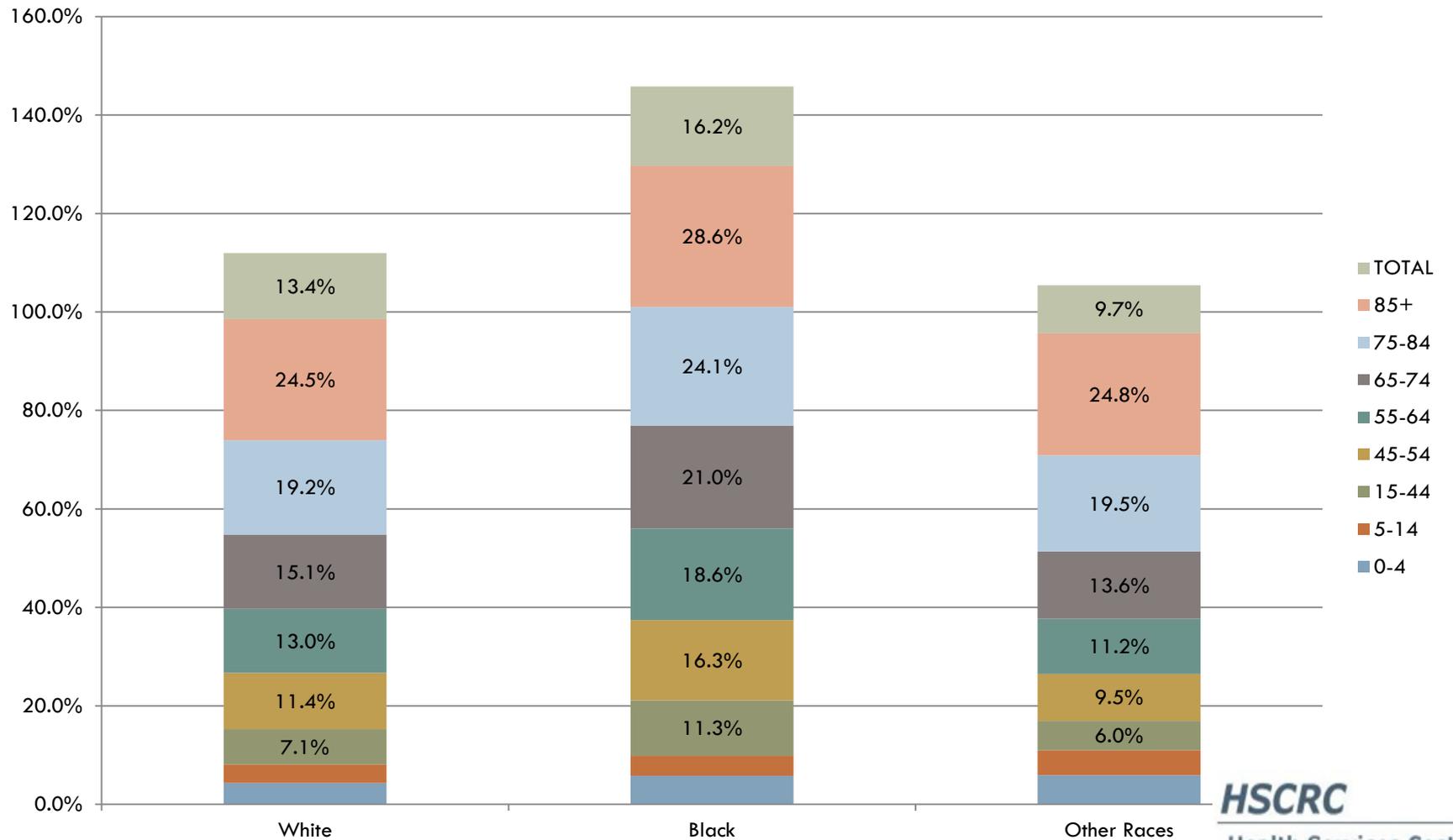
Rate per 100,000



Importance of Disparities - Per Capita Total Hospital Cost by Race (FY 2013)

