End Stage Renal Disease Culturally and Linguistically Appropriate Services Implementation Action Plan

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Executive Summary

Vision and Intent

As the U.S. population becomes more diverse, providers involved in healthcare delivery are interacting with people from many different cultural and linguistic backgrounds. A high prevalence of people with end stage renal disease (ESRD) have limited health literacy and other health-related social needs (HRSNs), underscoring the need for culturally and linguistically appropriate services (CLAS). This Action Plan aims to help guide healthcare organizations in the kidney community to implement the National CLAS Standards released by the Office of Minority Health (OMH) at the U.S. Department of Health and Human Services (HHS). The Action Plan provides strategies and action steps for dialysis facilities and transplant centers as they integrate CLAS into their daily workflow.

Call to Action

The Action Plan is organized around the Principal Standard and three overarching themes:

- Principal Standard: 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.
- Theme 1: Governance, Leadership, and Workforce
- Theme 2: Communication and Language Assistance
- Theme 3: Engagement, Continuous Improvement, and Accountability

Case studies, strategies, action steps, resources, and roadmaps are included to showcase how CLAS fits into the work facilities are already doing.

- **P**ick any theme or CLAS standard.
- **A**sk for feedback from the interdisciplinary team.
- **U**se one of the resources listed in the action step during staff meetings or team huddles.
- **S**tart small by picking one action step from the list.
- **E**ngage in discussions about case studies and dialogues about meeting the needs of diverse populations.

Incorporating CLAS standards involves identifying gaps, increasing awareness, garnering support, developing a plan, and taking actions.

- **A**ssess the needs. Conduct a needs assessment and use a facility CLAS self-assessment tool.
- **C**onduct and enhance staff training. Include discussion on culture-centered care.
- **T**ailor communication and educational materials. Integrate cultural sensitivity and ensure accessibility of communication.

This Action Plan outlines strategies, action steps, and resources to drive purposeful, meaningful, and measurable progress toward advancing health equity. The strategies embedded within the Action Plan will expand upon a person-centered care approach, including action-oriented coordination across all team members to integrate CLAS Standards. Applying CLAS Standards in kidney care ensures that all individuals, including those in our most vulnerable communities, will have equitable opportunities to access care to achieve optimal health, as we all deserve.

Introduction

The high prevalence of the ESRD patient population with limited health literacy and stark health disparities highlights the urgent need to implement services tailored to this population. However, barriers such as organizational resistance, lack of awareness, and staffing shortages impede the implementation of the National CLAS Standards in this setting.

To help address these barriers and provide a comprehensive document for healthcare organizations in implementing the National CLAS Standards, the ESRD National Coordinating Center (NCC), under contract with the Centers for Medicare & Medicaid Services (CMS), established the CLAS Strategic Workgroup. The purpose of the workgroup was to develop the *End Stage Renal Disease Culturally and Linguistically Appropriate Services Implementation Action Plan* ("Action Plan") specifically for the kidney community.

This Action Plan provides a guide for kidney professionals on how to implement the CLAS Standards to meet the needs of patients with ESRD. When the standards are implemented in facilities, they have implications to improve health outcomes and foster a more inclusive and equitable healthcare system. The Action Plan is user-friendly and resource-rich and includes interactive assessments. Real-life ESRD grievance cases were leveraged to provide users with relevant and applicable case studies and situational roadmaps. This approach was taken to help deepen their understanding of the place of CLAS in everyday workflow. With over 100 resources of various formats, more than 50 strategies, and over 100 accompanying action steps, this practical tool can help guide over 7,500 dialysis facilities and more than 200 transplant centers to implement the 15 National CLAS Standards effectively in their daily clinical practice.

CLAS Strategic Workgroup

The workgroup was composed of four members representing large dialysis organizations and 11 members representing all 18 of the ESRD Networks. The Network staff serving as workgroup members included patient service managers, executive directors, quality improvement managers, and health equity specialists. The group met monthly and provided iterative feedback throughout the Action Plan development. The collaboration helped ensure that challenges and needs faced by kidney professionals were addressed.

Organization of the Action Plan

The Action Plan is organized around the Principal Standard and three overarching themes: Theme 1: Governance, Leadership and Workforce; Theme 2: Communication and Language Assistance; and Theme 3: Engagement, Continuous Improvement, and Accountability. The Principal Standard, or Standard 1, serves as a conceptual guide for CLAS with the ultimate aim to achieve Standard 1 by adopting the remaining standards.

Each of the three overarching themes includes:

1. **Case Study** – a scenario based on a real grievance case relevant to the CLAS Standards

2. **Purpose** – the purpose of each CLAS standard within the overarching theme and in relation to the ESRD community
3. **Implementation Strategies** – practical strategies to help implement CLAS standards into the everyday clinical workflow
4. **Implementation Action Steps** – actionable steps to help users implement the strategies
5. **Implementation Resources** – resources in various formats to help integrate CLAS standards into the workflow
6. **Roadmap** – a graphic illustration based on real-life situational decision points to help guide users

Following these sections, additional resources are included.

How to Use This Guide

This Action Plan is intended for use by healthcare providers, including dialysis facilities, transplant centers, and large dialysis organizations. Professionals can access concrete implementation strategies to improve the provision of services to all individuals, regardless of race, ethnicity, language, socioeconomic status, and other cultural characteristics. The implementation strategies are guided by accompanying action steps and resources. Ways to integrate CLAS into daily workflow are supported by case studies, roadmaps, and discussion questions.

CLAS Overview

The Case for CLAS

Background

Ensuring equitable access to healthcare for all individuals is essential to improving healthcare outcomes, particularly in groups that have been economically and socially marginalized. The National CLAS Standards play a crucial role in healthcare settings to advance health equity, improve quality, and eliminate health disparities.[1] CLAS standards are a comprehensive set of guidelines that address cultural and linguistic differences to enhance population health. By adopting CLAS, healthcare providers can ensure that their services are respectful, understandable, effective, and equitable by considering cultural health beliefs, health literacy levels, communication needs, and cultural health practices.[1]

The ESRD Community's Need for CLAS

Health Disparities: Racial and ethnic disparities are well-documented within the ESRD community. Kidney disease affects racially minoritized communities disproportionately compared with their White counterparts. Risk of kidney failure is four times greater for Black Americans and 1.3 times greater for Hispanic Americans.[4,2] Racial and ethnic minorities and patients with low income are less likely to receive recommended care based on chronic kidney disease factors and are more likely to progress to ESRD.[3] To address these disparities, CLAS Standards offer a valuable framework for improving healthcare access and enhancing patient–provider communication, ultimately promoting culturally competent care. By adopting CLAS, healthcare providers can bridge the gap and ensure that individuals from diverse backgrounds receive equitable care that respects their cultural beliefs, enhances understanding, and fosters effective communication for improved health outcomes.

Language Barriers and Health Literacy: Research indicates that about 25% of patients with chronic kidney disease exhibit limited health literacy.[4,5] Limited health literacy is associated with poorer health outcomes, such as increased hospitalizations and emergency department use, cardiovascular events, missed dialysis, and faster disease progression.[6] Many patients with ESRD also come from linguistic minority backgrounds, which causes communication barriers and raises concerns about the quality of care.[7] Interpreters and other language services are available at no cost to the patient; however, dialysis units need to work to prioritize language access and make patients aware of their rights to language interpretation.[1,7] Referring to the CLAS Standards as a guide, offering interpretation services, and providing translated and easily comprehensible materials can significantly enhance understanding and empower patients to make informed decisions about their treatment.

Health Education and Prevention: CLAS Standards emphasize the importance of health education, promotion, and prevention strategies and tailoring them to patients' cultural contexts.[1] Furthermore, adopting CLAS Standards can help bridge the gap in doctor–patient communication. Effective communication is essential for conveying information about the prevention and management of ESRD.[3] Healthcare providers should strive to communicate clearly, using plain language and visual aids whenever possible to enhance understanding. Leveraging CLAS to improve outreach efforts and culturally appropriate educational materials can promote early intervention and help reduce the incidence of ESRD.

Barriers to Implementing CLAS Standards in the ESRD Community

Organizational Resistance and Guidance: Some healthcare organizations may resist change or need more awareness of the importance of the CLAS Standards, despite the positive implications for health outcomes.[8,9.] Limited resources, budget constraints, and competing priorities can also hinder the implementation of new policies to enhance health equity.[9,10] A disconnect between the cultural and linguistic characteristics of the populations served and the current workforce demographics can decrease an organization's ability to provide care and work.[9] Thus, it is imperative for organizations to have diverse leadership in terms of culture and language.

Challenges with Cultural Competency Training: Sufficient training is needed to provide practical learning for staff and alignment with CLAS Standards.[10,11] Cultural competency training varies in duration, frequency, and topic and must include structural and systematic instruction. It is essential that training contribute to the development of a climate focused on learning.[11] Leadership and organizations must establish policies and procedures that demonstrate their commitment to cultural competency and equity for their staff and the individuals they serve.

Cost: Implementing the CLAS Standards does come with associated costs. Hiring skilled interpreters, training staff, collecting data, and increasing organizational capacity to provide care pose costs to organizations.[10] However, not implementing the CLAS Standards can be even more costly because of the heightened risk of adverse patient outcomes, errors, and inefficiencies.[10] In the long run, investing in the services that align with CLAS Standards proves to be a more cost-effective approach, as it contributes to improved patient outcomes.[10] One study showed that implementing cultural communication training with an average cost of $138.51 per participant had an average cost-effectiveness ratio of $337.83 per 1-unit increase in culturally competent behavior scores.[12] Additionally, limited literacy creates excess cost for the healthcare system: Average healthcare costs for Medicaid enrollees are $2,800 but over $10,000 for those with limited literacy.[13] Further, organizations that receive federal funding must comply with the CLAS Standards, or they could incur financial penalties from CMS.[11]

Moving to Incorporate CLAS Standards

Creating awareness among organizations about the National CLAS Standards and having individuals within the organizations ensure compliance is an initial step in ensuring appropriate implementation of the standards. Understanding where the organization has gaps concerning National CLAS Standards will help organizations develop relevant ways to close the gaps. Strong leadership support is crucial for the seamless integration of CLAS Standards.[9] Therefore, obtaining buy-in and support from staff and senior leaders is essential. Developing a clear action plan with goals can guide the implementation process. Sharing lessons learned and successful experiences with other healthcare organizations can also contribute to the overall compliance of CLAS Standards across the healthcare sector. Health equity should always be a top priority for healthcare organizations, and using CLAS Standards can play a pivotal role in bridging gaps and reducing disparities within health systems. By incorporating the CLAS Standards into their practices, healthcare organizations can actively work toward ensuring that every individual has equal access to quality healthcare services, regardless of background or circumstances. This commitment to health equity aligns with the overarching goal of improving health outcomes and fostering a more inclusive and equitable healthcare system.

