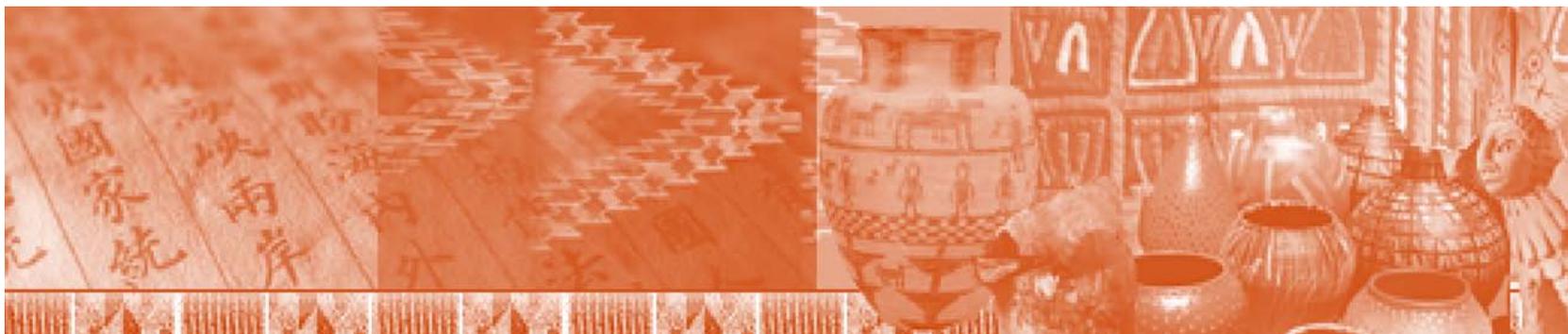




U.S. Department of Health and Human Services, OPHS
Office of Minority Health



National Standards for Culturally and Linguistically Appropriate Services in Health Care

FINAL REPORT

March 2001
Washington, D.C.

**National Standards for Culturally and Linguistically
Appropriate Services
in Health Care**

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**U.S. Department of Health and Human Services
Office of Minority Health**

March 2001

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PROJECT OVERVIEW

As the U.S. population becomes more diverse, medical providers and other people involved in health care delivery are interacting with patients/consumers from many different cultural and linguistic backgrounds. Because culture and language are vital factors in how health care services are delivered and received, it is important that health care organizations and their staff understand and respond with sensitivity to the needs and preferences that culturally and linguistically diverse patients/consumers bring to the health encounter. Providing culturally and linguistically appropriate services (CLAS) to these patients has the potential to improve access to care, quality of care, and, ultimately, health outcomes.

Unfortunately, a lack of comprehensive standards has left organizations and providers with no clear guidance on how to provide CLAS in health care settings. In 1997, the Office of Minority Health (OMH) undertook the development of national standards to provide a much-needed alternative to the current patchwork of independently developed definitions, practices, and requirements concerning CLAS. The Office initiated a project to develop recommended national CLAS standards that would support a more consistent and comprehensive approach to cultural and linguistic competence in health care.

The first stage of the project involved a review and analysis of existing cultural and linguistic competence standards and measures, the development of draft standards, and revisions based on a review by a national advisory committee. The second stage focused on obtaining and incorporating input from organizations, agencies, and individuals that have a vital stake in the establishment of CLAS standards. Publication of standards in the Federal Register on December 15, 1999, announced a 4-month public comment period, which provided three regional meetings and a Web site as well as traditional avenues (mail and fax) for submitting feedback on the CLAS standards. A project team (consisting of staff members of OMH, its contractor, and subcontractor) analyzed public comments from 413 individuals or organizations and proposed revised standards, with accompanying commentaries, to a National Project Advisory Committee (NPAC). Deliberations and additional review by NPAC members informed further refinements of the standards.

In their final version, the CLAS standards reflect input from a broad range of stakeholders, including hospitals, community-based clinics, managed care organizations, home health agencies, and other types of health care organizations; physicians, nurses, and other providers; professional associations; State and Federal agencies and other policymakers; purchasers of health care; accreditation and credentialing agencies; educators; and patient advocates, advocacy groups, and consumers.

The CLAS standards were published in final form in the Federal Register on December 22, 2000, as recommended national standards for adoption or adaptation by stakeholder organizations and agencies. A preamble and the fourteen CLAS standards follow.

National Standards for Culturally and Linguistically Appropriate Services in Health Care

Preamble

The following national standards issued by the U.S. Department of Health and Human Services' (HHS) Office of Minority Health (OMH) respond to the need to ensure that all people entering the health care system receive equitable and effective treatment in a culturally and linguistically appropriate manner. These standards for culturally and linguistically appropriate services (CLAS) are proposed as a means to correct inequities that currently exist in the provision of health services and to make these services more responsive to the individual needs of all patients/consumers. The standards are intended to be inclusive of all cultures and not limited to any particular population group or sets of groups; however, they are especially designed to address the needs of racial, ethnic, and linguistic population groups that experience unequal access to health services. Ultimately, the aim of the standards is to contribute to the elimination of racial and ethnic health disparities and to improve the health of all Americans.

The CLAS standards are primarily directed at health care organizations; however, individual providers are also encouraged to use the standards to make their practices more culturally and linguistically accessible. The principles and activities of culturally and linguistically appropriate services should be integrated throughout an organization and undertaken in partnership with the communities being served.

The 14 standards are organized by themes: Culturally Competent Care (Standards 1-3), Language Access Services (Standards 4-7), and Organizational Supports for Cultural Competence (Standards 8-14). Within this framework, there are three types of standards of varying stringency: mandates, guidelines, and recommendations as follows:

CLAS mandates are current Federal requirements for all recipients of Federal funds (Standards 4, 5, 6, and 7).

CLAS guidelines are activities recommended by OMH for adoption as mandates by Federal, State, and national accrediting agencies (Standards 1, 2, 3, 8, 9, 10, 11, 12, and 13).

CLAS recommendations are suggested by OMH for voluntary adoption by health care organizations (Standard 14).

The standards are also intended for use by:

- Policymakers, to draft consistent and comprehensive laws, regulations, and contract language. This audience would include Federal, State and local legislators, administrative and oversight staff, and program managers.
- Accreditation and credentialing agencies, to assess and compare providers who say they offer culturally competent services and to assure quality for diverse populations. This audience would include the Joint Commission on Accreditation of Healthcare Organizations, the National Committee for Quality Assurance, professional organizations such as the American Medical Association and American Nurses Association, and quality review organizations such as peer review organizations.

- Purchasers, to advocate for the needs of ethnic consumers of health benefits, and leverage responses from insurers and health plans. This audience would include government and employer purchasers of health benefits, including labor unions.
- Patients, to understand their right to receive accessible and appropriate health care services, and to evaluate whether providers can offer them.
- Advocates, to promote quality health care for diverse populations and to assess and monitor care being delivered by providers. The potential audience is wide, including legal services and consumer education/protection agencies; local and national ethnic, immigrant, and other community-focused organizations; and local and national nonprofit organizations that address health care issues.
- Educators, to incorporate cultural and linguistic competence into their curricula and to raise awareness about the impact of culture and language on health care delivery. This audience would include educators from health care professions and training institutions, as well as educators from legal and social services professions.
- The health care community in general, to debate and assess the applicability and adoption of culturally and linguistically appropriate health services into standard health care practice.

The CLAS standards employ key concepts that are defined as follows:

CLAS standards:

The collective set of CLAS mandates, guidelines, and recommendations issued by the HHS Office of Minority Health intended to inform, guide, and facilitate required and recommended practices related to culturally and linguistically appropriate health services.

Culture:

“The thoughts, communications, actions, customs, beliefs, values, and institutions of racial, ethnic, religious, or social groups. Culture defines how health care information is received, how rights and protections are exercised, what is considered to be a health problem, how symptoms and concerns about the problem are expressed, who should provide treatment for the problem, and what type of treatment should be given. In sum, because health care is a cultural construct, arising from beliefs about the nature of disease and the human body, cultural issues are actually central in the delivery of health services treatment and preventive interventions. By understanding, valuing, and incorporating the cultural differences of America’s diverse population and examining one’s own health-related values and beliefs, health care organizations, practitioners, and others can support a health care system that responds appropriately to, and directly serves the unique needs of populations whose cultures may be different from the prevailing culture” (Katz, Michael. Personal communication, November 1998).

Cultural and linguistic competence:

“Cultural and linguistic competence is a set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among professionals that enables effective work in cross-cultural situations. ‘Culture’ refers to integrated patterns of human behavior that include the

language, thoughts, communications, actions, customs, beliefs, values, and institutions of racial, ethnic, religious, or social groups. 'Competence' implies having the capacity to function effectively as an individual and an organization within the context of the cultural beliefs, behaviors, and needs presented by consumers and their communities" (Based on Cross, T., Bazron, B., Dennis, K., & Isaacs, M., (1989). Towards A Culturally Competent System of Care Volume I. Washington, DC: Georgetown University Child Development Center, CASSP Technical Assistance Center)

Culturally and linguistically appropriate services:

Health care services that are respectful of and responsive to cultural and linguistic needs.

Health care organizations:

Any public or private institution involved in any aspect of delivering health care services.

Patients/consumers:

Individuals, including accompanying family members, guardians, or companions, seeking physical or mental health care services, or other health-related services.

Staff:

Individuals employed directly by a health care organization, as well as those subcontracted or affiliated with the organization.

Standard 1. Health care organizations should ensure that patients/consumers receive from all staff members effective, understandable, and respectful care that is provided in a manner compatible with their cultural health beliefs and practices and preferred language

This standard constitutes the fundamental requirement on which all activities specified in the other CLAS standards are based. Its intent is to ensure that all patients/consumers receiving health care services experience culturally and linguistically competent encounters with an organization's staff. The standard is relevant not only to staff, who ultimately are responsible for the kinds of interactions they have with patients, but also to their organizations, which must provide the managers, policies, and systems that support the realities of culturally competent encounters.