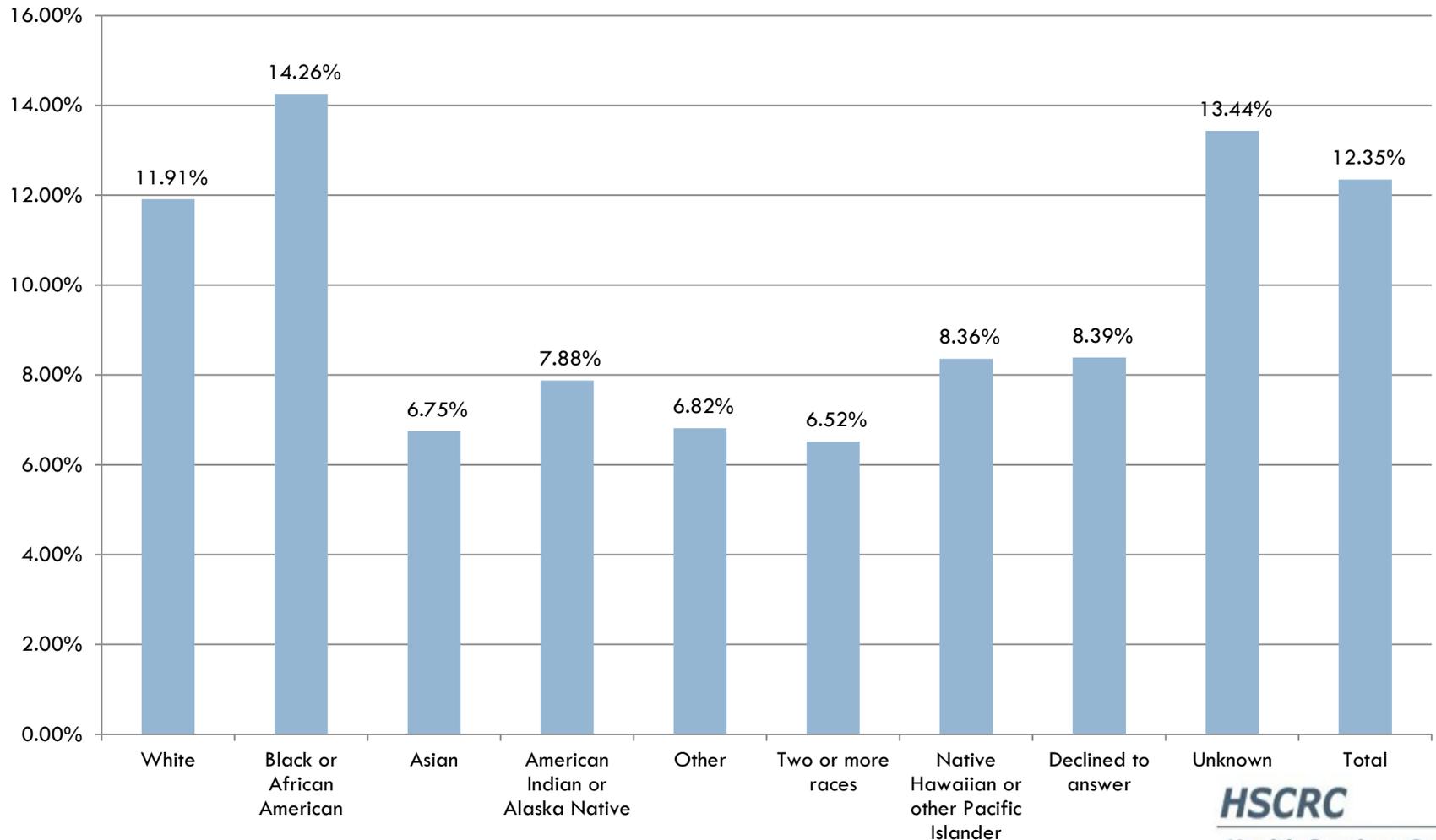


Potentially Avoidable Utilization by Race (FY 2013)



Readmission Rates by Race (FY 2014)

17



Cost of Disparities in Maryland

18

- **Minority Health Disparities cost Maryland between 1 and 2 Billion Dollars per year of direct medical costs.**
- **The excess charges from Black/White disparities in hospitalization alone were \$814 Million in 2011.**
 - *These are just the hospital charges, NOT including physician fees for hospital care, emergency department charges, or any outpatient costs.*
- **Assumption of significant outpatient and clinic excess charges due to disparities as well.**