What Are CLAS Standards?

The National CLAS Standards are intended to advance health equity, improve quality, and help eliminate healthcare disparities by establishing a blueprint for health and healthcare organizations.[14] The HHS Office of Minority Health released the following National CLAS Standards.[15]

Principal Standard

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

Governance, Leadership, and Workforce

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

Communication and Language Assistance

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

Engagement, Continuous Improvement, and Accountability

9. Establish culturally and linguistically appropriate goals, policies, and management accountability, and infuse them throughout the organization's planning and operations.
10. Conduct ongoing assessments of the organization's CLAS-related activities and integrate CLAS-related measures into measurement and continuous quality improvement activities.
11. Collect and maintain accurate and reliable demographic data to monitor and evaluate the impact of CLAS on health equity and outcomes and to inform service delivery.
12. Conduct regular assessments of community health assets and needs and use the results to plan and implement services that respond to the cultural and linguistic diversity of populations in the service area.
13. Partner with the community to design, implement, and evaluate policies, practices, and services to ensure cultural and linguistic appropriateness.

14. Create conflict and grievance resolution processes that are culturally and linguistically appropriate to identify, prevent, and resolve conflicts or complaints.
15. Communicate the organization's progress in implementing and sustaining CLAS to all stakeholders, constituents, and the general public.

Implementation Action Plan for the CLAS Standards

All case studies presented in this guide are based on actual events. Names and details have been changed to protect patient privacy. In certain cases, incidents, people, and timelines have been changed for educational purposes. Certain people may be composites or entirely fictitious.

Principal Standard

CLAS Standard 1: The Principal Standard provides 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.

Purpose

1. To create a safe and welcoming environment at every point of contact that both fosters appreciation of the diversity of individuals and provides patient- and family-centered care
2. To ensure that all individuals receiving healthcare and services experience culturally and linguistically appropriate encounters
3. To meet communication needs so that individuals understand the healthcare and services they are receiving, can participate effectively in their own care, and make informed decisions
4. To eliminate discrimination and disparities

Standard 1 is the Principal Standard because, conceptually, the ultimate aim in adopting the remaining Standards is to achieve Standard 1. Standards 2 through 15 represent the practices and policies intended to be the fundamental building blocks of culturally and linguistically appropriate services that are necessary to achieve the Principal Standard. For this reason, strategies for implementation specific to Standard 1 are not listed here. If each of Standards 2 through 15 are implemented and maintained, organizations will be better positioned to achieve the desired goal of “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.”

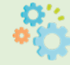
To complement the Action Plan, OMH has developed **An Implementation Checklist for the National CLAS Standards** to help with CLAS integration. This checklist provides successful implementation practices for CLAS-related organizational activities.

Case Study: Systematic Barriers in Accessing Healthcare

Background

Mr. Thompson, a non-Hispanic African American male in his 50s, faced significant barriers accessing healthcare due to drug use and lack of stable housing. A disagreement with a nephrologist at a private clinic exacerbated his situation. After the disagreement with his nephrologist, Mr. Thompson felt unsafe and decided to leave the private clinic, fearing potential retaliation or harm to his dialysis treatment. He sought alternative facilities, but no other clinic accepted him. It was reported that staff members at the private dialysis clinic were speaking to other clinics in the area about Mr. Thompson, describing him as dangerous and discouraging other facilities from accepting him as a patient. Mr. Thompson sought emergency dialysis at a nearby hospital but was rejected by this hospital and ultimately had to be airlifted to a different hospital.

Key Challenges



- **Disagreement With Healthcare Provider:** Mr. Thompson left the private clinic due to concerns about his safety and potential harm to his dialysis treatment after a disagreement with the nephrologist.
- **Refusal From Emergency Department (ED):** The ED refused to assist Mr. Thompson due to an altercation with hospital staff involving a detox from drug use. The hospital claimed he was a danger to the hospital.
- **Limited Local Resources:** Mr. Thompson resided in a rural area and had limited resources, treatment programs, and housing assistance programs available, exacerbating his difficulties in accessing healthcare.
- **Financial Barriers:** With no financial resources and the hospital's refusal to accept him, Mr. Thompson encountered a significant financial barrier to obtaining the necessary medical care.
- **Stigmas and Discrimination:** The staff at the clinic stigmatized Mr. Thompson's drug use and unstable housing, which resulted in his not being able to receive proper care.

Resolution Process

- **Advocacy for Patient's Rights:** Patient advocates became involved to address Mr. Thompson's case, emphasizing the importance of providing medical care irrespective of a person's housing or substance use disorder.
- **Community Resource Collaboration:** The facility initiated collaborations with local community organizations and gathered resources to assist Mr. Thompson with options for housing, substance misuse rehabilitation treatment, and financial support.
- **Education and Training:** Leadership at the facility provided its healthcare professionals, including social workers, with additional education and structural competency training to prevent implicit bias and microaggressions, as well as help the staff better recognize and respond to health and illness as downstream effects of broad social, political, and economic structures and be able to address the unique challenges faced by individuals with a history of drug use and unstable housing.

Outcomes

- **Increased Awareness:** The case highlighted the need for increased awareness and sensitivity within the medical community regarding the unique challenges faced by individuals with a history of drug use and housing issues.
- **Community Support:** Collaboration with local community resources provided Mr. Thompson with temporary housing and access to substance use disorder treatment programs, addressing some of the underlying broader socioeconomic challenges contributing to his situation.
- **Advocacy for Healthcare Equity:** The case spurred advocacy efforts to promote healthcare equity and address systemic issues contributing to disparities in access to care.

Conclusion

This case underscores the urgency of addressing healthcare disparities and the need for a more inclusive, compassionate approach to patient care, especially for individuals with a history of drug use and unstable housing. Facilities can provide a collaborative environment for healthcare providers and community groups, easing the burden of systemic barriers and helping ensure equitable access to medical care for all individuals, regardless of their social or economic circumstances.

Resource Highlight

Summary of HIPAA Privacy Rule

Discussion Questions

1. How might implicit bias among healthcare providers contribute to some of the stigma and discrimination that Mr. Thompson experienced? What initiatives or resources exist that could enhance healthcare providers' understanding of structural competency and implicit bias and contribute to an equitable healthcare system?
2. If the staff could have addressed Mr. Thompson's concerns about feeling unsafe, could this have made a difference? If the dialysis staff were to engage with Mr. Thompson, what are some approaches that could work to ease the fear and build trust?
3. What are some effective ways to manage disagreements with patients? What resources or activities can staff use to prevent disagreements from arising with patients? What policies or practices are in place to ensure resources are used in times of disagreement?

Fostering Inclusivity and Cultural Competency in Healthcare Facilities Through Person-Centered Care

1 A non-Hispanic African American female in her 30s who urgently needed to use the restroom was denied access to an unoccupied staff restroom.

What could have been done differently? The facility could have prioritized the patient's needs by temporarily allowing access to the staff restroom.

2 The patient felt discriminated against because she was denied use of the restroom when other patients had used the staff restroom in the past. This led to an embarrassing bathroom emergency.

What could have been done differently? The facility could have had regular training for the staff on cultural sensitivity and implicit bias, as well as established a system to address patient concerns of discrimination immediately.

3 Staff did not follow internal policies about staff-restricted areas consistently.

What could have been done differently? All staff need to follow listed policies. The facility needs to have comprehensive policies and protocols covering all aspects of patient care, including restroom access, and regularly review, update, and add policies as needed.

4 The patient chose to transfer to another facility.

What could have been done differently? The facility could have immediately addressed the patient's concerns and offered support, as well as provided opportunities for the patient to discuss her experience to help improve the facility's policies.

Ensuring patient well-being should be a top priority throughout all facility operations, especially in urgent situations. Additionally, making sure staff have regular training on protocols, cultural competency, and implicit bias, and that policies are comprehensive and updated regularly, is essential to a culturally competent organization.

Discussion Questions

1. How might the experience of being denied access to the restroom be interpreted/perceived by an individual as discriminatory? Given the historical context of African Americans being systemically denied access to places and resources, how might this incident be oppressive?
2. How does power play a role in this incident? How much power do I as a healthcare provider hold in this type of situation? How could withholding information from patients contribute to a feeling of marginalization? How can healthcare organizations create a culture of accountability and responsiveness to patient concerns?
3. How can we better explain facility operations to help patients understand the safety protocols and policies that are in place—for example, the reasons behind schedule constraints or limited access to certain areas in the facility?

Theme 1: Governance, Leadership, and Workforce

Case Study: Ensuring Person-Centered Care

Background

Mr. Johnson, a non-Hispanic African American male in his 80s, had been a patient at the clinic for a few years. Staff members recognized his potential as a patient advocate and invited him to participate in Quality Assessment and Performance Improvement (QAPI) meetings. Despite this collaborative involvement, Mr. Johnson was unexpectedly faced with an involuntary discharge due to alleged disruptive behavior. Mr. Johnson felt staff may have perceived his involvement as a patient advocate as intrusive rather than providing patient feedback. The decision to discharge Mr. Johnson was prompted by claims of disruptive behavior, vaguely described by staff as noncompliance, directing his own care, unpleasant and hostile demeanor, and intimidating verbal and nonverbal messages. The clinic staff reported these concerns, and a letter from the staff was presented to the Network as evidence for the discharge.

Key Challenges

- **Lack of Documentation:** The staff did not adequately document specific instances of disruptive behavior that led to the involuntary discharge, relying solely on the staff letters.
- **Vague Allegations:** The clinic described Mr. Johnson as noncompliant and hostile without providing concrete examples of disruptive behavior.
- **Timing of Complaints:** Complaints about Mr. Johnson's behavior coincided with his active role as a patient advocate, raising questions about the motivation behind the sudden grievances.
- **Unsubstantiated Threat Perception:** The staff described Mr. Johnson as intimidating, despite his age and fragility, without providing evidence of any physical harm or threat.
- **Lack of Alternative Solutions:** Rather than addressing concerns or working collaboratively with Mr. Johnson, the clinic opted to involuntary discharge him, causing significant disruption to his healthcare continuity.