Respectful care includes taking into consideration the values, preferences, and expressed needs of the patient/consumer. Understandable care involves communicating in the preferred language of patients/consumers and ensuring that they understand all clinical and administrative information. Effective care results in positive outcomes for patients/consumers, including satisfaction; appropriate preventive services, diagnosis, and treatment; adherence; and improved health status.

Cultural competence includes being able to recognize and respond to health-related beliefs and cultural values, disease incidence and prevalence, and treatment efficacy. Examples of culturally competent care include striving to overcome cultural, language, and communications barriers; providing an environment in which patients/consumers from diverse cultural backgrounds feel comfortable discussing their cultural health beliefs and practices in the context of negotiating treatment options; using community workers as a check on the effectiveness of communication and care; encouraging patients/consumers to express their spiritual beliefs and cultural practices; and being familiar with and respectful of various traditional healing systems and beliefs and, where appropriate, integrating these approaches into treatment plans. When individuals need additional assistance, it may be appropriate to involve a patient advocate, case manager, or ombudsperson with special expertise in cross-cultural issues.

Ways to operationalize this standard include implementing all the other CLAS standards. For example, in accordance with Standard 3, ensure that staff and other personnel receive cross-cultural education and training, and that their skills in providing culturally competent care are assessed through testing, direct observation, and monitoring of patient/consumer satisfaction with individual staff/personnel encounters. Assessment of staff and other personnel could also be done in the context of regular staff performance reviews or other evaluations that could be included in the organizational self-assessment called for in Standard 9. Health care organizations should provide patients/consumers with information regarding existing laws and policies prohibiting disrespectful or discriminatory treatment or marketing/enrollment practices.

Standard 2. Health care organizations should implement strategies to recruit, retain, and promote at all levels of the organization a diverse staff and leadership that are representative of the demographic characteristics of the service area.

The diversity of an organization's staff is a necessary, but not sufficient, condition for providing culturally and linguistically appropriate health care services. Although hiring bilingual individuals from different cultures does not in itself ensure that the staff is culturally competent and sensitive, this practice is a critical component to the delivery of relevant and effective services for all patients/consumers. Diverse staff is defined in the standard as being representative of the diverse demographic population of the service area and includes the leadership of the organization as well as its governing boards, clinicians, and administrative personnel. Building staff that adequately mirrors the diversity of the patient/consumer population should be based on continual assessment of staff demographics (collected as part of organizational self-assessment in accordance with Standard 9) as well as demographic data from the community maintained in accordance with Standard 11. Staff refers not only to personnel employed by the health care organization but also its subcontracted and affiliated personnel.

Staff diversity at all levels of an organization can play an important role in considering the needs of patients/consumers from various cultural and linguistic backgrounds in the decisions and structures of the organization. Examples of the types of staff members whose backgrounds should reflect the community's diversity include clinical staff such as doctors, nurses, and allied health professionals; support staff such as receptionists; administrative staff such as individuals in the billing department; clergy and lay volunteers; and high-level decisionmakers such as senior managers, corporate executives, and governing bodies such as boards of directors.

Acknowledging the practical difficulties in achieving full racial, ethnic, and cultural parity within the workforce, this standard emphasizes commitment and a good-faith effort rather than specific outcomes. It focuses not on numerical goals or quotas, but rather on the continuing efforts of an organization to design, implement, and evaluate strategies for recruiting and retaining a diverse staff as well as continual quality evaluation of improvements in this area. The goal of staff diversity should be incorporated into organizations' mission statements, strategic plans, and goals. Organizations should use proactive strategies, such as incentives, mentoring programs, and partnerships with local schools and employment programs, to build diverse workforce capacity. Organizations should encourage the retention of diverse staff by fostering a culture of responsiveness toward the ideas and challenges that a culturally diverse staff offers.

Standard 3. Health care organizations should ensure that staff at all levels and across all disciplines receive ongoing education and training in culturally and linguistically appropriate service delivery.

Hiring a diverse staff does not automatically guarantee the provision of culturally competent care. Staff education and training are also crucial to ensuring CLAS delivery because all staff will interact with patients/consumers representing different countries of origin, acculturation levels, and social and economic standing. Staff refers not only to personnel employed by the health care organization but also its subcontracted and affiliated personnel.

Health care organizations should either verify that staff at all levels and in all disciplines participate in ongoing CME- or CEU-accredited education or other training in CLAS delivery, or arrange for such education and training to be made available to staff. This training should be based on sound educational (i.e., adult learning) principles, include pre- and post-training assessments, and be conducted by appropriately qualified individuals. Training objectives should be tailored for relevance to the particular functions of the trainees and the needs of the specific populations served, and over time should include the following topics:

- Effects of differences in the cultures of staff and patients/consumers on clinical and other workforce encounters, including effects of the culture of American medicine and clinical training;
- elements of effective communication among staff and patients/consumers of different cultures and different languages, including how to work with interpreters and telephone language services;
- strategies and techniques for the resolution of racial, ethnic, or cultural conflicts between staff and patients/consumers;
- health care organizations' written language access policies and procedures, including how to access interpreters and translated written materials;
- the applicable provisions of:
 - Title VI of the Civil Rights Act of 1964, 42 U.S.C. §2000d, 45 C.F.R. §80.1 et seq. (including Office for Civil Rights Guidance on Title VI of the Civil Rights Act of 1964, with respect to services for (LEP) individuals (65 Fed. Reg. 52762-52774, August 30, 2000);
- health care organizations' complaint/grievance procedures;
- effects of cultural differences on health promotion and disease prevention, diagnosis and treatment, and supportive, rehabilitative, and end-of-life care;
- impact of poverty and socioeconomic status, race and racism, ethnicity, and sociocultural factors on access to care, service utilization, quality of care, and health outcomes;
- differences in the clinical management of preventable and chronic diseases and conditions indicated by differences in the race or ethnicity of patients/consumers; and
- effects of cultural differences among patients/consumers and staff upon health outcomes, patient satisfaction, and clinical management of preventable and chronic diseases and conditions.

Organizations that conduct the trainings should involve community representatives in the development of CLAS education and training programs, in accordance with Standard 12.

Standard 4. Health care organizations must offer and provide language assistance services, including bilingual staff and interpreter services, at no cost to each patient/consumer with limited English proficiency at all points of contact, in a timely manner during all hours of operation.

Standards 4, 5, 6, and 7 are based on Title VI of the Civil Rights Act of 1964 (Title VI) with respect to services for limited English proficient (LEP) individuals. Title VI requires all entities receiving Federal financial assistance, including health care organizations, take steps to ensure that LEP persons have meaningful access to the health services that they provide. The key to providing meaningful access for LEP persons is to ensure effective communication between the entity and the LEP person. For complete details on compliance with these requirements, consult the HHS guidance on Title VI with respect to services for (LEP) individuals (65 Fed. Reg. 52762-52774, August 30, 2000) at [www.hhs.gov/ocr/lep].

Language services, as described below, must be made available to each individual with limited English proficiency who seeks services, regardless of the size of the individual's language group in that community. Such an individual cannot speak, read, or understand the English language at a level that permits him or her to interact effectively with clinical or nonclinical staff at a health care organization. (Patients needing services in American Sign Language would also be covered by this standard, although other Federal laws and regulations apply and should be consulted separately.)

Language services include, as a first preference, the availability of bilingual staff who can communicate directly with patients/consumers in their preferred language. When such staff members are not available, face-to-face interpretation provided by trained staff, or contract or volunteer interpreters, is the next preference. Telephone interpreter services should be used as a supplemental system when an interpreter is needed instantly, or when services are needed in an unusual or infrequently encountered language. The competence and qualifications of individuals providing language services are discussed in Standard 6.

Standard 5. Health care organizations must provide to patients/consumers in their preferred language both verbal offers and written notices informing them of their right to receive language assistance services.

LEP individuals should be informed—in a language they can understand—that they have the right to free language services and that such services are readily available. At all points of contact, health care organizations should also distribute written notices with this information and post translated signage. Health care organizations should explicitly inquire about the preferred language of each patient/consumer and record this information in all records. The preferred language of each patient/consumer is the language in which he or she feels most comfortable in a clinical or nonclinical encounter.

Some successful methods of informing patients/consumers about language assistance services include: a) using language identification or “I speak . . .” cards; b) posting and maintaining signs in regularly encountered languages at all points of entry; c) creating uniform procedures for timely and effective telephone communication between staff and LEP persons; and d) including statements about the services available and the right to free language assistance services in appropriate non-English languages in brochures, booklets, outreach materials, and other materials that are routinely distributed to the public.

Standard 6. Health care organizations must assure the competence of language assistance provided to limited English proficient patients/consumers by interpreters and bilingual staff. Family and friends should not be used to provide interpretation services (except on request by the patient/consumer).

Accurate and effective communication between patients/consumers and clinicians is the most essential component of the health care encounter. Patients/consumers cannot fully utilize or negotiate other important services if they cannot communicate with the nonclinical staff of health care organizations. When language barriers exist, relying on staff who are not fully bilingual or lack interpreter training frequently leads to misunderstanding, dissatisfaction, omission of vital information, misdiagnoses, inappropriate treatment, and lack of compliance. It is insufficient for health care organizations to use any apparently bilingual person for delivering language services—they must assess and ensure the training and competency of individuals who deliver such services.

Bilingual clinicians and other staff who communicate directly with patients/consumers in their preferred language must demonstrate a command of both English and the target language that includes knowledge and facility with the terms and concepts relevant to the type of encounter. Ideally, this should be verified by formal testing. Research has shown that individuals with exposure to a second language, even those raised in bilingual homes, frequently overestimate their ability to communicate in that language, and make errors that could affect complete and accurate communication and comprehension.