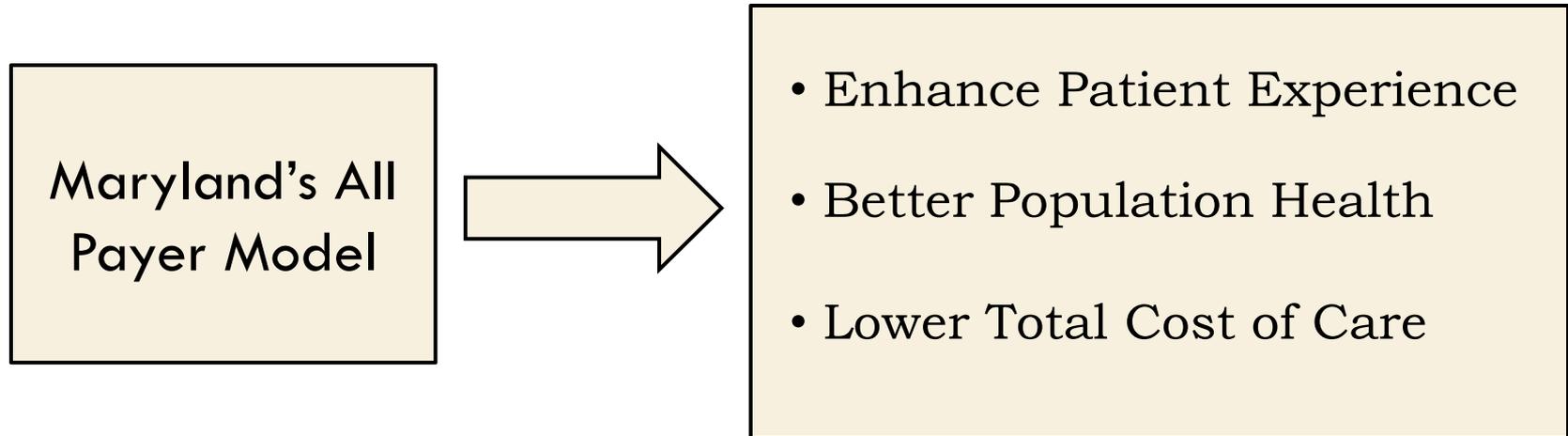
(Estimates derived from the following source: LaVeist TA, Gaskin DJ, Richard P. "The Economic Burden of Health Inequalities in the United States." Joint Center for Political and Economic Studies, September 2009. Available at: http://www.jointcenter.org/hpi/sites/all/files/Burden_Of_Health_FINAL_0.pdf)