Resolution Process

- **Review of Allegations:** Leadership conducted a thorough review of the allegations with a focus on obtaining specific examples or evidence of disruptive behavior.
- **Workforce Engagement:** Staff members were interviewed, and staff statements were taken to gather more information about their concerns and to verify the report of disruptive behaviors.
- **Patient's Perspective:** Mr. Johnson was given the opportunity to share his perspective on the allegations, emphasizing the nature of his advocacy work and his commitment to his own care.
- **Documentation Correction:** The clinic addressed the lack of proper documentation and implemented measures to ensure accurate and detailed reporting of patient behavior.
- **Conflict Resolution Mediation:** A conflict resolution session involving Mr. Johnson, staff members, and a neutral mediator was organized to foster open communication and address any misunderstandings.

Outcomes

- **Reinstatement of Patient:** Upon a comprehensive review and collaborative discussion, the clinic recognized the lack of substantiated evidence for the claims made against Mr. Johnson. As a result, the decision for involuntary discharge was revoked.
- **Policy Review and Training:** The clinic leadership conducted a review of its policies regarding patient discharge and implemented additional staff trainings related to explicit and implicit bias, systemic racism, and microaggression, as well as appropriate practices for patient discharge to ensure fair and unbiased handling of behavioral concerns.
- **Patient Advocacy Acknowledgment:** The clinic acknowledged Mr. Johnson's valuable role as a patient advocate and representative and expressed gratitude for his contributions to the improvement of healthcare services.
- **Continued Collaboration:** The clinic committed to engaging in continued collaboration and communication between staff and patients to prevent a similar situation in the future.

Conclusion

In addition to highlighting the importance of CLAS-aligned leadership, governance, and workforce practices in healthcare settings**,** Mr. Johnson's case underscores the importance of transparency, documentation, and fair procedures created by leadership to assist with handling behavioral concerns leading to involuntary discharge. It is essential to establish the policy and organizational culture needed to help prevent and address explicit and implicit bias and provide appropriate staff trainings to provide a safe and healthy environment to prevent discrimination in healthcare. Through open dialogue, conflict resolution, and policy improvement, the clinic aimed to resolve the situation and reaffirm its commitment to providing person-centered care in an equitable manner.

Resource Highlights

Dialysis Facility Involuntary Discharge Guidelines
Involuntary Discharge Process for Dialysis Facilities

Discussion Questions

1. Given the power dynamics in this situation, how might Mr. Johnson's age, race, and involvement as a patient influence staff perceptions and interactions? What training or other resources can facilities use to help reduce any staff biases?
2. What resolution steps should be in place prior to involuntarily discharging a patient when disruptive behavior is alleged? Do specific protocols or practices related to this exist in our facility?
3. What steps can healthcare facilities take to foster a culture of inclusivity and respect for patient advocacy, so patients feel empowered to participate in their care? What staff attitudes or feelings might prevent them from empowering patients, and what can be done to help shift these attitudes?

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

Purpose

1. To ensure the provision of appropriate resources and accountability needed to support and sustain initiatives
2. To model an appreciation and respect for diversity, inclusiveness, and all beliefs and practices
3. To support a model of transparency and communication between the service setting and the populations that it serves

CLAS Standard 2 Implementation Strategies, Action Steps, and Resources

Strategy	Action Steps	Resources
1. Create and sustain an environment of cultural competency through establishing leadership structures and systems or embedding them into existing structures and systems.	a. Work to incorporate cultural diversity awareness and competency training throughout the facility, including clinical managers and other leadership. b. Perform a cultural competency assessment of the organization.	○ Improving Cultural Competence – Quick Guide for Administrators ○ Assessment of Organizational Cultural Competence ○ Planning and Implementing Cultural Competence Organizational Self-Assessment ○ Person-Centered Practices Self-Assessment
2. Identify and develop informed and committed champions of cultural competency throughout the organization in order to focus efforts around providing culturally competent care.	a. Recruit staff who are supported by the organization's leadership, who will share educational resources about CLAS throughout the organization. b. Encourage patient and family member group members to help promote resources and spread awareness.	○ Just Culture Champion Role ○ Selecting a Health Equity Champion

Strategy	Action Steps	Resources
3. Ensure that a commitment to culturally competent care is reflected in the vision, goals, and mission of the organization and couple this with an actionable plan.	a. Involve community collaborators in reviewing and updating mission, vision, and value statements. b. Plan for periodic review of statements to ensure organizational responsiveness. c. Translate mission and vision statements into actionable objectives, accompanied by measurable indicators to gauge progress.	○ Cultural Competence Planning Guide ○ Establishing a Vision and Mission Checklist
4. Implement strategies to recruit, retain, and promote at all levels of the organization a diverse leadership that reflects the demographic characteristics of the populations in the service area.	a. Include cultural competency requirements in job descriptions. b. Include discussion on culturally centered care at QAPI meetings. c. Post job descriptions in local community media; hold job fairs in the communities served. d. Participate in college career fairs at institutions with a diverse student population and/or population reflective of the patient population.	○ Ensuring a Diverse Workforce: A Guide for Inclusive Hiring Practices ○ Creating a Culture of Belonging: A Guide for Retention ○ Understanding QAPI ○ Professional Module: Patient Engagement in QAPI ○ Best Practices for Recruiting Diverse Students and Post-docs
5. Ensure that the necessary fiscal and human resources, tools, skills, and knowledge to support and improve culturally competent policies and practices in the organization are available.	a. Identify gaps and areas that need improvement in terms of resources, tools, skills, and knowledge. b. Make continuous CLAS-related training available to leadership and staff. c. Disseminate CLAS resources using widely accessible platforms (e.g., webpage, organization-wide communication, break room).	○ Cultural Competency Deployment Refresher

Strategy	Action Steps	Resources
6. Commit to cultural competency through system-wide approaches articulated through written policies, practices, procedures, and programs.	a. Perform an annual assessment of materials and procedures to ensure different languages provided reflect the needs of the patient population. b. Conduct annual needs assessment of CLAS. c. Evaluate staff cultural competency training effectiveness.	○ A Physician's Practical Guide to Culturally Competent Care ○ Building a Culturally Competent Organization: The Quest for Equity in Health Care
7. Actively seek strategies to improve the knowledge and skills needed to address cultural competency in the organization.	a. Seek out patient feedback directly or through patient subject matter experts (PSMEs)/cultural health champions. b. Work with your respective ESRD Network to identify and implement resources. c. Use ESRD NCC Change Packages.	○ 2023 ESRD NCC Change Packages ○ A Comprehensive Framework and Preferred Practices for Measuring and Reporting Cultural Competency ○ The National Forum of ESRD Networks

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

Purpose

1. To create an environment in which culturally diverse individuals feel welcome and valued
2. To promote trust and engagement with the communities and populations served
3. To infuse multicultural perspectives into the planning, design, and implementation of CLAS
4. To ensure that diverse viewpoints are represented in governance decisions
5. To increase staff knowledge and experience related to culture and language

CLAS Standard 3 Implementation Strategies, Action Steps, and Resources

Strategy	Action Steps	Resources
1. Provide resources to help the administration identify pools of qualified leadership and staff members proportionately representative of the community served.	a. Conduct regular, explicit assessments of hiring and retention data, current workforce demographics, and community demographics. b. Highlight your organization's commitment to diversity and inclusiveness when posting and recruiting for open positions.	o County Health Rankings Health Data o Diversity in Health Care: Examples from the Field o A Toolkit for Recruiting and Hiring a More Diverse Workforce
2. Provide hiring opportunities through multiple strategies.	a. Develop relationships with local schools, adult education programs, training programs, and faith-based organizations to expand recruitment base. b. Use job fairs, advertisements in listservs, and newsletters of national ethnic associations or organizations. c. Connect with professional organizations aligned with organizational goals to enhance networking opportunities.	o University of Washington - Example Staff Diversity Hiring Toolkit

Strategy	Action Steps	Resources
3. Build community trust and engagement by hiring highly qualified professionals who are more reflective of the population of people served.	a. Assess the language and communication proficiency of staff to determine fluency and appropriateness for serving as interpreters. b. Consider the new employee experience and how a peer coach or work buddy might help with onboarding. c. Provide resources and trainings for existing employees to expand their talents.	○ Strategies for leadership: Does your hospital reflect the community it serves? A diversity and cultural proficiency assessment tool for leaders ○ Effective Practices for the Recruitment, Retention, and Education of Native American Medical Students (video)
4. Establish a CLAS Standards committee inclusive of diverse representatives from the population served to establish goals, objectives, tasks, and timelines; identify areas of improvement; and track progress over time.	a. Use community members, patient advocates, and PSMEs to help identify areas where access and service quality are lacking or need improvement. b. Develop a set of key activities and strategies focused on improving CLAS-driven equity, access, and quality service.	○ Communication Climate Assessment Toolkit (C-CAT) Framework ○ Authentic Community Engagement to Advance Equity

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

Purpose

1. To prepare, support and sustain a workforce that demonstrates the attitudes, knowledge, and skills necessary to work effectively with diverse populations
2. To increase the capacity of staff to provide culturally and linguistically appropriate services
3. To assess the progress of staff in developing skills in cultural, linguistic, and health literacy competency
4. To foster an individual's right to respect and nondiscrimination by developing and implementing education and training programs that address the impact of culture on health and healthcare

CLAS Standard 4 Implementation Strategies, Action Steps, and Resources

Strategy	Action Steps	Resources
1. Provide CLAS training and professional development resources and tools for service providers, staff, and administration.	a. Provide ongoing training on ways to meet the unique needs of the population and how and when to access language services for individuals with limited English proficiency. b. Take advantage of internal and external resources available to educate governance, leadership, and workforce on different cultural beliefs that they may encounter.	○ Culturally Competent Nursing Care: A Cornerstone of Caring ○ Improving Cultural Competency for Behavioral Health Professionals ○ Administrators and providers: The Guide to Providing Effective Communication and Language Assistance Services
2. Provide resources for new and existing ESRD service providers and collaborative community groups that focus on building collective CLAS competencies and making related policy, procedural, and practice enhancements.	a. Assess the resources available for CLAS projects, both financial and staff capacity. b. Develop or use existing training about CLAS competencies. c. Participate in open discussions with the ESRD community about best practices to improve health equity by attending Health Equity Learning in Action calls or calls hosted by ESRD Networks.	○ Learning and Action Network Call Series