Prospective and working interpreters must demonstrate a similar level of bilingual proficiency. Health care organizations should verify the completion of, or arrange for, formal training in the techniques, ethics, and cross-cultural issues related to medical interpreting (a minimum of 40 hours is recommended by the National Council on Interpretation in Health Care). Interpreters must be assessed for their ability to convey information accurately in both languages before they are allowed to interpret in a health care setting.

In order to ensure complete, accurate, impartial, and confidential communication, family, friends or other individuals, should not be required, suggested, or used as interpreters. A patient/consumer may choose to use a family member or friend as an interpreter after being informed of the availability of free interpreter services unless the effectiveness of services is compromised or the LEP person's confidentiality is violated. The health care organization's staff should suggest that a trained interpreter be present during the encounter to ensure accurate interpretation and should document the offer and declination in the LEP person's file. Minor children should never be used as interpreters, nor be allowed to interpret for their parents when they are the patients/consumers.

Standard 7. Health care organizations must make available easily understood patient-related materials and post signage in the languages of the commonly encountered groups and/or groups represented in the service area.

An effective language assistance program ensures that written materials routinely provided in English to applicants, patients/consumers, and the public are available in commonly encountered languages other than English. It is important to translate materials that are essential to patients/consumers accessing and making educated decisions about health care. Examples of relevant patient-related materials include applications, consent forms, and medical or treatment instructions; however, health care organizations should consult OCR guidance on Title VI for more information on what the Office considers to be “vital” documents that are particularly important to ensure translation (65 Fed. Reg. 52762-52774, August 30, 2000) at [www.hhs.gov/ocr/lep].

Commonly encountered languages are languages that are used by a significant number or percentage of the population in the service area. Consult the OCR guidance for guidelines regarding the LEP language groups for which translated written materials should be provided. Persons in language groups that do not fall within these guidelines should be notified of their right to receive oral translation of written materials.

Signage in commonly encountered languages should provide notices of a variety of patient rights, the availability of conflict and grievance resolution processes, and directions to facility services. Way-finding signage should identify or label the location of specific services (e.g., admissions, pediatrics, emergency room). Written notices about patient/consumer rights to receive language assistance services are discussed in Standard 5.

Materials in commonly encountered languages should be responsive to the cultures as well as the levels of literacy of patients/consumers. Organizations should provide notice of the availability of oral translation of written materials to LEP individuals who cannot read or who speak nonwritten languages. Materials in alternative formats should be developed for these individuals as well as for people with sensory, developmental, and/or cognitive impairments.

The obligation to provide meaningful access is not limited to written translations. Oral communication often is a necessary part of the exchange of information, and written materials should never be used as substitutes for oral interpreters. A health care organization that limits its language services to the provision of written materials may not be allowing LEP persons equal access to programs and services available to persons who speak English.

Organizations should develop policies and procedures to ensure development of quality non-English signage and patient-related materials that are appropriate for their target audiences. At a minimum, the translation process should include translation by a trained individual, back translation and/or review by target audience groups, and periodic updates.

It is important to note that in some circumstances verbatim translation may not accurately or appropriately convey the substance of what is contained in materials written in English. Additionally, health care organizations should be aware of and comply with existing State or local nondiscrimination laws that are not superceded by Federal requirements.

Standard 8. Health care organizations should develop, implement, and promote a written strategic plan that outlines clear goals, policies, operational plans, and management accountability/oversight mechanisms to provide culturally and linguistically appropriate services.

Successful implementation of the CLAS standards depends on an organization's ability to target attention and resources on the needs of culturally diverse populations. The purpose of strategic planning is to help the organization define and structure activities, policy development, and goal setting relevant to culturally and linguistically appropriate services. It also allows the agency to identify, monitor, and evaluate system features that may warrant implementing new policies or programs consistent with the overall mission.

The attainment of cultural competence depends on the willingness of the organization to learn and adapt values that are explicitly articulated in its guiding mission. A sound strategic plan for CLAS is integrally tied to the organization's mission, operating principles, and service focus. Accountability for CLAS activities must reside at the highest levels of leadership including the governing body of the organization. Without the strategic plan, the organization may be at a disadvantage to identify and prioritize patient/consumer service need priorities.

Designated personnel or departments should have authority to implement CLAS-specific activities as well as to monitor the responsiveness of the whole organization to the cultural and linguistic needs of patients/consumers.

Consistent with Standard 12, the strategic plan should be developed with the participation of consumers, community, and staff who can convey the needs and concerns of all communities and all parts of the organization affected by the strategy. And, consistent with Standards 9, 10, and 11, the results of data gathering and self-assessment processes should inform the development and refinement of goals, plans, and policies.

Standard 9. Health care organizations should conduct initial and ongoing organizational self-assessments of CLAS-related activities and are encouraged to integrate cultural and linguistic competence-related measures into their internal audits, performance improvement programs, patient satisfaction assessments, and outcomes-based evaluations.

Ideally, these self-assessments should address all the activities called for in the 14 CLAS standards. Initial self-assessment, including an inventory of organizational policies, practices, and procedures, is a prerequisite to developing and implementing the strategic plan called for in Standard 8. Ongoing self-assessment is necessary to determine the degree to which the organization has made progress in implementing all CLAS standards. The purpose of ongoing organizational self-assessment is to obtain baseline and updated information that can be used to define service needs, identify opportunities for improvement, develop action plans, and design programs and activities. The self-assessment should focus on the capacities, strengths, and weaknesses of the organization in meeting the CLAS standards.

Integrating cultural and linguistic competence-related measures into existing quality improvement activities will also help institutionalize a focus on CLAS within the organization. Linking CLAS-related measures with routine quality and outcome efforts may help build the evidence base regarding the impact of CLAS interventions on access, patient satisfaction, quality, and clinical outcomes.

Patient/consumer and community surveys and other methods of obtaining input are important components of organizational quality improvement activities. But they should not constitute the only method of assessing quality with respect to CLAS. When used, such surveys should be culturally and linguistically appropriate.

Standard 10. Health care organizations should ensure that data on the individual patient's/consumer's race, ethnicity, and spoken and written language are collected in health records, integrated into the organization's management information systems, and periodically updated.

The purposes of collecting information on race, ethnicity, and language are to:

- Adequately identify population groups within a service area;
- ensure appropriate monitoring of patient/consumer needs, utilization, quality of care, and outcome patterns;
- prioritize allocation of organizational resources;
- improve service planning to enhance access and coordination of care; and
- assure that health care services are provided equitably.

Collection of data on self-identified race/ethnicity should adhere to the standard procedures and racial and ethnic categories specified in the Office of Management and Budget's most current policy directive and adapted in the U.S. Census 2000. To improve the accuracy and reliability of race and ethnic identifier data, health care organizations should adapt intake and registration procedures to facilitate patient/consumer self-identification and avoid use of observational/visual assessment methods whenever possible. Individuals should be allowed to indicate all racial and ethnic categories that apply. Health care organizations can enhance their information on subpopulation differences by collecting additional identifiers such as self-identified country of origin, which provides information relevant to patient/consumer care that is unobtainable from other identifiers.

The purpose of collecting information on language is to enable staff to identify the preferred mode of spoken and written communication that a patient/consumer is most comfortable using in a health care encounter. Language data also can help organizations develop language services that facilitate LEP patients/consumers receiving care in a timely manner. To improve the accuracy and reliability of language data, health care organizations should adapt procedures to document patient/consumer preferred spoken and written language. Written language refers to the patient/consumer preference for receiving health-related materials. Data collected on language should include dialects and American Sign Language.

For health encounters that involve or require the presence of a legal parent or guardian who does not speak English (e.g., when the patient/consumer is a minor or severely disabled), the management information system record and chart should document the language not only of the patient/consumer but also of the accompanying adult(s).

Health care organizations should collect data from patients/consumers at the first point of contact using personnel who are trained to be culturally competent in the data collection process. Health care organizations should inform patients/consumers about the purposes (as stated above) of collecting data on race, ethnicity, and language, and should emphasize that such data are confidential and will not be used for discriminatory purposes. No patient/consumer should be required to provide race, ethnicity, or language information, nor be denied care or services if he or she chooses not to provide such information. All patient/consumer data should be maintained according to the highest standards of ethics, confidentiality, and privacy, and should not be used for discriminatory purposes.

Standard 11. Health care organizations should maintain a current demographic cultural, and epidemiological profile of the community as well as a needs assessment to accurately plan for and implement services that respond to the cultural and linguistic characteristics of the service area.

The purpose of this standard is to ensure that health care organizations obtain a variety of baseline data and update the data regularly to better understand their communities, and to accurately plan for and implement services that respond to the cultural and linguistic characteristics of the service area.

Health care organizations should regularly use a variety of methods and information sources to maintain data on racial and ethnic groups in the service area. It is important that health care organizations go beyond their own data, such as marketing, enrollment, and termination figures, which may provide an incomplete portrait of the potential patient/consumer population, many of whom may not be aware of or use the organization's services. A more useful and in-depth approach would use data sources such as census figures and/or adjustments, voter registration data, school enrollment profiles, county and State health status reports, and data from community agencies and organizations. Both quantitative and qualitative methods should be used to determine cultural factors related to patient/consumer needs, attitudes, behaviors, health practices, and concerns about using health care services as well as the surrounding community's resources, assets, and needs related to CLAS. Methods could include epidemiological and ethnographic profiles as well as focus groups, interviews, and surveys conducted in the appropriate languages spoken by the patient/consumer population. Health care organizations should not use the collected data for discriminatory purposes.

In accordance with Standard 12, health care organizations should involve the community in the design and implementation of the community profile and needs assessment.

Standard 12. Health care organizations should develop participatory, collaborative partnerships with communities and utilize a variety of formal and informal mechanisms to facilitate community and patient/consumer involvement in designing and implementing CLAS-related activities.