19

The Case for the CLAS Standards: Business, Legal, and Ethical Case

Aim of Maryland's All-Payer Model

20

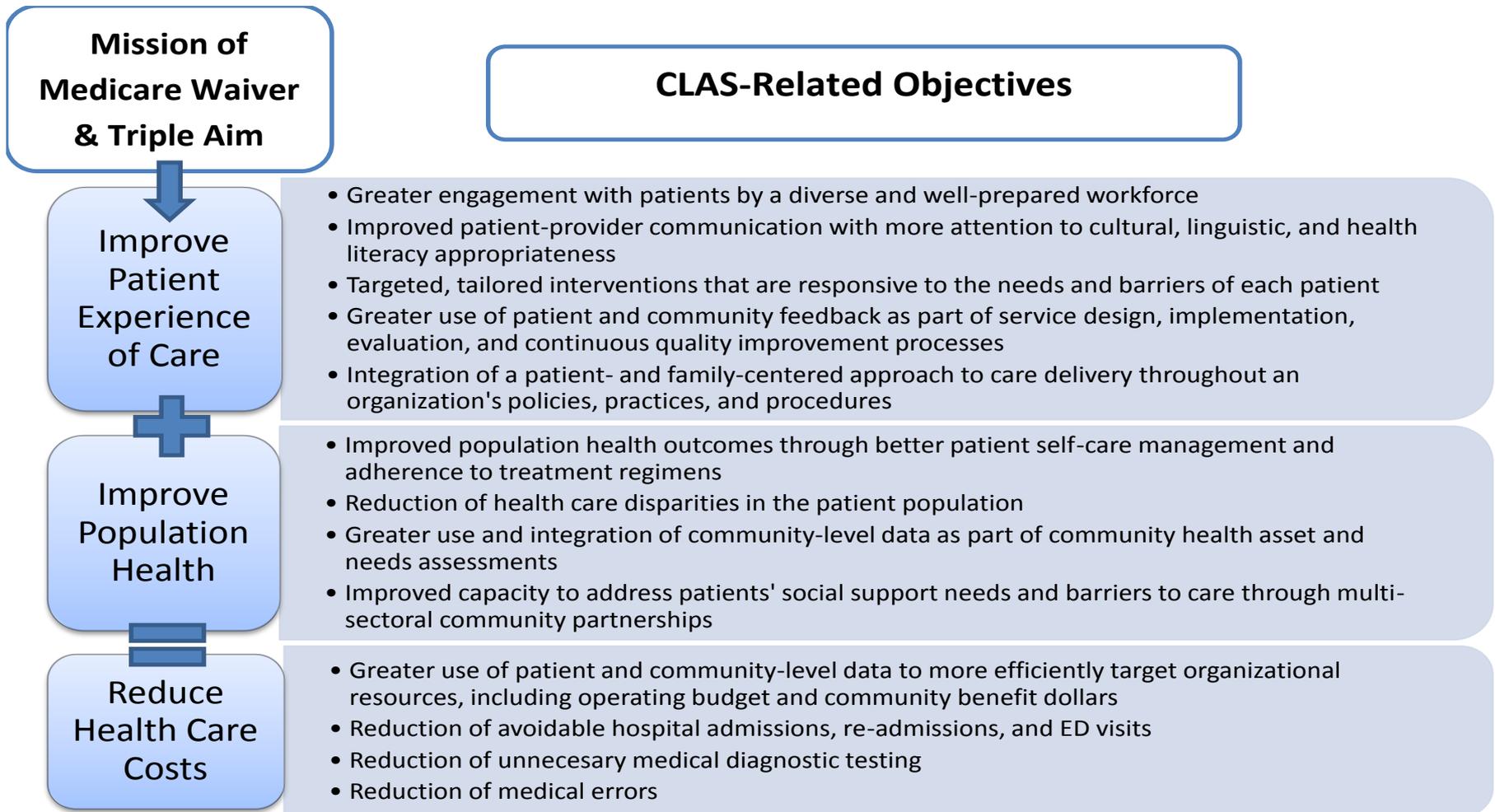


Hypothesis: An all-payer system that is accountable for the total cost of care on a per capita basis is an effective model for establishing policies and incentives to drive system progress toward achieving the Three Part Aim.

Linkages: the CLAS Standards, the Medicare Waiver, and the Triple Aim



21



The Case for Culturally and Linguistically Appropriate Services



22

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

National Committee on Quality Assurance (NCQA) Patient-Centered Medical Home Standards; Joint Commission Hospital Accreditation 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 1974; 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

The Case for Culturally and Linguistically Appropriate Services



23

Missed Appointments

Ethnic minorities are disproportionately represented in the Medicaid population—this population is more likely to face problems that affect the ability to access care and keep medical appointments, such as lack of transportation, limited or no leave from work, and language and literacy difficulties. (Source: Kaiser Family Foundation. *Key Facts: Race, Ethnicity & Medical Care*. The Henry J. Kaiser Family Foundation, 2003 .)

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.)

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.)

Market Share

Implementation of the CLAS Standards in diverse types of health care organizations can attract business by both drawing in new consumers and retaining patients who want easier and more comfortable access to quality, culturally competent services. (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.)

More on the Business Case ...

24

Potential for the following benefits:

- Improves patient safety
- Improves quality of patient data collection
- Reduces preventable service utilizations
- Reduces avoidable 30-day hospital readmissions
- Increases cost savings (↓ number of patient treatments; ↓ hospital LOS; ↓ number of medical errors)
- Improves efficiency of care and services by decreasing barriers that slow progress
- Improves patients' satisfaction and self-reported QOC measures
- Promotes positive public perception of organization
- Increases provider productivity and satisfaction
- Incorporates a diversity of perspectives, ideas and strategies into the decision-making process

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).

Potential for the following benefits:

- ❑ Improves risk management
 - Reduces risk of medical liability
 - Reduces care disparities in the patient population and subsequent legal action
 - Improves patient safety and reduces number of medical errors

- ❑ Reduces risk of sanctions and penalties
 - Facilitates fulfillment of legal and regulatory guidelines
 - Improves compliance with:
 - Title VI of Civil Rights Act of 1964
 - Americans with Disabilities Act
 - Rehabilitation Act of 1973
 - Patient Protection and Affordable Care Act of 2010
 - State and Federal community benefit reporting and needs assessments

Ethical & Social Case



26

Potential for the following benefits:

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

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

Case for CLAS within the PCMH Model of Care



27

The CLAS Standards can help to facilitate the core functions and attributes of the PCMH Model of Care:

- Comprehensive care
- Patient-centeredness
- Coordinated care
- Accessible services
- Quality and safety

CLAS and NCQA-PCMH Recognition



28

NCQA's PCMH Recognition Program recognizes practices that successfully use **systematic processes** and IT to enhance the quality of patient care.

[NCQA Standards \(2014\)](#)

- 1) Patient-Centered Access
- 2) Team-Based Care
- 3) Population Health Management
- 4) Care Management and Support
- 5) Care Coordination and Care Transitions
- 6) Performance Measurement and Quality Improvement

[Correlated CLAS Standards \(2013\)](#) *

- 1) CLAS Standard # 1,11,12
- 2) CLAS Standard # 1,2,3,4,5,6,7,8,9,10,11,12,13,14,15
- 3) CLAS Standard # 1,4,11
- 4) CLAS Standard # 1,4,5,8,11,12
- 5) CLAS Standard # 1,4,11
- 6) CLAS Standard # 1,2,4,9,10,11,13,15

* Proposed crosswalk between NCQA Standards and the National CLAS Standards

CLAS-Related Policy Environment in Maryland



29

Legislation:

- Maryland Health Improvement and Disparities Reduction Act of 2012:
 - ▣ Establishes 5 Health Enterprise Zones (HEZs)
 - ▣ Encourages development of recommendations for criteria to measure the impact of PCMHs in elimination of health disparities
 - ▣ Promotes Cultural Competency
 - Maryland Health Care Commission to track efforts by health plans to provide culturally appropriate educational materials for members
 - Maryland Health Quality & Cost Council to make recommendations on cultural competency and health literacy training
 - ▣ Encourages Reporting and Analysis of Health Disparities Data
 - Hospital Community Benefit Reports (health disparities-reduction activities)
 - Racial/ethnic performance data tracking (hospitals and health plans)

CLAS-Related Policy Environment in Maryland (cont'd)



30

Recent Actions:

- Medicare Waiver and All-Payer Model
 - ▣ Financial Tests and Quality Targets that make it necessary for hospitals to know their patients and to tailor their strategies to:
 - Keep patients out of the hospital
 - Help manage health of the community

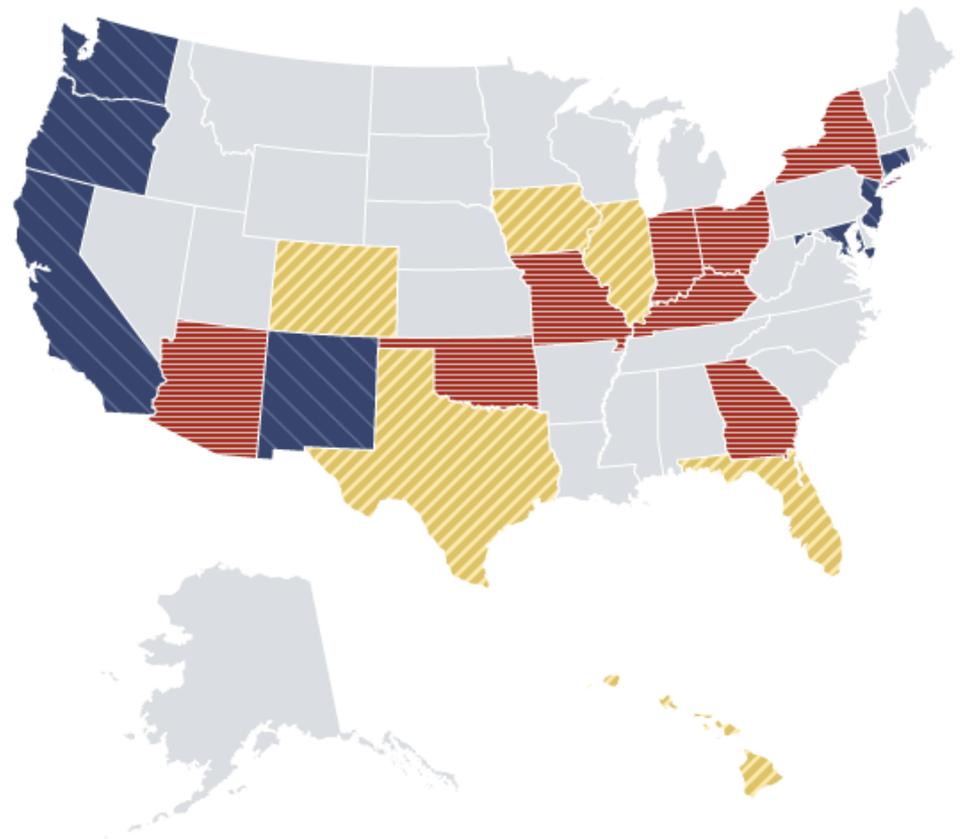
U.S. Map of CLAS Legislation

31

- Denotes legislation that was signed into law requiring (CA, CT, NJ, NM, OR, WA) or strongly recommending (MD) cultural competence training.

- Denotes legislation that was referred to committee and/or is currently under consideration.