Strategy	Action Steps	Resources
3. Seek guidance from professional personnel to understand how to honor cultural beliefs and practices and incorporate them alongside medical practices.	a. Engage staff in dialogues about meeting the needs of diverse populations in homerooms and other staff meetings. b. Implement regular training on working with diverse cultures.	o Think Cultural Health Trainings o Conscious and Unconscious Biases in Health Care
4. Monitor progress of staff in delivering culturally and linguistically appropriate practices.	a. Incorporate an ongoing assessment of CLAS competency into staff performance ratings (e.g., cross-cultural communication). b. Conduct regular training refreshers using real-life scenarios to reinforce the importance of respectful and nondiscriminatory service delivery.	o Measuring Performance to Advance Equity o Cultural Competency Deployment Refresher
5. Establish procedures to support the rights of patients, their families, and community to receive respectful and nondiscriminatory services.	a. Develop and implement diversity education and training programs that address the impact of culture on health and healthcare. b. Provide patients and their families educational resources about their rights, available services, and how to report discrimination or disrespectful behavior. c. Develop and display a nondiscrimination statement in the healthcare facility. d. Implement a confidential system for patients and their families to provide feedback on their experiences at the clinic and organizational levels.	o How to File a Discrimination Complaint with the Office for Civil Rights o Know Your Rights Against Discrimination o General Non-Discrimination Policy Tips o Notices of Nondiscrimination and Taglines

Improving Language Access to Enhance Patient-Provider Communication

1 A Hispanic non-English-speaking White male in his 50s faced potential discharge for breaking Medicaid protocol due to lack of paperwork, causing him to lose coverage.

What could have been done differently?
The facility should have performed an early communication assessment to identify language interpreter services and used resources like "I speak" cards to help ensure the patient understood all the information being presented to him.

2 The facility called the Network to report the patient, and the Network requested documented interpreter service attempts. The facility had no such attempts to report and said the patient understood "enough English."

What could have been done differently?
The facility could have attempted to use the language line and ensured that communication was performed in the patient's preferred language to avoid miscommunication.

3 The facility performed a language assessment that revealed the patient's primary language was Spanish.

What could have been done differently?
The facility could have implemented cultural competency training for staff, as well as introduced regular training sessions on the use of communication resources. This could have helped staff understand the importance of language assessments early in the patient intake process.

4 There was improved understanding between the patient and facility regarding Medicaid protocols, and the facility closed the case without implementing training or standards to prevent future incidents.

What could have been done differently?
Continuous improvement strategies to understand the effectiveness of communication initiatives and periodic reviews of policies and procedures could have been implemented to help avoid this situation from reoccurring.

Prioritizing proactive communication assessments for all patients upon first contact will help to reduce miscommunication. Additionally, implementing regular staff training on using communication resources and employing protocols to ensure documentation of language resources used can help improve patient-provider communication.

Discussion Questions

1. How can we recognize and check the patient's understanding early on? What are verbal and nonverbal cues that might indicate confusion? What different communication strategies are available that could meet patients where they are?
2. What best practices exist within our team to work with patients who may have limited English proficiency, low literacy, or other communication needs? How can team members better communicate with each other to prevent miscommunication from happening?
3. What resources exist in our facility to identify and assist patients who could benefit from language services? Are there practices or trainings in place to help staff know when and how to access various language resources (e.g., teach-back methods, no side conversations)?

Theme 2: Communication and Language Assistance

Case Study: Telemedicine Communication

Background

Robert, a non-Hispanic White man in his 70s, contacted his healthcare facility with a complaint about a perceived lack of care and distance in the provider-patient relationship. Robert had been relying on telemedicine for his healthcare needs because of COVID-19. However, his transition to virtual care presented unforeseen challenges. His hearing impairment, compounded by the virtual nature of consultations, created an environment where communication barriers emerged.

Key Challenges

- **Hearing Impairment:** Robert's age-related hearing loss made it difficult for him to understand and engage effectively during telemedicine appointments.
- **Telemedicine Interface:** Conducting care through telemedicine posed challenges in conveying nonverbal cues, which are crucial for effective communication, especially with elderly patients.
- **Provider's Accent:** Though highly qualified, the healthcare provider had an accent that further complicated the communication process for Robert.
- **Mask Usage:** With the use of masks during consultations, visual cues from lip movements were lost, adding a layer of difficulty for the patient.

Resolution Process

- **Patient and Family Engagement:** Staff engaged with Robert and his family to gain insights into his specific challenges during telemedicine consultations. This involved understanding his daily routine, communication preferences, and any additional support he might require.
- **Provider Communication Training:** The healthcare team provided feedback to the provider, emphasizing the need for clear and louder communication. The provider underwent additional training sessions to enhance staff’s communication skills, focusing on adapting to the challenges posed by virtual care.
- **Technology Optimization:** The healthcare facility explored technological solutions to mitigate the impact of virtual communication challenges. This included analyzing features within the telemedicine platform that could improve audio and visual communication clarity.
- **Evaluation Adjustments:** Thinking about future evaluations, staff implemented screening processes to learn whether telehealth is a viable possibility for the patient and, if necessary, to create processes to ensure telehealth is implemented in the most accessible way.

Outcomes

- **Improved Patient-Provider Communication:** With adjustments in the provider's communication style and the use of technological enhancements, Robert reported a significant improvement in his ability to understand and engage during telemedicine consultations.
- **Enhanced Patient Satisfaction:** The healthcare facility's proactive approach to address the communication challenges resulted in improved patient satisfaction. Robert and his family expressed gratitude for the personalized attention and efforts to meet their unique needs.
- **Provider Learning and Adaptation:** The case prompted the healthcare provider to refine communication skills further, fostering a more person-centered approach. The experience was a valuable learning opportunity for the provider and the healthcare team.

Conclusion

This case study underscores the importance of proactive communication and adaptability in the evolving landscape of telemedicine. By recognizing and addressing the unique challenges elderly patients face, particularly those with hearing impairments, healthcare providers can enhance the patient experience and build stronger, more effective patient-provider relationships in the virtual realm.

Resource Highlight

ESRD Provider Telehealth and Telemedicine Tool Kit

Discussion Questions

1. What are potential challenges and benefits of implementing screening processes to assess the suitability of telemedicine for each patient? How can healthcare facilities make sure this process does not exclude certain patient populations?
2. How do patient accommodations due to hearing-related impairments impact effective communication? How does empathy play a role in making accommodations to meet the needs of patients? How might the team engage with patients and their families to better understand individual communication preferences and needs?
3. What role can patient and family engagement play in identifying and addressing communication challenges in telehealth and beyond? How can healthcare providers collaborate with patients and care partners to better tailor care to fit patient's needs and preferences?

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

Purpose

1. To ensure that individuals with limited English proficiency and/or other communication needs have equitable access to health services
2. To help individuals understand their care and service options and participate in decisions regarding their health and healthcare
3. To increase individuals' satisfaction and adherence to care and services
4. To improve patient safety and reduce medical errors related to miscommunication
5. To help organizations adhere to requirements such as Title VI of the Civil Rights Act of 1964, the Americans with Disabilities Act (ADA) of 1990, and other relevant federal, state, and local requirements
6. To ensure the competency of the individuals providing language assistance (i.e., to avoid use of untrained individuals and minors)

CLAS Standard 5 Implementation Strategies, Action Steps, and Resources

Strategy	Action Steps	Resources
1. Assess the language needs of patients and family members.	a. Assess the non-English languages most spoken in your community. b. Use language assessment information to ensure resources for languages spoken in the community are provided. c. Complete an organizational assessment specific to language assistance services to examine the use of existing language assistance services and to determine capacity for effectiveness.	○ Language Spoken at Home ○ CMS Top 15 Non-English Languages by State ○ Guide to Developing a Language Access Plan- Needs Assessment ○ Organizational Self-Assessment Worksheet
2. Ensure that staff are fully aware of, and trained in, the use of language assistance services, policies, and procedures.	a. Conduct regular and refresher trainings to review available language services. b. Partner with organizations and community members to ensure training incorporates aspects of cultural humility.	○ The Guide to Providing Effective Communication and Language Assistance Services ○ Tips On Building an Effective Staff Language Service Program ○ Effective Communication for Healthcare Teams ○ Guidelines for Use of Medical Interpreter Services

Strategy	Action Steps	Resources
		○ Guide to Developing a Language Access Plan- Training
3. Develop strategies for identifying the language(s) an individual speaks and add this information to the person's health record.	a. Use the standardized procedure and script for staff to inform about language assistance services. b. Use "I speak" cards. c. Add a policy requiring that the patient's preferred language is highlighted in the health record.	○ United States Department of Agriculture (USDA) "I Speak" Statements ○ Example of a Policy and Procedure for Providing Meaningful Communication with Persons with Limited English Proficiency
4. Use qualified and trained interpreters to facilitate communication, including ensuring the quality of the language skills of self-reported bilingual staff who use their non-English language skills during patient encounters.	a. Use assessment from Standard 5 action step 1a to determine organizational capabilities, including the capacity to provide free language interpretation. b. Recruit and hire qualified bilingual providers/ practitioners.	○ Language Access Assessment and Planning Tool for Federally Conducted and Federally Assisted Programs
5. Ensure that communication with community members is appropriate to various linguistic characteristics, including primary language, literacy skills, and disability status.	a. Obtain patient and family feedback about linguistic services using PSMEs and patient representatives. b. Ensure intake forms collect information about specific patient needs. c. Use patient intake files and information to tailor all touchpoints to patients' needs.	○ Working effectively with an interpreter ○ Equitable Language Guide ○ Improving Communication – Improving Care: How health care organizations can ensure effective, person-centered communication with people from diverse populations