The culturally competent organization views responsive service delivery to a community as a collaborative process that is informed and influenced by community interests, expertise, and needs. Services that are designed and improved with attention to community needs and desires are more likely to be used by patients/consumers, thus leading to more acceptable, responsive, efficient, and effective care. As described below, this standard addresses two levels of consumer/patient and community involvement that are not token in nature, but involve working with the community in a mutual exchange of expertise that will help shape the direction and practices of the health care organization.

Patients/consumers and community representatives should be actively consulted and involved in a broad range of service design and delivery activities. In addition to providing input on the planning and implementation of CLAS activities, they should be solicited for input on broad organizational policies, evaluation mechanisms, marketing and communication strategies, staff training programs, and so forth. There are many formal and informal mechanisms available for this, including participation in governing boards, community advisory committees, ad hoc advisory groups, and community meetings as well as informal conversations, interviews, and focus groups.

Health care organizations should also collaborate and consult with community-based organizations, providers, and leaders for the purposes of partnering on outreach, building provider networks, providing service referrals, and enhancing public relations with the community being served.

Related to Standard 11, health care organizations should involve relevant community groups and patients/consumers in the implementation of the community profile and needs assessment.

Standard 13. Health care organizations should ensure that conflict and grievance resolution processes are culturally and linguistically sensitive and capable of identifying, preventing, and resolving cross-cultural conflicts or complaints by patients/consumers.

This standard requires health care organizations to anticipate and be responsive to the inevitable cross-cultural differences that arise between patients/consumers and the organization and its staff. Ideally, this responsiveness may be achieved by integrating cultural sensitivity and staff diversity into existing complaint and grievance procedures as well as into policies, programs, offices or committees charged with responsibility for patient relations, and legal or ethical issues. When these existing structures are inadequate, new approaches may need to be developed.

Patients/consumers who bring racial, cultural, religious, or linguistic differences to the health care setting are particularly vulnerable to experiencing situations where those differences are not accommodated or respected by the health care institution or its staff. These situations may range from differences related to informed consent and advanced directives, to difficulty in accessing services or denial of services, to outright discriminatory treatment. Health care organizations should ensure that all staff members are trained to recognize and prevent these potential conflicts, and that patients are informed about and have access to complaint and grievance procedures that cover all aspects of their interaction with the organization. In anticipation of patients/consumers who are not comfortable with expressing or acting on their own concerns, the organization should have informal and formal procedures such as focus groups, staff-peer observation, and medical record review to identify and address potential conflicts.

Among the steps health care organizations can take to fulfill this standard are: providing cultural competence training to staff who handle complaints and grievances or other legal or ethical conflict issues; providing notice in other languages about the right of each patient/consumer to file a complaint or grievance; providing the contact name and number of the individual responsible for disposition of a grievance; and offering ombudsperson services. Health care organizations should include oversight and monitoring of these culturally or linguistically related complaints/grievances as part of the overall quality assurance program for the institution.

Standard 14. Health care organizations are encouraged to regularly make available to the public information about their progress and successful innovations in implementing the CLAS standards and to provide public notice in their communities about the availability of this information.

Sharing information with the public about a health care organization's efforts to implement the CLAS standards can serve many purposes. It is a way for the organization to communicate to communities and patients/consumers about its efforts and accomplishments in meeting the CLAS standards. It can help institutionalize the CLAS standards by prompting the organization to regularly focus on the extent to which it has implemented each standard. It also can be a mechanism for organizations to learn from each other about new ideas and successful approaches to implementing CLAS.

Health care organizations can exercise considerable latitude in both the information they make available and the means by which they report it to the public. For example, organizations can describe specific organizational changes or new programs that have been instituted in response to the standards, CLAS-related interventions or initiatives undertaken, and/or accomplishments made in meeting the needs of diverse populations. Organizations that wish to provide more in-depth information can report on the data collected about the populations and communities served in accordance with Standard 11 and the self-assessment results gathered from Standard 9. Organizations should not report scores or use data from self-assessment tools that have not been validated. However, as standard self-assessment instruments and performance measures are developed and validated, additional information gathered by using these tools could be made available to the public.

Health care organizations can use a variety of methods to communicate or report information about progress in implementing the CLAS standards, including publication of stand-alone documents focused specifically on cultural and linguistic competence or inclusion of CLAS components within existing organizational reports and documents. Other channels for sharing this information include the organization's member publications; newsletters targeting the communities being served; presentations at conferences; newspaper articles; television, radio, and other broadcast media; and postings on Web sites.

NARRATIVE OUTLINE

This report recommends national standards for culturally and linguistically appropriate services (CLAS) in health care. Based on an analytical review of key laws, regulations, contracts, and standards currently in use by Federal and State agencies and other national organizations, these standards were developed and refined with significant input from a nationwide public comment process and the guidance of two national project advisory committees.

Part I of this report provides background on the importance of cultural competence in health care in the United States, reviews the role and interest of the U.S. Department of Health and Human Services and its Office of Minority Health in cultural competence, and briefly summarizes the process of developing national standards for CLAS in health care. It also explains the purpose, intended audience of and organizing principles behind the standards; reviews the most important general comments received on the standards; and discusses the implications of the CLAS standards for the U.S. health care system. Part I ends with recommendations for actions that could be taken in the public and private sector to facilitate implementation of the CLAS standards.

Part II, which is the main section of the report, contains the 14 CLAS standards. In this section, each standard is accompanied by commentary that defines key concepts and issues and a discussion section that provides an overview of critical implementation issues.

Part III of the report summarizes the process for developing and revising the CLAS standards over 3 years. The Methodology and Analysis section briefly reviews stage one of the process (1997-1999), describes in more detail stage two of the process (1999-2001), and summarizes the changes made to individual standards based on the analysis of public comments and input from the National Project Advisory Committee.

Part IV presents a glossary of terms found within the standards. It also contains a bibliography of all sources used in preparing this final report.

Attached **Appendices** include rosters of those who attended the three regional meetings held during the public comment period of the CLAS Standards' development. The National Project Advisory Committee (NPAC) membership is also presented.

PART I: BACKGROUND AND PURPOSE

INTRODUCTION

This chapter provides background on the importance of cultural competence in health care in the United States, reviews the role and interest of the U.S. Department of Health and Human Services (HHS) and its Office of Minority Health (OMH) in cultural competence, and briefly summarizes the process of developing national standards for culturally and linguistically appropriate services (CLAS) in health care. It also explains the purpose, intended audience of, and organizing principles behind the standards; reviews the most important general comments received on the standards; and discusses the implications of the CLAS standards for the U.S. health care system. Part I ends with recommendations for actions that could be taken in the public and private sector to facilitate implementation of the CLAS standards.

The Importance of Cultural Competence in Health Care

Consistent with long-standing predictions, Census 2000 data has revealed significant increases in minority and foreign-born populations across the United States. California's "minority" populations became the majority in 1999, and many other states not historically perceived as racially or ethnically diverse are yearly receiving thousands of newcomers from around the globe. The state of Iowa is actively recruiting immigrants and refugees, citing the opportunity to help resolve a growing worker shortage and declining population.

The increasing diversity of the nation brings with it a host of opportunities and challenges that are experienced with increasing frequency and immediacy in health care facilities, from small rural clinics to large urban medical centers. Sensitivity, empathetic listening, and a little extra effort can often go a long way to bridge the gap between the staff of health care organizations and patients who bring cultural differences to the health encounter. But these personal efforts are usually not enough to overcome the common organizational barriers presented by mainstream health care organizations. These barriers affect how diverse patient populations navigate their health care and how health care organizations and providers deliver that care.

The notion of cultural competence has been promoted for many years as the way for health care providers and health care organizations to understand and respond effectively to the cultural and linguistic needs brought by patients to the health care encounter. Many excellent examples of culturally responsive organizations exist around the country, and many tools and resources are available to assist health care organizations improve their ability to serve diverse populations.

Many national, state, and local policymakers have also recognized the importance of cultural competence in facilitating accessible and effective health care for culturally diverse populations. But many of these leaders are still in the early stages of defining cultural competence in a way that is measurable and enforceable. Some approaches to policymaking on cultural competence attempt to be comprehensive, while others target only a specific issue, geographic area, or subfield of health care such as mental health. The result is a wide spectrum of ideas about what constitutes culturally competent health services, including significant differences with respect to target population, scope, and quality of services.

The Role of HHS/OMH in Advancing Cultural Competence

HHS has long been committed to improving access to health services for disadvantaged populations. In recent years, HHS has advanced several significant initiatives in this area, including the President's initiative to eliminate racial and ethnic disparities in health care, and the issuance of guidance by the Office for Civil Rights (OCR) on equal access to services for individuals with limited English proficiency.

Each agency of the Department has taken an independent approach to defining and addressing the health care needs of minority and foreign-born populations, but OMH often provides a focal point in HHS for these concerns. Created in 1986 to address the health needs and disparities experienced by minority populations in this country, OMH has provided more than \$6.9 million dollars of seed funding to develop and promote models of cultural and linguistic competence.

OMH's work in cultural and linguistic competence includes demonstration projects, fellowship programs, training and technical assistance networks, data collection, and the development of monographs and models. Examples of OMH projects include the following:

- **Bilingual/Bicultural Service Demonstration Program**—Developed in 1993, this program is designed to reduce social, cultural and linguistic barriers between providers and clients with limited-English proficiency and to improve their access to quality health care.
- **Grants for Centers of Excellence Bilingual and Bicultural Minority Pre-Faculty Fellowship Program**—This demonstration program was launched to assess whether formal pre-faculty development programs would increase underrepresented minorities in faculty positions in health professions schools for the purpose of incorporating linguistic and culturally appropriate curriculum models.
- **Proyecto Informar Training and Technical Assistance Network**—This project focused on building the capacity of providers and institutions in providing cultural competency training to Hispanics.
- **Survey of local health departments**—The survey, conducted by the National Association of County and City Health Officials with OMH's support, acquired baseline data on county efforts to provide linguistically and culturally appropriate community health promotion programs to address racial/ethnic health disparities.
- **Monograph series**—Five publications, supported by OMH, the Health Resources and Services Administration (HRSA), and the Substance Abuse and Mental Health Services Administration, addressed cultural competency service delivery issues of racial and ethnic populations.
- **Cultural competence practice models**—The University of Texas, with OMH support, is developing a model for incorporating elements of cultural competence into their pre-clinical medical school curriculum for students and faculty.
- **Study of interpreters services**—OMH supports research being conducted by the Portland State University to determine whether the introduction of professional interpreters services improves access to and use of health care services by language minority populations.