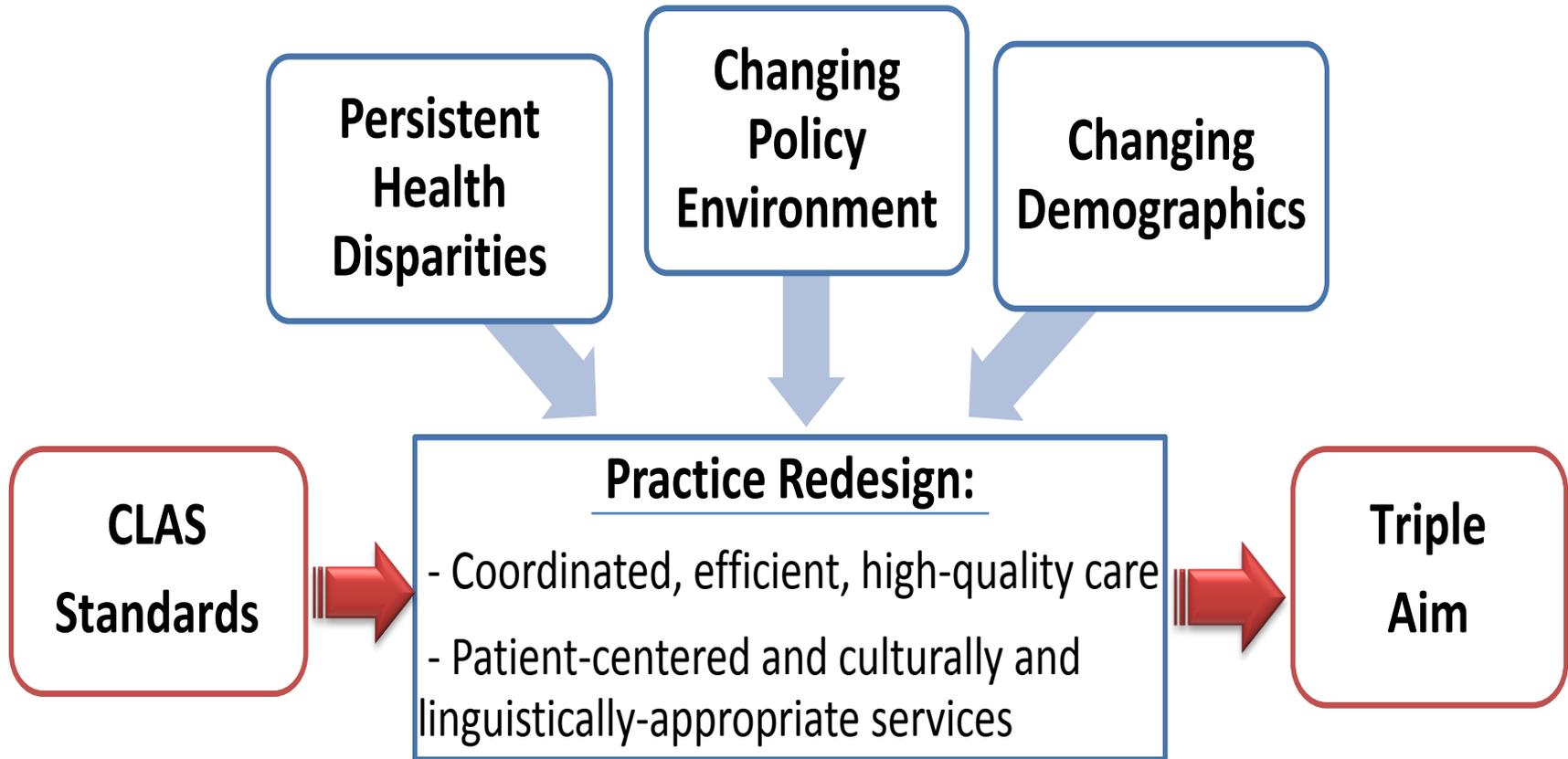
- Denotes legislation that died in committee or was vetoed.



Bottom Line



32



33

How Will the CLAS Standards Training Project Be Conducted?

Training: Winter 2015

34

Training session(s) will be scheduled for the participating FQHCs. Sessions will include presentations, group activities and discussions.

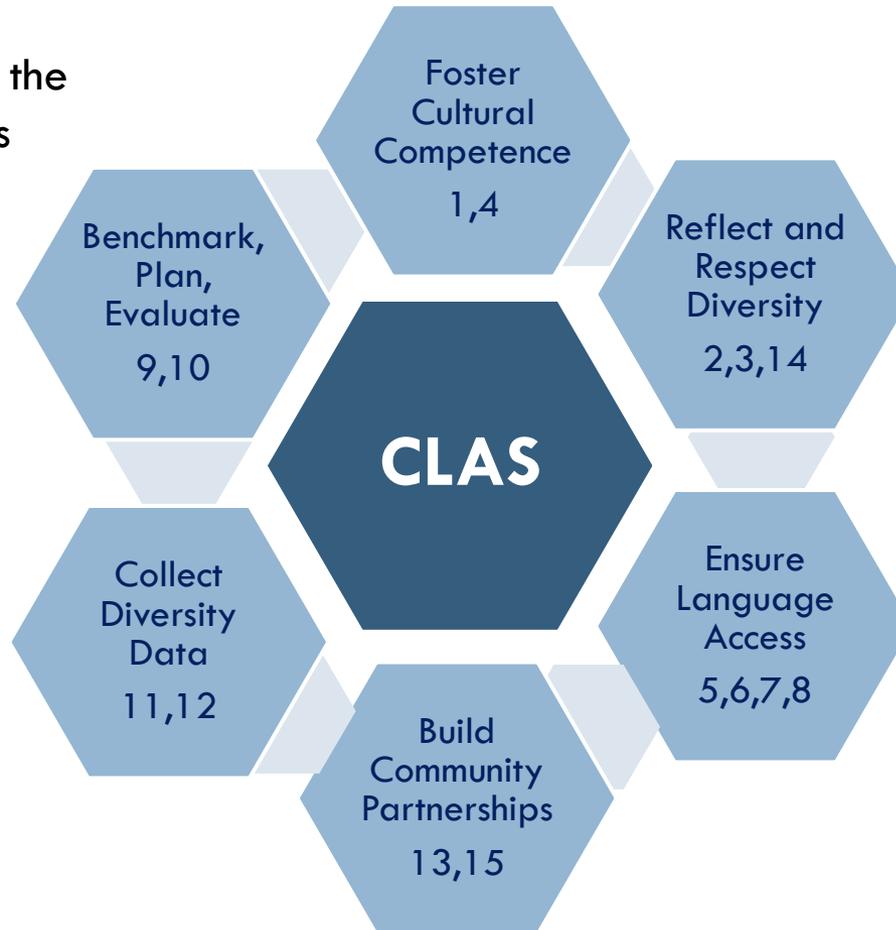
Participants will be chosen by health center leadership, with a suggestion to include personnel (i.e. managers) from each of the following areas if applicable:

- ▣ Direct patient services
- ▣ Human resources and professional development
- ▣ Quality Improvement
- ▣ Language and community outreach services
- ▣ Executive team member/sponsor

Training Framework: Six Areas for Action

35

Numbers represent the
15 CLAS Standards



Assessment: Spring/Summer 2015



36

- Pre- and Post-Training Surveys
 - CLAS Comprehension – Questionnaire administered to all individual participants in the program prior to the training and then again after the training to determine any increase in their knowledge of the CLAS Standards
 - CLAS Adoption – Organizational survey administered prior to the training and then again 6 months after the training to identify any increase in the level of adoption of the CLAS Standards at the organizational level

Follow-up and Reporting: Spring/Summer 2015



37

- Encourage establishment of on-going training and development
- Provide follow-up and technical assistance, as requested
- Share program results with leadership and staff

38

Final Thoughts

Next Steps: Your Role

39

- Arrange a full training on the CLAS Standards for your staff.
- Identify leadership and frontline staff who would benefit most from learning about the CLAS Standards and how to incorporate CLAS strategies into existing service delivery practices.

Resources



40

- 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 and Mental Hygiene. Office of Minority Health and Health Disparities Webpage. Available at: <http://dhmh.maryland.gov/mhhd/SitePages/Home.aspx>
- Maryland Department of Health and Mental Hygiene. State Health Improvement Process Webpage. Available at: <http://dhmh.maryland.gov/ship/SitePages/Home.aspx>
- Agency for Healthcare Research and Quality, U.S. Department of Health & Human Services. *National Healthcare Disparities Report, 2013*. Available at: <http://www.ahrq.gov/research/findings/nhqrdr/nhdr13/2013nhdr.pdf>
- Office of Minority Health, U.S. Department of Health & Human Services. *The National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care*. Available at: <https://www.thinkculturalhealth.hhs.gov/pdfs/NationalCLASStandardsFactSheet.pdf>

MHHD Contact



41

**To Arrange Training at Your
Health Center, please contact:**

(410) 767-7117

dhmh.healthdisparities@maryland.gov

General Contact Information:

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

201 W. Preston Street, Room 500

Baltimore, Maryland 21201

410-767-7117

Email: dhmh.healthdisparities@maryland.gov

Website: www.dhmh.maryland.gov/mhhd

Facebook:

<https://www.facebook.com/MarylandMHHD>

Twitter: @MarylandDHMH

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

Maryland Hospital CLAS Assessment Tool

- 1. Does the hospital have a senior level position dedicated to diversity and disparity issues?**
 - Yes
 - No

- 2. 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 includes 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)

- 3. In what ways does the community participate in determining the array of services and the manner in which services are delivered and evaluated?**
 - Community members hold positions on the board of directors.
 - Members of the community give input via surveys and questionnaires
 - Staff hold focus groups with members of the community
 - 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)

4. What strategies are used to identify 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)

5. What strategies are used to address 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 or lay outreach 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)

6. 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)

7. 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 5th-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)

8. 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)

9. 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)

10. Does the hospital provide formal training in medical interpretation for staff with bilingual skills?

- Yes
- No

11. What policies are in place to ensure the quality 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)

12. 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)

13. 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)

14. 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 changes in the race and ethnicity of the workforce
- 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)

15. 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

If yes, please describe. _____

16. 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)

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

- Yes
- No

If yes, please describe. _____

18. What trainings, practices, protocols and policies that 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)

19. In what ways do the organization'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 organization's mission statement, goals and strategic plan.
- The organization 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 organization'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)

20. Has the hospital previously conducted any organizational cultural competency assessments?

- Yes
- No

If yes, how often are assessments conducted?