Strategy	Action Steps	Resources
6. Support community members' access to language services.	a. Make patients aware of their right to access federally required interpreters. b. Plan and implement interpretation services that are low-cost or no-cost. c. Post signs in known patient-spoken languages to inform patients that language assistance services are available. d. Establish contracts with interpreter services for in-person, over-the-phone, and video interpreting.	○ Address Language Differences ○ Working with Linguistically Diverse Populations

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

Purpose

1. To inform individuals with limited English proficiency (LEP), in their preferred language, that language services are readily available at no cost to them
2. To facilitate access to language services
3. To help organizations comply with the requirements of such laws as Title VI of the Civil Rights Act of 1964, the ADA of 1990, and other relevant federal, state, and local requirements

CLAS Standard 6 Implementation Strategies, Action Steps, and Resources

Strategy	Action Steps	Resources
1. Place written language service notifications, which are easy to understand at low literacy levels, on the registration desks, in the waiting rooms, and in exam rooms.	a. Consult with PSMEs, patient advocates, and staff to ensure that information is straightforward. b. Ensure information is easy to understand for those who speak different languages.	o Language Assistance Tagline Translations
2. Standardize procedures for personnel who serve as initial points of contact to patients.	a. Provide staff with a script to ensure that they inform clients and family members of the availability of language aid in both a verbal and a written manner. b. Ensure all written intake forms clearly state that the organization provides communication and language assistance and whether it is free for individuals. c. Develop and use a patient survey tool (oral or written) that identifies the patient's language preferences and type of language services needed. d. Include language information in the patient's medical files.	o Personal Health Literacy Measurement Tools: Rapid Estimate of Adult Literacy in Medicine—Short Form (REALM-SF) o Cultural Competence: It Starts at the Front Desk o Notice of Communication and Language Assistance Services Worksheet
3. Develop organization policies for cross-communication exchange and interpreter services.	a. Provide "I speak" cards written in multiple languages for patients to indicate their preferred language to personnel upon arrival.	o USDA "I Speak" Statements

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.

Purpose

1. To provide accurate and effective communication between individuals and providers
2. To reduce misunderstanding, dissatisfaction, omission of vital information, misdiagnoses, inappropriate treatment, and patient safety issues caused by reliance on staff or individuals lacking interpreter training
3. To empower individuals to negotiate and advocate for important services on their own behalf through effective and accurate communication with health and healthcare staff
4. To help organizations comply with the requirements of such laws as Title VI of the Civil Rights Act of 1964, the ADA of 1990, and other relevant federal, state, and local requirements

CLAS Standard 7 Implementation Strategies, Action Steps, and Resources

Strategy	Action Steps	Resources
1. Establish policies that recognize interpreting in a medical situation is a specialized skill even for experienced healthcare interpreters.	a. Encourage interpreters and staff to obtain medical interpreter certifications tailored to the ESRD population. b. Ensure that all staff know that there are standards for interpreters. c. Partner with certifying agencies for healthcare interpreters for language assistance training.	o National Certification for Healthcare Interpreters o Qualified Interpreting for Quality Health Care: A Training Video for Clinical Staff on How to Work with Interpreters (video) o Interpreter Qualification Checklist
2. Develop a process for ensuring the availability of qualified individuals who can provide language assistance services based on the language, hearing, and visual needs of patients in the service area.	a. Ensure language assistance services are provided by individuals who meet established standards. b. Ensure the staff who wish to communicate in a language other than English are trained and certified. c. Partner with the foreign language, public health education, and communication departments of local colleges and universities to identify and recruit faculty members and/or advanced/graduate students who can be or are trained to serve as certified medical interpreters and translators.	o TeamSTEPPS Video: Limited English Proficiency Safety: Video Example (video) o Providing Language Services to Diverse Populations: Lessons from The Field

Strategy	Action Steps	Resources
3. Develop and administer a survey questionnaire that rates the effectiveness of the interpreter services your dialysis facility offers.	a. Collaborate with patients and staff to create the interpreter services questionnaire. b. Use best practice examples to help with survey development. c. Create a policy that requires the survey be administered after use of an interpreter.	o Consumer Assessment of Healthcare Providers and Systems (CAHPS) Interpreter Services Survey o Interpreter Guidelines
4. Employ a multifaceted model of language assistance.	a. Provide language assistance in a variety of models, including bilingual staff, dedicated language assistance services (e.g., a contract interpreter), or through telephone and digital technology. b. Collaborate with patients to ensure language assistance services are appropriate to patient needs. c. Engage community members to do translation, including dialects used in the community. Create and sustain community partnerships to meet diverse cultural and linguistic needs.	o Guide to Developing a Language Access Plan o FAQs-Translators and Interpreters o ADA Requirements: Effective Communication o Using Culturally and Linguistically Appropriate Services to Improve Delivery of Care
5. Hire qualified translators to translate all materials into the languages used in the area.	a. Ensure translators are trained in languages needed in the community. b. Ensure that the provider uses translator services that meet the needs of patients in the facility.	o Language Spoken at Home

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

Purpose

1. To ensure that readers of other languages and individuals of various health literacy levels are able to access care and services
2. To provide access to health-related information and facilitate comprehension of and adherence to instructions and health plan requirements
3. To enable all individuals to make informed decisions regarding their health, healthcare, and service options
4. To offer an effective way to communicate with large numbers of people and supplement information provided orally by staff members
5. To help organizations comply with requirements such as Title VI of the Civil Rights Act of 1964, the ADA of 1990, and other relevant federal, state, and local requirements

CLAS Standard 8 Implementation Strategies, Action Steps, and Resources

Strategy	Action Steps	Resources
1. Conduct ongoing needs assessments of the cultural and linguistic appropriateness of the communication and language assistance.	a. Update needs assessment yearly. b. Ensure that plain language guidelines are followed. c. Consult with interpreters and other language specialists to ensure translated materials are clear.	o Patient Education Materials Assessment Tool o Centers for Disease Control and Prevention (CDC) Clear Communication Index o Federal Plain Language Guidelines
2. Develop protocols to evaluate whether print and multimedia materials and signage use easy-to-understand language and are responsive to the populations served.	a. Develop and administer patient and staff surveys to assess the literacy levels of educational materials and the variety/quality of translated languages used in educational materials. b. Use PSMEs and patient advocates to help assess and give feedback about educational materials.	o Accessible Digital Content: Tips and Tricks o Peer Mentoring Resources o Tips for Developing Health Literate Patient Materials
3. Develop protocols to establish a standard for the availability of copies of important documents in languages other than English.	a. Include provisions for sight translation so that an interpreter explains an English form to a patient on the spot. b. Conduct ongoing assessments of staff and personnel of the understanding and availability of patients' educational materials and the cultural and linguistic appropriateness of signs and maps.	o Sight Translation and Written Translation Guidelines for Healthcare Interpreters

Strategy	Action Steps	Resources
4. Promote translated print and multimedia materials and language assistance signage to all patients and families and supplement written information with oral translation by trained staff members when needed.	a. Use signs throughout the facility advertising language services. b. Ensure during the first patient touchpoint that patients receive appropriate language assistance as needed.	o Interpretive Services Poster

ESRD NCC NATIONAL COORDINATING CENTER

Improving Communication and Standardizing Protocols for Patient Safety

1 A non-Hispanic Asian female who uses a wheelchair and has limited English proficiency (LEP) is waiting alone in the facility waiting room after evening treatment.

What could have been done differently? *Having a policy to ensure that LEP patients and patients with disabilities receive assistance from a staff member with transportation could better address patient needs.*

2 The patient was missing when the correct transportation arrived.

What could have been done differently? *LEP patients and patients with disabilities using transportation services should be provided with cards or another printed resource to confirm their identity and destination. Improving communication with the transportation company and implementing additional safety protocols are essential steps to prevent potential issues.*

3 The patient's caregiver was not notified when the patient went missing for over two hours.

What could have been done differently? *Staff should provide regular updates about the incident to both the patient's caregiver and all staff members engaged in the patient's care. This practice is important for fostering a culture of transparency and accountability.*

4 The patient was returned to the facility after being taken to the wrong destination.

What could have been done differently? *Training and education should be prioritized for the staff to better understand transportation policies and the needs of LEP patients and patients with disabilities. Regularly reviewing the quality of transportation services is also crucial to ensure patient safety.*

Continuous improvement should be focused on incorporating a feedback loop between transportation services, patients, and caregivers to establish preventive measures and ensure the safety and well-being of patients during transportation.

Discussion Questions

1. When patients have a need for accommodation, what are the roles and responsibilities of each person on the team? What does it mean that everyone has ownership of each patient's quality of care?
2. What communication practices and policies are in place at our facility to ensure that families and care partners are informed about any transportation issues? What strategies could our facility use to help patients with transportation needs to ensure their safety?
3. What modes of communication with transportation companies and drivers are available and effective? How can we ensure the driver understands patients' needs? How might this process be sustainable?

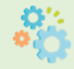
Theme 3: Engagement, Continuous Improvement, and Accountability:

Case Study: Addressing Facility-level Barriers to Care

Background

Mr. Garcia, a Hispanic White male in his 30s, found himself without dialysis care when staff requested that he not return to a dialysis center as a transient patient. The disagreement arose from staff concerns about his behavior, including loud talking and playing music, which escalated to involve the police. According to accounts from the staff, Mr. Garcia was perceived as aggressive, making finger-pointing gestures at staff members. The patient believed that his native dialect played a role in his removal. The culmination of these issues led the facility to request that Mr. Garcia no longer return as a transient patient.

Key Challenges



- **Communication Style and Cultural Differences:** Staff perceived Mr. Garcia's communication style, including his native dialect, as disruptive and aggressive. Mr. Garcia, on the other hand, believed that his removal was due to bias against his native language.
- **Need for Staff Training:** Staff needed to be appropriately trained to work with transient patients, such as getting information in advance to include gathering information on the patient's preferred language and cultural background. The staff did not communicate with the patient's home facility or use interpreter services, nor were any materials in other languages available to help communicate with the patient.
- **Implicit Bias and Discrimination:** Due to a lack of cross-cultural awareness, staff reported feeling threatened by Mr. Garcia's behavior, including his finger-pointing gestures, leading to concerns about safety in the facility.
- **Involvement of Law Enforcement:** The situation escalated, and law enforcement was called to intervene, intensifying the conflict.