- Assessment of managed care services—OMH is supporting a national assessment of culturally and linguistically appropriate services in managed care organizations serving racially/ethnically diverse populations.

In the late 1990s, OMH began to concentrate on policy and research products to support the practice of culturally competent health care. The national standards presented in this report constitute a central part of OMH's agenda to promote culturally and linguistically competent health care among organizations and policymakers in the United States.

CLAS Standards Project Overview

In 1997, OMH asked Resources for Cross Cultural Health Care (RCCHC) and the Center for the Advancement of Health to review and compare existing cultural and linguistic competence standards and measures in a national context, propose draft national standard language where appropriate, assess the information or research needed to relate these guidelines to outcomes, and develop an agenda for future work in this area. *Assuring Cultural Competence in Health Care: Recommendations for National Standards and an Outcomes-Focused Research Agenda* was the result of this request, with a two-part report submitted to OMH in May 1999.

The first part of the 1999 report contained draft national standards for culturally and linguistically appropriate services in health care. Based on an analytical review of key laws, regulations, contracts, and standards currently in use by Federal and State agencies and other national organizations, these draft standards were developed with input from a national project advisory committee of policymakers, health care organizations, and researchers. Each standard was accompanied by a discussion that addressed the proposed guideline's relationship to existing laws and standards, and offered recommendations for implementation and oversight to organizations, policymakers, and advocates.

Following receipt of the report, OMH determined that the appropriate next step for the draft CLAS standards was to undergo a national process of public comment that would result in a broader awareness of HHS interest in CLAS in health care, significant input from stakeholder groups on the draft standards, and a final revision of the standards and accompanying commentary supported by the expertise of a second Project Advisory Committee. This task was assigned to IQ Solutions and its subcontractor RCCHC.

The draft CLAS standards were published in the Federal Register on December 15, 1999 (Volume 64, Number 240, pages 70042-70044), launching a four-month public comment period, which ran from January 1 to April 30, 2000. Individuals also had the opportunity to participate in one of three regional meetings on the CLAS standards. The purpose of these one-day meetings was to present information on the standards' development process and for participants to discuss and provide feedback on issues related to the standards themselves or their implementation. Following the closure of the public comment period, the project team (consisting of staff members of IQ Solutions, RCCHC, and OMH) analyzed the public comments on the CLAS standards. These findings were presented to a National Project Advisory Committee (NPAC) composed of 27 individuals representing health care organizations, health care professionals, consumers, unions, State and Federal agencies, and health care accrediting agencies.

Following the meeting, the project team revised the standards based on the public comments and the deliberations of the NPAC. The final revisions are contained in this report and were published in the Federal Register on December 22, 2000 (Vol. 65, No. 247, pp. 80865-80879) as national standards for adoption or adaptation by stakeholder organizations and agencies.

Purpose of the Standards and Intended Audience

The CLAS standards are proposed as one means to correct inequities that currently exist in the provision of health services and to make these services more responsive to the individual needs of all patients/consumers. The standards are intended to be inclusive of all cultures and not limited to any particular population group or sets of groups. However, they are especially designed to address the needs of racial, ethnic, and linguistic population groups that experience unequal access to health services. Ultimately, the aim of the standards is to contribute to the elimination of racial and ethnic health disparities and to improve the health of all Americans.

The CLAS standards serve several purposes. They provide a common understanding and consistent definitions of culturally and linguistically appropriate services in health care. They offer a practical framework for the implementation of services and organizational structures that can help health care organizations and providers be responsive to the cultural and linguistic issues presented by diverse populations.

As mentioned above, the CLAS standards were initially derived from an analysis of current practice and policy on cultural competence, and shaped by the experiences and expertise of health care organizations, policymakers, and consumers. This process was guided by the following overarching definition of cultural competence:

“Cultural and linguistic competence is a set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among professionals that enables effective work in cross-cultural situations. ‘Culture’ refers to integrated patterns of human behavior that include the language, thoughts, communications, actions, customs, beliefs, values, and institutions of racial, ethnic, religious, or social groups. ‘Competence’ implies having the capacity to function effectively as an individual and an organization within the context of the cultural beliefs, behaviors, and needs presented by consumers and their communities.” (Adapted from Cross, 1989).

The final 14 standards are organized by themes: Culturally Competent Care (Standards 1-3), Language Access Services (Standards 4-7), and Organizational Supports for Cultural Competence (Standards 8-14). Standards 1-7 address interventions that have the most direct impact on clinical care. Standards 8-14 address organizational structures, policies and processes that support the implementation of the first seven standards. The 14 standards can also be categorized into three types of standards of varying stringency: mandates, guidelines, and recommendations as follows:

CLAS mandates are current Federal requirements for all recipients of Federal funds (Standards 4, 5, 6, and 7).

CLAS guidelines are activities recommended by OMH for adoption as mandates by Federal, State, and national accrediting agencies (Standards 1, 2, 3, 8, 9, 10, 11, 12, and 13).

CLAS recommendations suggested by OMH for voluntary adoption by health care organizations (Standard 14).

The CLAS standards are primarily directed at health care organizations; however, individual providers are also encouraged to use the standards to make their practices more culturally and linguistically accessible. The principles and activities of CLAS should be integrated throughout an organization and undertaken in partnership with the communities being served.

As stated in the 1999 report, the CLAS standards are also presented as guidelines for:

Policymakers, to draft consistent and comprehensive laws, regulations and contract language. This audience would include Federal, state and local legislators, administrative and oversight staff, and program managers.

Accreditation and credentialing agencies, to assess and compare organizations who say they provide culturally competent services, and to assure quality for diverse populations. This audience would include the Joint Commission on Accreditation of Healthcare Organizations, the National Committee on Quality Assurance, professional organizations such as the American Medical and Nurses associations, and quality review organizations such as Peer Review Organizations.

Purchasers, to advocate for the needs of ethnic consumers of health benefits and to leverage responses from insurers and health plans. This audience would include government and employer purchasers of health benefits, including labor unions.

Patients, to be able to understand their right to receive accessible and appropriate health care services, and to evaluate whether health care organizations and providers can offer such services.

Advocates, to promote quality health care for diverse populations, and to assess and monitor care being delivered by health care organizations and providers. The potential audience is quite wide, including legal services and consumer education/protection agencies; local and national ethnic, immigrant and other community-focused organizations; and local and national nonprofit organizations that address health care issues.

Educators, to incorporate cultural and linguistic competence into their curricula and to raise awareness about the impact of culture and language on health care delivery. This audience would include health care professions educators and training institutions, as well as legal and social services professions educators.

The health care community in general, to debate and assess their applicability and adoption into standard health care practice.

Major Issues Raised in Response to the CLAS Standards

One of the great assets of the public comment process on the draft CLAS standards has been the collection of a wide variety of views and information about the role and practice of cultural and linguistic competence in American health care. The public comment process allowed individuals and organizations to comment on individual standards, as well as on the CLAS project overall. With respect to the project, commenters were invited to offer their views on any of the following topics: the concept of national standards for cultural and linguistic competence; the role of OMH and HHS in sponsoring this effort; the methodology

for developing the standards; and the implications of having national standards for organizations and policymakers. Seventy pages of general comments were received, and they offer a rich source of information and perspectives on the CLAS standards and cultural competence in health care generally (see the CLAS website at [www.omhrc.gov/CLAS] for the complete set of public comments received). The following discussion will summarize some key issues raised that have implications for the future acceptability and adoption of the CLAS standards. Specific responses by the project team to these and other issues will be discussed in more detail in the Methodology and Analysis section of the report (see Part III).

Support for and Critiques of the Standards

Public comment processes typically stimulate a wide range of opinions, and OMH received more than 20 pages of public comments that addressed issues related to support for, or criticism of, the concept of standards for CLAS. A few key observations can be made about the way different individuals and organizations perceived the notion of draft model standards. A number of commenters clearly did not understand that the draft standards printed in the Federal Register were not anticipated to be regulations in the near future. On the other hand, other comments indicated that many people were not aware of existing laws that address some issues raised by the CLAS standards. Many commenters who were aware of this relationship felt that some standards needed to be strengthened on the basis of those Federal requirements.

Many comments raised questions about whether the recommended CLAS standards should be finalized as guidelines, standards, or mandates. Overall, there was a broad continuum of support for, and opposition to, different conceptualizations of the standards. Fifty comments supported the standards as mandates, with another 37 offering endorsement, support for their adoption, agreement with the intent, and other general expressions of praise. Thirty-four comments expressed some level of concern about seeing the standards as national standards or requirements. Some commenters preferred the standards as guidelines, and others disliked them in any format. Among the reasons for concern or opposition were the potential costs/burden of implementation; the perception that the standards were too broad, too narrow, or too prescriptive; and the lack of research evidence to support many CLAS activities.

The following examples of public comments received reveal the variety of opinions articulated.

“We understand the significance of this activity and the potential that the standards embody for improving health care outcomes. We share and support your concern for the need to develop and release clear guidance to plans and other providers as they respond to a rapidly growing culturally diverse population.”

“To have any effect in practice, finalized standards must be more than mere ‘guideposts.’ To the extent possible, the final standards should be issued as enforceable regulations. Without an enforcement mechanism to support the final standards, we fear many health care organizations and providers will not prioritize linguistic and cultural competence and our communities will continue to lack access to quality health care.”