21. Which organizational cultural competency assessment tools has the hospital used?

- Please describe: _____
- Not Applicable

22. In what ways has the organization 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 the organization has taken culture into account when designing and decorating the facility
- The organization does not currently have a physical environment that is representative of or accommodating to the cultures in the community being served
- Other (Please describe)

23. How accessible is the organization 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

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

- Appointment reminder calls
- Walk-in or same-day 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)

25. 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

26. Is nationality or country of origin data collected?

- Yes
- No

27. Is patient race data collected?

- Yes
- No

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

- Yes
- No

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

- Yes
- No

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

- Yes
- No

31. Is patient language data collected?

- Yes
- No

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

- Yes
- No

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

	<u>Yes</u>	<u>No</u>
Gender	<input type="checkbox"/>	<input type="checkbox"/>
Race	<input type="checkbox"/>	<input type="checkbox"/>
Ethnicity	<input type="checkbox"/>	<input type="checkbox"/>
Language	<input type="checkbox"/>	<input type="checkbox"/>

34. Is patient satisfaction/experience of care data collected?

- Yes
- No

35. If patient satisfaction/experience of care data is collected, which survey instruments or services are used to collect this data?

- Please describe. _____
- Not Applicable

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

- Yes
- No

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

- | | Yes | No |
|--|--------------------------|--------------------------|
| <input type="radio"/> CAHPS Cultural Competence Item Set | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="radio"/> CAHPS Health Literacy Item Set | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="radio"/> Not Applicable | | |

38. 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 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
- The organization's data system has the capacity to document and track complaints, their status, and resolution for both patients 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)

39. How does the organization communicate its dedication and progress in implementing and sustaining CLAS 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)

40. What are some specific areas in which the hospital has experienced barriers to adopting CLAS Standards and would need assistance, such as resources or training?

- 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 Committee for Quality Assurance. "Standards for Multicultural Health Care". 2010. Available at:

<http://www.ncqa.org/tabid/1157/Default.aspx>

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

Smedley, Brian et al (ed.). *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care*. Washington, DC: Institute of Medicine, 2002.

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.

Maryland FQHC/PCMH CLAS Assessment Tool

- 1. Do you have a senior level position dedicated to diversity and disparity issues in your organization?**
 - Yes
 - No
 - Not sure

- 2. 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)

- 3. In what ways does the community participate in determining the array of services and the manner in which services are delivered and evaluated?**
 - Community members hold positions on the board of directors.
 - Members of the community give input via surveys and questionnaires
 - Staff hold focus groups with members of the community
 - 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)

4. What strategies are used to identify 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)

5. What strategies are used to address 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)

6. 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)

7. 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 5th-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)

8. 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)

9. 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)

10. Does your organization provide formal training in medical interpretation for staff with bilingual skills?

- Yes
- No
- Not sure

11. What policies are in place to ensure the quality 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)

12. 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)

13. 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)

14. 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 changes in the race and ethnicity of the workforce
- 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)

15. 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.

16. 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)

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

- No
- Yes

If yes, Please describe: _____

18. 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)

19. In what ways do the organization'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 organization's mission statement, goals and strategic plan.
- The organization 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 organization'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)

20. Has your organization 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?

21. In what ways has the organization 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 the organization has taken culture into account when designing and decorating the facility
- The organization does not currently have a physical environment that is representative of or accommodating to the cultures in the community being served
- Other (Please describe)

22. How accessible is the organization 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

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

- Appointment reminder calls
- Walk-in or same-day 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)

24. 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

25. Is patient race data collected?

- Yes
- No
- Not sure

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

- Yes
- No
- Not sure

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

- Yes
- No
- Not sure

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

- Please describe: _____
- Not Applicable

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

- Yes
- No
- Not sure

30. Is patient language data collected?

- Yes
- No
- Not sure

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

- Yes
- No
- Not sure

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

	<u>Yes</u>	<u>No</u>	<u>Not sure</u>
Gender	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Race	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ethnicity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Language	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

33. 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?

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

- Yes
- No
- Not sure

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

	Yes	No	Not sure
<input type="radio"/> CAHPS Cultural Competence Item Set	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="radio"/> CAHPS Health Literacy Item Set	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="radio"/> Not Applicable			

36. 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
- The organization's 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)

37. How does the organization 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)

38. What are some specific areas in which the organization has experienced barriers to adopting CLAS Standards and would need assistance, such as resources or training?

- 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 Committee for Quality Assurance. "Standards for Multicultural Health Care". 2010. Available at:

<http://www.ncqa.org/tabid/1157/Default.aspx>

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

Smedley, Brian et al (ed.). *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care*. Washington, DC: Institute of Medicine, 2002.

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.