Resolution Process

- **Immediate Communication:** Facility management engaged in immediate communication with Mr. Garcia to understand his perspective and address his concerns about the reasons for his removal.
- **Staff Debriefing:** Staff involved in the incident underwent a debriefing session to share their perspectives and ensure a comprehensive understanding of the events leading to the request for Mr. Garcia not to return.
- **External Mediation:** An external mediator was brought in to facilitate a dialogue between Mr. Garcia and the facility staff, aiming to address miscommunications and cultural differences.
- **Police Involvement Review:** Facility management conducted a review of law enforcement involvement to assess the appropriateness of its intervention and explore alternatives for future incidents.

- **Policy Review and Training:** The dialysis facility conducted a review of its policies and procedures for handling disruptive behavior, aiming to ensure a fair and culturally sensitive approach in the future. The facility also provided training and added additional policies about reviewing transient patient medical records (e.g., demographics, preferred languages) and any additional needs by contacting the patient's home facility, as well as communicating with the patient about the facility's rules and expectations prior to the transient patient arriving.

Outcomes

- **Improved Understanding:** Through open communication and external mediation, there was an improved understanding between Mr. Garcia and the facility staff regarding the factors that led to the incident.
- **Improved Training Structures:** Based on the lack of understanding from the staff, policies were put in place to ensure staff received cultural competency training with regular training evaluations to improve how staff members collaborate with patients of varying cultures, languages, and dialects.
- **Improved Transient Patient Care:** With the addition of training and policies related to caring for transient patients, staff established a comprehensive preparation process to meet the needs of transient patients and ensure equitable care for all transient patients.

Conclusion

This case highlights the importance of cultural sensitivity and effective communication in healthcare settings. By addressing miscommunications, cultural differences, and seeking alternative solutions, the facility aimed to create a more inclusive environment for patients with diverse backgrounds. The incident served as a pathway for policy review and improvement, emphasizing the ongoing commitment to person-centered care.

Discussion Questions

1. How can proactive measures such as reviewing transient patient information and communicating expectations in advance help prevent conflicts from occurring? What protocols should be in place to ensure that proper communication between transient patients and staff occurs?
2. How is acknowledging linguistic diversity important in developing person-centered care? What strategies or resources exist that could ensure effective communication with patients who speak different languages or dialects? What could be done to better prepare for the patient's arrival?
3. What does a facility consider a threat versus disrespect? How should staff handle these situations? Are there resources or tools (e.g., communication techniques) to help staff who may feel uncomfortable about a patient's actions? How could we apply those tools?

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

Purpose

1. To make CLAS central to the organization's service, administrative, and supportive functions
2. To integrate CLAS throughout the organization (including the mission) and highlight its importance through specific goals
3. To link CLAS to other organizational activities, including policy, procedures, and decision making related to outcomes accountability

CLAS Standard 9 Implementation Strategies, Action Steps, and Resources

Strategy	Action Steps	Resources
1. Engage the support of governance and leadership and encourage the allocation of resources to support the development, implementation, and maintenance of culturally and linguistically appropriate services.	a. Ensure that cultural and religious beliefs, emotional needs, desires and motivations to learn, physical or cognitive limitations, or barriers to communication are considered. b. Use best practices or examples on collecting demographic and holistic health needs.	○ The Accountable Health Communities Health-Related Social Needs Screening Tool ○ Race, Ethnicity and Language Patient Demographic Data Collection Resources ○ Upstream Risks Screening Tool & Guide ○ Protocol for Responding to and Assessing Patient Assets, Risks, and Experiences ○ American Academy of family Physicians (AAFP) Social Needs Screening Tool ○ Scripting Examples for Social Drivers of Health Screening ○ Sexual Orientation and Gender Identity (SOGI) Data Action Plan ○ Trauma-Informed Care ○ Identification of Health-Related Social Needs
2. Encourage governance and leadership to establish education and training requirements relating to CLAS for all individuals in the organization, including executives	a. Consult with and survey staff about cultural competency training needs. b. Use data from staff evaluations to determine training priorities. c. Hold organizational retreats to identify goals, objectives, and timelines to provide CLAS services.	○ Training Needs Assessment – Planning and Evaluation

Strategy	Action Steps	Resources
and management team.		
3. Identify champions within and outside the organization to advocate for CLAS, emphasize the rationale for CLAS, and encourage full-scale implementation.	a. Identify individuals within the organization who already demonstrate a strong commitment to cultural diversity and inclusivity. b. Look for external partners or professionals who have expertise in CLAS and are recognized advocates in the field. c. Provide comprehensive training and information about CLAS to the identified champions.	o Just Culture Champion Role o Selecting a Health Equity Champion
4. Establish accountability mechanisms throughout the organization.	a. Use staff evaluations, individuals' satisfaction measures, and quality improvement measures to ensure CLAS standards are met. b. Regularly update community needs assessment and demographic data to guide CLAS implementation.	o Guide to Developing A Language Access Plan-Evaluation o PLACES: Local Data for Better Health
5. Involve the populations in the service area in the implementation of CLAS through the strategic plan.	a. Collaborate with patient advocates and staff regularly to assess gaps in implementing CLAS standards.	o Engaging People Most Affected by the Problem

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

Purpose

1. To assess performance and monitor progress in implementing the National CLAS Standards
2. To obtain information about the organization and the people it serves to tailor and improve services
3. To assess the value of CLAS-related activities relative to the fulfillment of governance, leadership, and workforce responsibilities

CLAS Standard 10 Implementation Strategies, Action Steps, and Resources

Strategy	Action Steps	Resources
1. Conduct an organizational assessment or a cultural audit using cultural and linguistic competency assessment tools to catalog policies, procedures, and practices.	a. Use the information from the assessment or audit to determine whether the core structures and processes necessary for providing CLAS are in place. b. Use assessment findings to pinpoint strengths, weaknesses, and opportunities to enhance cultural and linguistic competence in care.	○ CLAS Self-Assessment Tool ○ ESRD CLAS Facility Self-Assessment Example
2. Collect feedback about CLAS implementation in a variety of ways.	a. Provide individuals with CLAS-oriented feedback forms and include self-addressed, stamped envelopes to improve receipt of feedback. b. Conduct focus groups to monitor the progress of and identify barriers in implementing CLAS. c. Add CLAS-related questions to staff orientation materials and yearly reviews.	○ Identifying Barriers and Enablers Worksheet
3. Assess the standard of care to determine whether services are uniformly provided across cultural groups.	a. Use guidelines from government health agencies and medical associations to set criteria to assess the standard of care. b. Use treatment plans and outcomes to gather necessary data. c. Analyze patient outcomes across groups to identify health disparities. d. Engage with patients through interviews and surveys to	○ Dialysis Safety: Guidelines, Recommendations and Resources ○ CAHPS® Patient Experience Surveys and Guidance

Strategy	Action Steps	Resources
	understand patient experiences from different groups.	
4. Identify outcome goals regarding cultural and linguistic competency, including metrics, and assess at regular intervals.	a. Develop a system of reviewing and incorporating feedback and suggestions received.	○ Engaging Primary Care Practices in Quality Improvement Strategies for Practice Facilitators

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.

Purpose

1. To accurately identify population groups within a service area
2. To monitor individual needs, access, utilization, quality of care, and outcome patterns
3. To ensure equitable allocation of organizational resources
4. To improve service planning to enhance access and coordination of care
5. To assess and improve to what extent healthcare services are provided equitably

CLAS Standard 11 Implementation Strategies, Action Steps, and Resources

Strategy	Action Steps	Resources
1. Develop protocols to streamline data collection processes.	a. Familiarize staff with HHS Data Collection Standards. b. Identify the specific data elements required. c. Clearly outline the data collection plan, including the data elements to be collected, data sources, collection methods, and frequency of collection. d. Provide training on the new data collection protocols and instruments to staff.	○ HHS Implementation Guidance on Data Collection Standards for Race, Ethnicity, Sex, Primary Language, and Disability Status ○ Data Collection Worksheet ○ REAL Data Collection Script and Definition ○ Collecting and Validating Race, Ethnicity, and Language (REaL) Data (video)
2. Develop and use comprehensive data collection tools.	a. Work with community members to identify the racial, ethnic, gender, language, sexual orientation, gender identity, and disability status categories most relevant to the community. b. Develop a process that can facilitate client self-identification versus staff observation and visual determinations.	○ Inventory of Resources for Standardized Demographic and Language Data Collection
3. Regularly validate and evaluate data collection tools.	a. Use demographic data with clinical and quality care data for evaluation and continuous quality improvement activities. b. Use a validated and reliable self-assessment tool to inform continuous quality improvement in implementing CLAS Standards.	○ Collecting the Data: The Nuts and Bolts

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.

Purpose

1. To determine the service assets and needs of the populations in service areas (needs assessment)
2. To identify all services available and unavailable to populations in the service areas (resource inventory and gap analysis)
3. To determine which services to provide and how to implement them, based on the results of the community assessment
4. To ensure that health and healthcare organizations obtain demographic, cultural, linguistic, and epidemiological baseline data (quantitative and qualitative), and update the data regularly to better understand the populations in their service areas

CLAS Standard 12 Implementation Strategies, Action Steps, and Resources

Strategy	Action Steps	Resources
1. Establish a coalition that includes representatives of the community to help identify community needs.	a. Conduct a community needs assessment. b. Invite cultural leaders to guide the coalition and provide inclusive program planning that addresses the community needs.	○ Creating and Maintaining Coalitions and Partnerships
2. Analyze data from the needs assessment and information from the coalition to inform culturally appropriate services that meet the unique needs of the community's diverse population.	a. Collaborate with a local university or other community partner to analyze assessment data, disaggregated by race, ethnicity, gender, language, sexual orientation, gender identity, and disability status. b. Identify disparities or disproportionalities from the disaggregated data through a community participatory effort.	○ Race and Ethnicity Data Improvement Toolkit

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

Purpose

1. To provide responsive and appropriate service delivery to a community
2. To ensure that services are informed and guided by community interests, expertise, and needs
3. To increase the use of services by engaging individuals and community-based groups in designing and improving services to meet their needs and desires
4. To create an organizational culture that leads to more responsive, efficient, and effective services and accountability to the community
5. To empower members of the community to become active participants in the health and healthcare process