“We believe the standards are achievable for all states. [The Washington Department of Social and Health Services] and partners all agree that in order for cultural and linguistic competence to become commonplace in today’s health-care system, it has to

be embraced, supported, and made a priority by state and health care executive management.”

“The American Academy of Pediatrics agrees with the intent of the DHHS recommendations for cultural competence standards. However, the Academy has concerns regarding the availability of education, training, qualified personnel, adequate reimbursement, evaluation mechanisms and other resources required to implement and comply with the standards.”

“While perhaps serving as a good beginning, especially for organizations with little experience serving the minority populations, these recommendations do not define the essential elements for delivering CLAS. There’s also no firm evidence that utilizing these recommendations enhances acceptance and effectiveness of services by the target populations. It would be appropriate to recommend these as guidelines rather than standards and study the experience in their implementation for various populations before finalizing ‘standards’.”

“Mayo Foundation [We do] not believe that culturally and linguistically appropriate health care services are an area of health care that should be highly regulated. When a guideline or standard is strictly mandated and regulated, all possible opportunities for flexibility and innovation are eliminated. This approach is not in the best interests of the patient or customer needing the service. We believe that health care institutions and other quality businesses will adopt the proposed principals as guidelines to ensure that they provide high-quality health care that encompasses the needs of the patient, the patient’s family, and the community.”

Issues related to incentives, costs, reimbursement and other administrative concerns engendered more than 10 pages of public comments. Health care providers and provider organizations were particularly apprehensive about the impact of requiring the CLAS standards. They expressed concerns about the “unreasonable burden in costs and resources associated with the draft standards,” and noted that “if applied literally, they would likely overwhelm most hospitals’ and physicians’ resources — both time and money.” Home health care agencies were particularly adamant in their concerns about how the standards would affect their businesses. “Specifically, OMH’s proposed CLAS standards would require the financial resources to hire new and additional staff or contract services, as well as to develop new policies and procedures—new standards, training materials, and subsequent training of staff. Implementation of the proposed CLAS standards would be financially prohibitive for home care agencies that are struggling in the current Medicare and Medicaid environment. Providers are being asked to supply additional services without the ability to set prices, or to recoup the cost of unfunded mandates.” Cost constraints across the health care industry, especially in government-funded programs such as Medicare and Medicaid, were posed as inherently contradictory to the notion of government-sponsored requirements for additional expenditures related to culturally competent care. Several commenters suggested that financially strapped providers, especially those participating in low reimbursement programs, would likely opt out of continued participation in those programs if they were required to comply with the CLAS standards.

There were many calls for economic impact analyses of the CLAS standards and a demonstration of cost-effectiveness before the standards are mandated. At the same time, many commenters remarked on the need for better awareness of the cost-effectiveness arguments and existing evidence that already support culturally appropriate services. “The Washington Business Group on Health believes that employer consideration of cultural competence can lead to more efficient use of health dollars and can contribute to increased productivity and a reduction in absenteeism and disability. Increased patient compliance and satisfaction can improve health outcomes. As employers respond to an increasingly consumer-driven health system, emphasis on cultural competence and assessment of what services are available and how they’re delivered to a diverse workforce will become increasingly important.”

For example, errors made due to cultural or linguistic misunderstandings in health care encounters can lead to repeat appointments, extra time spent rectifying misdiagnoses, unnecessary emergency room visits, longer hospital stays, and canceled diagnostic or surgical procedures. While cultural competence training and language assistance services require financial and staff resources, avoiding one costly lawsuit can finance a considerable number of activities related to the CLAS standards. However, while some supporting research exists, many of the proofs for the cost effectiveness of cultural competence services are anecdotal. As one commenter noted, “if only one thing was mandated, it should be the collection of cost effectiveness data” related to cultural and linguistic interventions. Community-based providers offered another interesting perspective. “Implementing the CLAS standards may be costly, but the costs of culturally and linguistically competent health care services currently are borne by small, grass-roots, community-based organizations which are least able to afford it. Implementing the standards will remove the ‘ethnic tax’ on providers who have always provided CLAS to people who often cannot afford to pay. The standards will ensure that others providing such services will share the costs.”

It is impossible to adequately summarize and respond to all the supporting and detracting comments related to the CLAS standards, and those with further interest in these issues are encouraged to read the related public comments on the CLAS standards web site [<http://www.omhrc.gov/clas>]. All the preceding issues were raised in the analytical report prepared for the NPAC, recommended to the committee for special consideration, and discussed in detail at the committee meeting. In the end, the project team and the committee acknowledged that there is more hard evidence to support concerns about cost/burdens than there is to support the financial incentive argument for some CLAS activities. Notwithstanding this, the clinical, ethical, and social justice arguments for cultural and linguistic competence were more compelling to the group than arguments against it. The committee attempted to account for this dichotomy by suggesting a flexible implementation approach and recommendations for additional resources for health care organizations to implement the standards.

Critiques on the Approach and Applicability of the Standards

A wide spectrum of concerns was raised about the approach taken by the CLAS standards to articulate a set of cultural competence activities for health care organizations. The comments received suggest that different individuals and organizations perceived the standards very differently. Some commenters thought the standards were too prescriptive; others felt they

needed to be more specific. Issues were raised about the complexity, comprehensiveness, measurability, and flexibility of the standards. It is not possible to generalize by stakeholder types (e.g., health care providers or consumer advocates) whether these issues were raised as strengths or weaknesses. For example, one provider organization expressed great concern that the proposed standards were too general in nature and did not provide enough detail and direction to facilitate proper implementation and ensure compliance by the full range of health care organizations and providers. Another health provider organization felt that national standards would impede the current flexible and responsive approach used by their constituents, and create a “checklist” environment for determining compliance with a “set of rigid model requirements.” Generally, consumer advocates felt that the standards needed to be specific and directive requirements to sufficiently motivate health care organizations to take action. Health care providers generally felt that the standards in their draft iteration were too vague to be held accountable to in a fair manner, but they also feared a final product that was a collection of complex and burdensome requirements.

A related set of concerns addressed how the CLAS standards might be applied to different types of health care organizations. Despite the stated focus on health care organizations, physician groups expressed considerable anxiety over their perceived inability to comply with the standards. Small health care organizations and those located in rural areas were also concerned how they would be able to address all the activities described in the standards. Home health care agencies consistently claimed that the CLAS standards constituted an impossible burden in the context of existing regulatory requirements and cutbacks in reimbursement. In light of these concerns, it is important to view the CLAS standards as a framework that describes the types of cultural competence activities that an organization should undertake in the context of its size, location, organizational type, and available resources. In the final version, some standards (related to language access services) are described as mandates. These standards simply reflect current Federal requirements for recipients of Federal funds. However, these Federal requirements are also intended by HHS to be implemented flexibly in relation to the individual characteristics of the organization.

The Role of the CLAS Standards in Guiding a National Agenda on Cultural Competence

Ideally, the issuance of national standards for CLAS should result in the replacement of the patchwork of different definitions and requirements with one universally understood set of guidance. Experience from other fields demonstrates that health care organizations, providers, policymakers, and accreditation organizations benefit when expectations are clear yet flexible, resources for implementation are made available, and mechanisms for review and oversight are specific. Naturally, this is a process that takes place in the context of years of experimentation, adaptation, and refinement of the standards themselves. In the short term, it is a marker of success when the standards are used as models for improving policy and practice. Even before the publication of the final standards in the Federal Register, the draft standards have inspired and guided activity around cultural competence in a wide variety of contexts.

Over the last few years, HHS has begun to integrate cultural and linguistic competence in an expanding number of important program rules and regulations. HCFA regulations for Medicare+ Choice and Medicaid address cultural and linguistic competence, and cultural competence will be the focus of quality improvement projects under the Quality Improvement

System for Managed Care (QUISMC) in the coming fiscal year. Many aspects of the CLAS standards are reflected in the OCR Guidance on Limited English Proficiency, and the power of the guidance to affect provider behavior suggests that this will be an area of significant activity in the coming years. The Consumer Bill of Rights mentions a variety of consumer protections that are influenced by cultural and linguistic issues, and these protections have been considered in a variety of legislative and HHS initiatives.

This wide range of efforts affects nearly every health care organization in the country, and is complemented by other efforts within HHS to quantify and provide direction on cultural competence. OMH is developing a survey of cultural competence activities by managed care organizations using the CLAS standards as a framework. HRSA's Center for Managed Care has recently released model cultural competence purchasing specifications for Medicaid managed care based on the CLAS standards (online at [www.gwumc.edu/~chsrp] — under the Sample Purchasing Specifications link. The HRSA Office of Minority Health has just begun work on performance measures for cultural competence.

Although the CLAS standards project team has not formally kept track of other efforts to use the standards, the project team has been made aware of initiatives by private providers, county health departments and State agencies to implement, adapt, or reference the draft CLAS standards in policy directives. Inspired in part by their participation in the development of the draft and final standards, the Joint Commission on Accreditation of Healthcare Organizations will be initiating surveyor education on cultural competence. We anticipate that these efforts will increase with the publication of the final standards in the Federal Register

A better understanding of the relationship between culturally competent health services and patient satisfaction/clinical outcomes/health status is needed, and these issues will be more fully explored in the forthcoming research agenda for CLAS, sponsored by OMH and the Agency for Health Research and Quality. Recently published studies reinforce the intuition that a lack of attention to cultural issues leads to less than optimal health care, and that addressing these concerns or using certain CLAS interventions leads to improved outcomes. This research does not exist for every population or every type of CLAS intervention—most of it is concentrated on the impact of language or communication barriers—but it is sufficient to suggest that additional work in this area is warranted. One might also consider innovative ways of looking at the existing literature for links between relevant factors that would support the concept of CLAS interventions. Brach (2000) and Betancourt (1999) both propose that one can “connect the dots” between studies on communication, patient satisfaction, adherence and health outcomes to demonstrate that attention to each element has an impact on the next, and a link between improved communication (the heart of most CLAS interventions) and improved health outcomes can convincingly be made. Nevertheless, as the discussion on the relationship between CLAS and outcomes continues, it is important to remember that the vast majority of health practices and protocols in use today are unsupported by research-based outcomes analysis.