CLAS Standard 13 Implementation Strategies, Action Steps, and Resources

Strategy	Action Steps	Resources
1. Involve the community in identifying, planning, designing, implementing, and evaluating culturally and linguistically appropriate programs.	a. Gather community input through tailored outreach, especially from historically underrepresented groups.	o Partnering with Residents Worksheet o Community Engagement and Partnerships Improve Access to Medical Homes
2. Evaluate existing organizational policies that affect practices to determine whether they are producing the intended outcome.	a. Assess areas that lack organizational policies and, with partners, develop new policies and work to enact them if the existing ones are ineffective.	o Cultural and Linguistic Competence Policy Assessment o A Guide for Using the Cultural and Linguistic Competence Policy Assessment Instrument
3. Identify "cultural brokers" who are known and trusted members of the community to serve as a bridge between the community where they are trusted and the facility that provides services.	a. Seek out community health workers to engage with the community. b. Adapt community engagement strategies to local context.	o Bridging the Cultural Divide in Health Care Settings: The Essential Role of Cultural Broker Programs

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

Purpose

1. To facilitate open and transparent two-way communication and feedback mechanisms between individuals and organizations
2. To anticipate, identify, and respond to cross-cultural needs
3. To meet federal and/or state-level regulations that address topics such as grievance procedures, use of ombudspersons, and discrimination policies and procedures

CLAS Standard 14 Implementation Strategies, Action Steps, and Resources

Strategy	Action Steps	Resources
1. Provide cross-cultural communication training, including how to work with an interpreter, and conflict resolution training to staff who handle conflicts, complaints, and feedback.	a. Survey staff and use feedback to determine training needs. b. Use training modules to help improve cross-cultural communication and conflict resolution. c. Include real-life scenarios and case studies in the training modules.	○ Guide to Providing Effective Communication and Language Assistance Services
2. Provide notice in signage, translated materials, and other media about the right of each individual to provide feedback, including the right to file a complaint or grievance.	a. Place signage in high traffic areas such as waiting rooms and front desk areas.	○ IPRO example - Grievance Process Guide
3. Develop a clear process to address grievances that includes follow-up and ensures that the individual is contacted with a resolution and next steps.	a. Hire patient advocates. b. Obtain feedback via focus groups and other community events. c. Review conflict and grievance resolution processes to ensure their cultural and linguistic appropriateness as part of the organization's overall quality assurance program.	○ ESRD Complaints and Grievances

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

Purpose

1. To convey information to intended audiences about efforts and accomplishments in meeting the National CLAS Standards
2. To learn from other organizations about new ideas and successful approaches to implementing the National CLAS Standards
3. To build and sustain communication on CLAS priorities and foster trust between the community and the service setting
4. To meet community benefit and other reporting requirements, including accountability for meeting healthcare objectives for addressing the needs of diverse individuals or groups

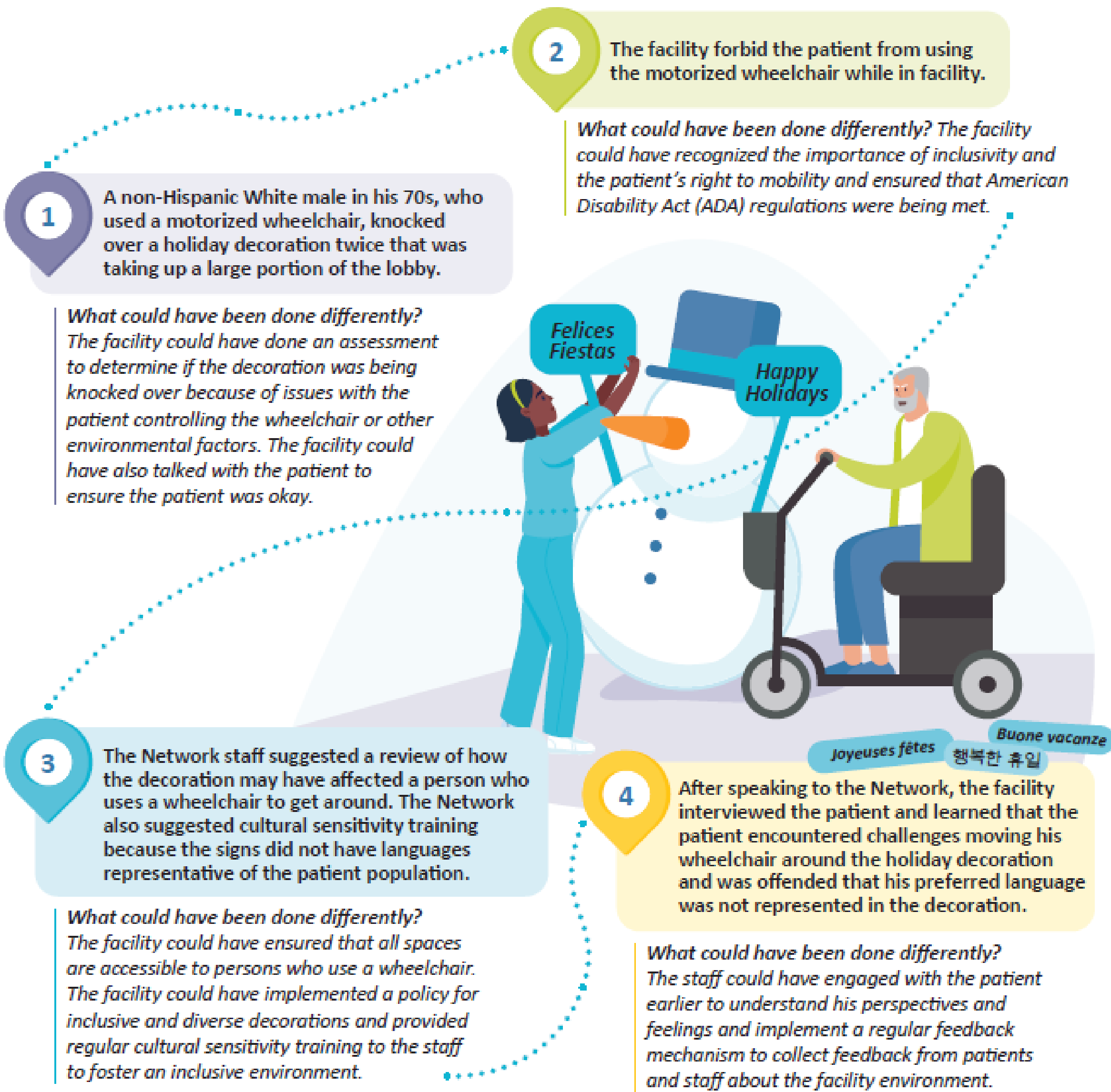
CLAS Standard 15 Implementation Strategies, Action Steps, and Resources

Strategy	Action Steps	Resources
1. Establish a CLAS advisory board with representatives from partner organizations and key community-based offices with representatives from underserved populations.	a. Use the CLAS advisory board to discuss issues affecting the diverse communities and address identified disparities. b. Consider partnering with hospitals and rural health clinics.	o Building an Effective Advisory Committee o Supporting and Co-Creating Meaningful Community Advisory Boards
2. Develop and distribute data factsheets containing current community data to all advisory board members.	a. Compile current community data, disaggregated by underserved demographic groups. b. Create informative data factsheets. c. Distribute the factsheets to all advisory board members before each meeting for review.	o The Racial Equity in Data Visualization Checklist o Diversity, Equity, And Inclusion in Data Visualization: General Recommendations
3. Provide updates that summarize agency-level efforts to provide CLAS in the community.	a. Design updates in appropriate languages that are easy to understand. b. Include demographic data on subpopulations, summaries of related staff competency trainings, results from the community needs assessment, and a summary of issues and complaints from patients.	o Dissemination email template in Appendix o Engaging Stakeholders in a Care Management Program

Strategy	Action Steps	Resources
	c. Distribute updates through agency and community-based organization listservs. d. Post updates on agency websites for public access.	
4. Host community forums that are open to the public to review progress and needs related to CLAS.	a. Establish forums to offer written materials addressing CLAS-related ESRD issues to service providers, patients, and families representative of the service areas. b. Arrange to have forums broadcast online, on local television, or through a similar venue to reach community members who are unable to attend in-person.	o Conducting Public Forums and Listening Sessions

Navigating Cultural Sensitivity and Accessibility in Facility Environments to Promote Inclusivity

ESRD NCC NATIONAL COORDINATING CENTER



Continuous engagement with patients to collect feedback about the facility's inclusivity should be incorporated into regular staff activities. Additionally, leadership should support policies and training that help foster cultural sensitivity within the facility.

Discussion Questions

1. How can patients' needs be considered when deciding on decorations at our facility? How can we ensure that patients with different mobility needs do not encounter roadblocks and can maneuver comfortably and safely after decorations are in place? How well do team members understand the ADA?
2. How can facilities and teams create open and trusting lines of communication with patients to learn any concerns or issues that patients may be facing?
3. What traditions and holidays are celebrated at our facility? How can we represent the cultural celebrations of the patient and staff population in an inclusive and safe manner that is respectful of all diverse backgrounds?

Additional Resources

1. Getting Started with CLAS
    a. The CLAS Booklet
    b. A Practical Guide to Implement the National CLAS Standards
    c. Introduction to CLAS
    d. Health Equity Quickinar Series
2. Cost
    a. Return on Investment Calculator Tool
    b. Translation and Interpretation Services Medicaid Reimbursement
3. Training
    a. How to Better Understand Different Social Identities
    b. Combating Implicit Bias and Stereotypes
    c. ESRD NCC Structural Competency Training
    d. What is Systematic Racism Video Trainings
    e. The Groundwater Approach: Building a Practical Understanding of Structural Racism
    f. Racial Equity Institute Public Trainings
4. Organizational Resistance
    a. Creating a Business Case for CLAS Worksheet
    b. Identifying Barriers and Enablers Worksheet
    c. The Case for CLAS
5. Finding Patient Resources
    a. Neighborhood Navigator

Appendix

Dissemination Email Template

Dear [Recipient's Name],

I hope this message finds you well. We are excited to share with you the progress and efforts our dialysis facility has made in ensuring culturally and linguistically appropriate services (CLAS) for our community. Over the past [insert time frame], our team has been dedicated to fostering an inclusive environment that caters to the unique needs of our diverse patient population. As part of our commitment to CLAS, here are some of the initiatives and achievements we are proud to highlight [Example topics listed below]:

Cultural competency training: [Describe training initiatives]

Patient education materials: [Describe materials (ex. Topics covered, languages used, number created, etc.)]

Language access services: [Describe interpreter services offered, multilingual staff available, etc.]

Community outreach programs: [local community partnerships, community events, community initiatives]

Feedback mechanism: [Describe how patient feedback is collected on services offered, experience, etc.]

We are dedicated to maintaining and expanding our commitment to CLAS. We would love to hear your thoughts and suggestions on how we can further improve our services to meet the unique needs of our community.

Thank you for your ongoing support, and we look forward to continuing to serve our community.

Sincerely,

Glossary

1. ***ESRD National Coordinating Center:*** A central organization that coordinates emergency preparedness and response services; convenes patient engagement meetings; develops and distributes technical materials to members of the ESRD community; collects and analyzes reporting data for use by the ESRD Networks and CMS; and provides support for the ESRD Network clinical goals.

2. ***ESRD Network Program:*** Comprised of 18 ESRD Networks that form the local infrastructure for achieving national goals that result in measurable improvement in the care and services provided to Medicare ESRD beneficiaries and their families.

3. ***Health equity:*** Attainment of the highest level of health for all people, where everyone has a fair and just opportunity to attain their optimal health regardless of race, ethnicity, disability, sexual orientation, gender identity, socioeconomic status, geography, preferred language, or other factors that affect access to care and health outcomes.

4. ***Health inequities:*** Differences in health status that are avoidable, unfair, and unjust and make some population groups more likely to have poorer health outcomes than others.

5. ***Social drivers of health:*** Circumstances in which people are born, grow up, live, work, and age and the systems put in place to deal with illness.

6. ***Health-related social needs (HRSN):*** The nonmedical, social, or economic circumstances of individuals that hinder their ability to stay healthy and/or recover from illness. Unmet HRSNs, such as food insecurity or inadequate or unstable housing, may increase the risk of developing chronic conditions, reduce an individual's ability to manage these conditions, increase healthcare costs, and lead to avoidable healthcare utilization.

7. ***Implicit bias:*** Also referred to as cognitive bias, unconscious bias, or hidden bias, this consists of the attitudes and stereotypes that people unknowingly hold.

8. ***Limited English proficiency (LEP):*** A limited ability to read, speak, write, or understand English. Individuals who do not speak English as their primary language can be limited-English proficient, or "LEP."[16]

9. ***Plain language:*** Communication that your audience can understand the first time they read or hear it. Knowing the intended audience is important; language that is plain to one set of readers may not be plain to others. Written material is in plain language if your audience can find what they need; understand what they find; and use what they find to meet their needs.[17]

10. ***Organizational self-assessment***: Identifies the communication and language service needs of the individuals receiving care and services from your organization and evaluates your staff's communication skills and your organization's language assistance resources. An organizational self-assessment gives your organization the information it needs to understand its capacity for

offering effective communication that addresses the needs of individuals accessing your organization's services.[18]

11. ***Structural barriers*:** Obstacles that collectively affect a group disproportionately and perpetuate or maintain stark disparities in health outcomes. They include but are not limited to policies, practices, and other norms that favor an advantaged group while systematically disadvantaging a marginalized group.
12. ***Structural racism***: The normalization and legitimization of an array of dynamics—historical, cultural, institutional, and interpersonal—that routinely advantage White people while producing cumulative and chronic adverse outcomes for people of color. Systemic racism can manifest in multiple forms and at various levels, including individual, interpersonal, institutional, and structural levels. Structural racism continues to influence disparities at all stages of kidney care, including transplantation.
13. ***Cultural humility:*** This refers to a lifelong process of self-reflection and self-critique whereby the individual not only learns about another's culture but starts with an examination of her/his own beliefs and cultural identities.
14. ***Community needs assessment:*** Collects information that provides a complete picture of a community's needs and existing resources. The assessment helps to identify and prioritize a community's areas of need, which helps avoid investing valuable resources into services that may be unnecessary or are not a good fit for a community.[19]
15. ***Patient subject matter experts (PSMEs):*** PSMEs are committed and informed patients, family members, caregivers, and professionals who are representative of the demographic characteristics of the Network's service area. PSMEs help spread best practices and design and implement quality improvement activities.

CMS Health Equity–Related ESRD Quality Measures

Facility Commitment to Health Equity Reporting Measure (Beginning Payment Year [PY] 2026)

This structural measure assesses facility commitment to health equity using a suite of equity-focused organizational competencies aimed at achieving health equity for everyone. This includes racial and ethnic minority groups; people with disabilities; members of the lesbian, gay, bisexual, transgender, and queer (LGBTQ+) community; individuals with limited English proficiency; rural populations; religious minorities; and people living near or below poverty level. Facilities will receive two points each for attesting to five different domains of commitment to advancing health equity for a total of 10 points.

Screening for Social Drivers of Health Reporting Measure (Beginning PY 2027)

The Screening for Social Drivers of Health measure assesses the percentage of patients, ages 18 years and older, screened for health-related social needs (HRSNs). This specifically includes food insecurity, housing instability, transportation needs, utility difficulties, and interpersonal safety during established care in dialysis facilities.

Screen Positive Rate for Social Drivers of Health Reporting Measure (Beginning PY 2027)

The Screen Positive Rate for Social Drivers of Health is a health equity measure that provides information on the percentage of patients who were screened for all five HRSNs, and who screen positive for one or more of five HRSNs. Specifically, the HRSNs may include food insecurity, housing instability, transportation needs, utility difficulties, or interpersonal safety. For the ESRD Qualitive Incentive Program (QIP), facilities will receive credit for reporting “Yes” or “No” (non-missing) responses.

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References

1. Centers for Medicare & Medicaid Services (CMS). A Practical Guide to Implementing the National CLAS Standards. 2016. Available at: https://www.cms.gov/About-CMS/Agency-Information/OMH/Downloads/CLAS-Toolkit-12-7-16.pdf. Accessed on: September 21, 2023.
2. United States Renal Data System (USRDS). 2023 USRDS Annual Data Report: Epidemiology of kidney disease in the United States. 2023. Available at: https://adr.usrds.org/2023. Accessed on: April 18, 2024.
3. CMS. Chronic Kidney Disease Disparities: Educational Guide for Primary Care. 2021. Available at: https://www.cms.gov/files/document/chronic-kidney-disease-disparities-educational-guide-primary-care.pdf. Accessed on: September 21, 2023.
4. Taylor DM, Fraser SDS, Bradley JA, et al. A systematic review of the prevalence and associations of limited health literacy in CKD. *Clin J Am Soc Nephrol.* 2017; 12(7): 1070–1084.
5. Taylor DM, Fraser S, Dudley C, et al. Health literacy and patient outcomes in chronic kidney disease: A systematic review. *Nephrol Dial Transplant*. 2018; 33(9): 1545–1558.
6. Green JA, Mor MK, Shields AM, et al. Associations of health literacy with dialysis adherence and health resource utilization in patients receiving maintenance hemodialysis. *Am J Kidney Dis.* 2013; 62(1): 73–80.
7. Cervantes L, Rizzolo K, Carr AL, et al. Social and cultural challenges in caring for Latinx individuals with kidney failure in urban settings. *JAMA Netw Open.* 2021; 4(9): e2125838.
8. Davis JA, Whitman MV. Organizational characteristics associated with cultural and linguistic service provision within Alabama hospitals. *Health Care Manag*. 2008; 27(1): 79–88.
9. Barksdale CL, Rodick WH 3rd, Hopson R, et al. Literature review of the National CLAS Standards: Policy and practical implications in reducing health disparities. *J Racial Ethn Health Disparities*. 2017; 4(4): 632–647.
10. Office of Minority Health (OMB). HHS. Awareness, Knowledge, Adoption, and Implementation of the National CLAS Standards in Health and Health Care Organizations Evaluation Project. Available at: https://thinkculturalhealth.hhs.gov/assets/pdfs/clas-ncs-evaluation-project.pdf. Accessed on: September 25, 2023.
11. Ogbolu Y, Scrandis DA, Fitzpatrick G. Barriers and facilitators of care for diverse patients: Nurse leader perspectives and nurse manager implications. *J Nurs Manag*. 2018; 26(1): 3–10.
12. Parker M, Fang X, Bradlyn A. Costs and effectiveness of a culturally tailored communication training program to increase cultural competence among multi-disciplinary care management teams. *BMC Health Serv Res*. 2020; 20(1): 784.
13. Office of Minority Health. HHS. The National CLAS Standards, Health Literacy, and Communication. Video. Think Cultural Health. Presented by Darci Graves. 2014. Available at: https://thinkculturalhealth.hhs.gov/resources/presentations/8/the-national-clas-standards-health-literacy-and-communication. Accessed on: September 25, 2023.
14. OMH. HHS. National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care: A Blueprint for Advancing and Sustaining CLAS Policy and Practice. 2013. Available at:

https://thinkculturalhealth.hhs.gov/assets/pdfs/EnhancedCLASStandardsBlueprint.pdf. Accessed on: April 18, 2024.

15. OMB. HHS. National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health and Health Care. Available at: https://thinkculturalhealth.hhs.gov/assets/pdfs/EnhancedNationalCLASStandards.pdf. Accessed on: April 18, 2024.
16. Massachusetts Department of Public Health, Office of Health Equity. Making CLAS happen (2013) Glossary and List of Acronyms. 2013. Available at: https://www.mass.gov/doc/appendices-and-glossary/download. Accessed on: April 18, 2024.
17. The Joint Commission. Advancing Effective Communication, Cultural Competence, and Patient- and Family-Centered Care: A Roadmap for Hospitals. 2010. Available at: https://www.jointcommission.org/-/media/tjc/documents/resources/patient-safety-topics/health-equity/aroadmapforhospitalsfinalversion727pdf.pdf. Accessed on: April 18, 2024.
18. OMB. HHS. Guide to Providing Effective Communication and Language Assistance Services. Available at: https://hclsig.thinkculturalhealth.hhs.gov/default.asp. Accessed on: April 18, 2024.
19. CMS. Step 1: Needs Assessment. 2023. Available at: https://www.cms.gov/training-education/partner-outreach-resources/american-indian-alaska-native/ltss-ta-center/planning/step-1-needs-assessment. Accessed on: April 18, 2024.

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