Further work on the relationship between culturally competent services and patient outcomes will also clarify concerns related to the costs and cost-benefits of CLAS. Risk management is sufficient incentive for some organizations that have experienced the results of inappropriate or unnecessary testing, clinical inefficiency, misdiagnosis, negative outcomes, and malpractice due to cultural and linguistic issues. The Mutual Insurance Corp of America sees enough of a

link between these factors and liability that it offers a discount on malpractice insurance to physicians who participate in cultural competence training (Trosty, 1998). But it is also conceivable that many health care organizations and policymakers will be uncomfortable with adopting standards for CLAS because implementation will involve spending money on the educational, staffing, and organizational changes required to make services more accessible. For example, in the Medicaid program, where significant numbers of ethnically diverse patients are receiving care, reimbursement has never been adequate for the cost of medical services. States may not allocate more resources to provide services of adequate quality in an appropriate manner, given the long history of unsuccessful legal and legislative maneuvers to enhance reimbursement for other reasons.

The implementation of CLAS may be particularly challenging for private practitioners, community clinics, and public hospitals; the latter two already are struggling with large uncompensated care burdens. Accommodations will also have to be made when an organization is small or is in a rural or frontier area where cultural resources may be hard to come by. For such organizations, it may be valuable to consider offering government grants to implement networks of culturally competent services, or direct reimbursement from government for certain services (such as for interpreters in Washington State). But in the for-profit sector, whether through private insurance or in managed care contracts, these services should be considered the cost of doing business. Managed care organizations and other health care organizations should consider the ethics of collecting premiums or reimbursement for services that certain populations cannot use because they are ineffectively delivered or inaccessible. It is even worse to penalize consumers for inappropriately utilizing services because they cannot understand the rules for using them.

It is increasingly common to hear health care organizations and analysts speak of the “business case” for addressing diversity. The trade literature in health care has witnessed an upsurge of articles on cultural and linguistic competence in the last three years, and the cited industry leaders come from around the country. In many areas, ethnic communities are an attractive target for marketing strategies because they represent an untapped “niche” in a tight health care market. Cambridge Health Alliance and the New York Downtown Hospital are two health systems that have harnessed the potential of culturally competent services to strengthen and satisfy their customer base. Other health care organizations, such as Kaiser Permanente and Harvard Pilgrim Health Care, have strategically addressed diversity issues because of the obvious demographic changes in their communities or because patient/staff satisfaction surveys demand greater attention to CLAS services. All these examples are characterized by efforts to integrate responsiveness to cultural and linguistic issues into the whole fabric of their operations, rather than just as a marketing add-on.

Given the tremendous variations in organization type, local populations, resources and expertise, the path to culturally responsive health services will be different for every health care organization. The CLAS standards can provide a substantial framework for guiding implementation in a common direction, although the work does not end here. As the following recommendations for future action will attest, the standards are a necessary initial tool that must be buttressed by supportive experimentation, development, and research that will give stakeholders the full set of resources they need to improve their services to diverse populations. Out of this improved service delivery, we believe that culturally diverse

populations will benefit from increased access to health services, more appropriate utilization of those services, better clinical outcomes and, in time, decreased disparities in health status.

RECOMMENDATIONS

The underlying theme of feedback from public and expert comments was that health care organizations and providers need clear guidance on how to implement CLAS in health care settings. The standards themselves outline the basic activities that constitute a framework for organizational cultural and linguistic competence. The commentary and discussion accompanying each standard in the following section of this report provide further guidance. However, considerable challenges are posed by the lack of synthesis, standardization, consensus, or resources in many areas addressed by the standards. The following recommendations suggest actions that could be taken in the public and private sector to facilitate implementation of the CLAS standards by addressing the “gaps” in these areas. The recommendations are based on input from public comments and the NPAC, with additional insights from the project team.

These recommendations are designed to stimulate the interest and support of a variety of policymaking, advocacy and funding agencies, including national health care organizations, local and national foundations, and local, state and Federal health agencies. Any work done in response to the recommendations should be collaborative and focused on building consensus and support among all key stakeholders in CLAS.¹ (See page 43 for footnote.)

Culturally Competent Care

Develop a consensus on core cultural competencies for clinicians, providers and other staff members, and develop and validate measures for assessing these competencies in individuals.

There currently is no agreement across health professional specialties on what specifically constitutes individual cultural competence or how it is best measured. Existing guides and assessment tools, although not scientifically validated, collectively provide a body of knowledge on cultural competency and its assessment in individuals. A synthesis of this knowledge and subsequent consensus-building efforts to establish core cultural competencies could provide the foundation for the development of cultural competency training programs and assessment measures. Validated assessment measures, in turn, could help organizations link the demonstration of cultural competence skills and behaviors to performance evaluations and staff rewards for their improvements.

Conduct and disseminate research to connect cultural competency behaviors to specific health outcomes.

Although some studies show that a lack of attention to cultural and linguistic issues is associated with less optimal health care, research has not yet fully explicated the relationship between culturally and linguistically competent health services and clinical outcomes/health status. Further work in this area could help build a convincing evidence base in support of CLAS interventions and clarify concerns related to the costs and cost-benefits of CLAS. OMH currently is funding a project to identify key research areas and questions related to CLAS and to propose a research agenda for future work in this area.

Support and increase national, state, and local efforts to expand the pool of health care professionals who are from diverse communities.

One of the major challenges to building a culturally diverse staff at all levels of an organization is the current lack of capacity within the workforce of health professionals, particularly clinical staff. Organizational efforts to recruit and “grow their own” diverse staff need to be reinforced at the national, state and local levels, and financial support for health professions students from disadvantaged backgrounds needs to be increased. Other activities in this area could include the establishment of a recruitment database of bilingual and bicultural health care practitioners and support for the development of pathways for foreign-trained health care professionals to receive credentialing and licensure in the United States.

Develop a consensus on curricula standards and evaluative tools for cultural competency training for both clinical providers and nonclinical staff.

In the absence of standardized curricula or universally accepted certification or credentialing for cultural competence, training programs and curricula vary widely. These variations, along with the lack of adequately validated assessment tools, make it difficult to evaluate or compare the effectiveness of cultural competence trainings. The development of curricula standards and evaluation tools would help organizations determine which training programs are most likely to foster cultural competence among their providers and staff. An example of current work related to this recommendation is the California Endowment’s funding of efforts to develop a consensus standard on cultural competency training.

Cultural competency training should be substantively integrated into health professions education and training at all levels, both academic and functional.

Currently, cultural competence education in academic settings varies widely, ranging from semester-long courses to a few hours of training. Collaboration among Federal agencies, health professions schools, state licensure bodies, and accreditation agencies could help ensure that cultural competency training is integrated into all phases of health professions education, including core curriculum, professional licensure, and continuing professional development programs. An example of work in the area addressed by this recommendation is the Association of American Medical Colleges’ (AAMC) recent approval of mandatory diversity accreditation requirements.

Language Access Services**Collect and disseminate information on model programs and strategies of implementing language assistance services.**

There is broad experience nationally in developing and managing language assistance services, and many informal networks of information-sharing and technical assistance exist to support the refinement of these models. These resources, including case studies, program summaries, and technical information, should be widely promoted to health care providers and state and national provider organizations.

Support direct and indirect financing of language assistance services at all levels of health services delivery.

In addition to facilitating equal access to publicly and privately available health services, language assistance services can be a critical diagnostic tool for health care providers working with individuals with LEP, and the services should be financially supported in the same way as other diagnostic procedures. Federal and State policymakers should support and implement direct reimbursement of interpretation and translation costs through the Medicare and Medicaid program, and private insurers should do the same for their commercial products. At a minimum, interpretation and translation services should be allowable for inclusion under administrative or other overhead reimbursement allowances. Grants or contracts for health care services provided by government agencies and foundations should also include the costs of interpretation and translation when funded services are of potential benefit to individuals with LEP. These services would include direct medical, mental health, substance abuse, health promotion, and related social services, as well as health education campaigns and participation in biomedical research or clinical trials.

Support the development of national standards for medical and community interpreter training, skills assessment, certification and codes of ethics.

This process could be facilitated by supporting current regional efforts in these areas, and convening a national group to develop national guidelines.

Develop national standards or guidelines for the translation of health-related materials according to the principles laid out in Standard 7. Support the adoption of these standards by government agencies and health care organizations that purchase or produce materials in other languages.

Develop standard language or templates for key documents used by many health care organizations, such as consent forms, advanced directives, health information, and medication information.

Such documents could be translated into a range of languages, and made available through the Internet for downloading and customization by individual providers. This could also be done within individual large agencies or health care organizations to streamline the process of producing such materials and greatly reduce associated costs. For example, Washington State Department of Social and Health Services has translated and electronically stores standard templates for dozens of commonly used documents. Slight alterations are made to customize each document for different recipients.

Develop an Internet clearinghouse of downloadable sample translated documents developed by agencies around the country.

Such a clearinghouse would be an excellent and highly cost-effective venture that could partner government agencies, foundations and national health organizations to reduce or eliminate the re-creation and duplication of effort to develop materials that already exist. Models for such an effort have been sponsored by a government health agency in Australia,

and a public-private partnership in Canada (see the discussion section of Standard 7 for more detail on these models).

Organizational Supports for Cultural Competence

Develop model implementation plan and toolkit for CLAS that includes model strategies, policies, and a phase-in timetable with checklists and measurable short-and long-term process goals.

Health care organizations without much experience in designing or implementing CLAS services need guidance on where to start and what can be accomplished over a given timeframe. Based on the experience of other organizations that have implemented CLAS services, a customizable implementation plan and detailed toolkit would support the development of an organizational strategic plan and efficient implementation of services. The Heartland Alliance's cultural competence toolkit for managed care organizations is one model of such a product that could be more closely tailored to the CLAS standards and expanded to address the needs and structures of other types of health care organizations.

Expand the availability of centralized information on CLAS model programs and practices, with contacts, detailed resource information, and bibliographic references.

Health care organizations frequently feel unable to begin work on CLAS because they are unaware of successful implementation models for each standard. A well-publicized clearinghouse of information would help organizations avoid reinventing the wheel or investing in strategies that have not proven their worth. This recommendation will be discussed in further detail in the general recommendations section below.

Survey and disseminate information about model strategies to involve ethnic communities in the development and oversight of CLAS services.

Designing structures and processes to meaningfully involve ethnic community representatives in the development and oversight of health services is an ongoing challenge for health care organizations. Community and migrant health centers have a long history of experience in this area, and many mainstream organizations have begun to develop community advisory committees and other mechanisms to facilitate this involvement. Surveying and analyzing the elements of successful and failed strategies of integrating community and consumer involvement in the design and delivery of CLAS services would be a useful resource for those working towards this goal.

Conduct a critical review of current organizational self-assessment tools, and define baseline and ongoing organizational self-assessment processes for cultural and linguistic competence

Organizational self-assessment can help identify problems and develop strategies for improving delivery of CLAS. However, available tools for organizational self-assessment of cultural competence have not been validated against each other and often are not suited for every type of institution. Defining processes for conducting baseline and ongoing organizational self-assessment of CLAS-related activities will help organizations track their progress in implementing the CLAS standards.

Develop standard tools or processes for health care organizations to measure performance satisfaction, and access related to CLAS.

Integrating measures related to cultural and linguistic competence into existing quality improvement programs could help organizations learn whether CLAS delivery processes produce the desired results. However, no consensus on state-of-the-art measures of performance, satisfaction, and access related to CLAS currently exists. Developing standard, CLAS-related measurement tools or processes could help organizations link these measures with routine quality efforts, and could help build the evidence base regarding the impact of CLAS interventions on performance, patient satisfaction, and access.

Federal, state, and accreditation agencies should develop and require standardized, uniform data sets related to the race, ethnicity, and language of their patients/consumers.

The collection and analyses of race, ethnicity, and language data can help organizations provide CLAS to their patients/consumers and identify and track similarities and differences in performance and quality of care in ethnic, cultural, and geographic communities. However, one of the difficulties in analyzing these data is the wide variation of collection methodologies. Collaborative efforts among local, state, and Federal agencies to develop and require the use of uniform race, ethnicity, and language data sets would foster the sharing and broader use of these data and facilitate research and analysis.

Develop best practices or methods to help health care organizations integrate race, ethnicity, and language data components into their data collection processes.

Collecting data on race, ethnicity, and language is not yet a universal practice, and health care organizations have concerns about issues related to implementation and maintenance, confidentiality, and costs. Exploring lessons learned by organizations that have successfully integrated these data components into their data collection processes and developing a primer that explains identified best practices or methods could help other organizations overcome barriers to implementing CLAS Standard 10.

Develop a guide to help health care organizations incorporate race, ethnicity, and language variables into routine outcomes analyses.

In the process of conducting standard outcomes or risk management assessments, many health care organizations neglect to look at race, ethnicity, and language variables. As a result, they are unable to track health outcomes disparities associated with these variables or to make improvements in services based on quantifiable experience. Health care organizations would benefit from a guide outlining sample methodologies and examples from health care organizations already engaged in this work.

Develop a framework or process for maintaining a culture-sensitive community file and needs assessment.

Obtaining demographic, cultural, and epidemiological data on the racial and ethnic groups in the service area and identifying the health care needs and preferences of those groups can help health care organizations better understand and serve their diverse communities. However,

many organizations have neither the in-house capacity to maintain a community profile/needs assessment nor the resources to hire consultants to conduct this CLAS activity. Other organizations use standard public health frameworks to obtain information about their communities but do not yet collect data relevant to CLAS. The development of a framework or process that organizations can follow to obtain and analyze key elements of CLAS-related information on their community will foster implementation of Standard 11. For example, a national organization such as the Association of State and Territorial Health Officials, the National Association of City and County Health Organizations, or the U.S. Conference of Mayors could develop a strategy and tool for state and local health departments to collaborate with health care organizations in their area to centrally collect data relevant to community profiles and needs assessments (see the discussion section of Standard 11).

Develop guidance for the human resources, legal and ethics staff or committees of health care organizations on the impact and management of cross-cultural ethics issues.

Health care organizations and clinicians are often faced with cultural and religious beliefs that may contradict standard clinical or institutional practices. For example, a family may have cultural reasons for not sharing a terminal diagnosis with a patient relative, or a patient may refuse to read and sign informed consent documents that outline potentially negative outcomes. An instructional problem-solving case-book and training program on cross-cultural conflict, ethical and legal issues, including model institutional processes and policies, should be developed and made widely available to staff who participate in resolving institutional ethical or legal conflicts.

Develop reporting guidelines to help organizations share information with the public about efforts to implement the CLAS standards.

Providing information about an organization's progress toward implementing the CLAS standards can help an organization reach out to potential patients/consumers and educate staff about the cultural and linguistic competence goals of the organization. The information would also help community residents to understand and monitor the progress that the organization is making towards implementation of CLAS standards. Without reporting guidelines, however, every organization could have its own approach to evaluating its progress toward what it has defined as CLAS, and consumers will not be able to compare reported results from various health care organizations. The development of a common set of reporting requirements will enhance the comparability of reported information and the ability of consumers to make informed choices about their health care.

General Recommendations on the Overall CLAS Standards Agenda

In addition to recommendations listed above on the specific performance areas outlined in the CLAS standards, the public comments, the National Project Advisory Committee, and Project Team made recommendations on how to support implementation of the overall CLAS standards agenda. These recommendations are listed by general categories below.

Raise awareness about and promote the adoption of the CLAS standards

The CLAS standards should be disseminated and promoted widely to all key stakeholder groups identified in the Federal Register notice: providers, policymakers, accreditation and

credentialing agencies, purchasers, patients, advocates, educators, and the health care community in general. For example, national ethnic organizations should work with local affiliates and other community-based ethnic organizations to educate consumers about how to use the CLAS standards with local health organizations to make services more culturally and linguistically accessible. National and state health professional and health provider organizations should communicate with their constituencies about the standards through conferences, newsletters, journals, and electronic media. Health professions training institutions and organizations should incorporate information about CLAS into their training, curricula development, accreditation and licensing processes. Health care accreditation organizations and purchasers should all be targeted for awareness-raising efforts that suggest how representatives of these stakeholder groups can integrate the CLAS standards into their own goals. A national coalition with representatives of multiple stakeholder groups should be formed to advocate for changes in health care delivery, payment and policymaking arenas around CLAS.

HHS should formally adopt the standards, through regulation and program guidance, for all Federally funded health programs. State health agencies should also consider adopting the standards for their own agencies as well as for health care services for which they contract with public and private providers. The standards should be incorporated into the standards and performance measures of key national accrediting organizations such as the Joint Commission on Accreditation of Health Care Organizations and the National Committee on Quality Assurance, as well as state licensing and accrediting bodies. Individual health care provider organizations should also consider adopting the CLAS standards into their missions and strategic plans.

Support the development and dissemination of resources and technical assistance on CLAS implementation

Develop a national clearinghouse of information on the implementation of CLAS. Such a resource, which ideally would be internet based, could include information about model programs; assessments of different approaches, techniques and tools; evaluations of and links to other information sources, and interactive forums for individuals to share information and resources with each other. Such a clearinghouse should coordinate and enhance, not duplicate, existing Internet and physical sources of information about cross-cultural health care.

Support the development and dissemination of specific resource needs, such as model interpreter and cultural competence training, standard translation techniques, community involvement strategies, performance measures, etc.

Coordinate and support the delivery of technical assistance specifically on CLAS, building on the efforts of other technical centers, such as the OMH Resource Center and the National Center for Cultural Competence. This technical assistance could be delivered free or on a sliding scale fee-base through telephone, e-mail, conferences, and on-site training.

Support assessments, evaluations, and oversight on implementation of the CLAS standards

Conduct pilot tests on the implementation of CLAS by health care organizations to determine

the feasibility of different approaches, assess the impact of implementation on organizational behavior, and document an experience base that can be used in other settings.

Support the development of a variety of tools that would facilitate the assessment, evaluation, and monitoring of CLAS activities by health care organizations. Standardized tools for self assessments, and measuring performance would help these organizations track their own progress in implementing CLAS, and assist outside agencies with evaluating and comparing performance over time and between similar types of health care organizations.

Support research on the impact of CLAS interventions on health care outcomes, including the identification of key questions, data sets, researchers, and funding for such research.

Dissemination of the results of such research will aid providers and policymakers who need a stronger evidence base on the value of CLAS to support their implementation activities or policymaking. OMH is currently supporting the development of a CLAS research agenda to provide guidance on these issues.

Next steps

Track the implementation and adoption of the CLAS standards by different types of health organizations around the country. An internet-based clearinghouse of this information would facilitate the ability of health care organizations to learn from and build on the experiences rather than recreate the wheel. It would also assist researchers and policymakers who want to track and evaluate the progress of CLAS implementation. This could be developed as a part of the national CLAS clearinghouse recommended above or separately.

Analyze the data collected about CLAS implementation experience to document trends, best practices, and lessons learned. Such an evaluation would support future revisions of the CLAS standards.

The CLAS Standards should be reviewed, revised, and reissued on a periodic basis by a national task force of experts, potentially modeled after the US Preventive Services Task Force [<http://www.ahcpr.gov/clinic/uspsfact.htm>]. This group could review the evidence base on implementation activities, the results of outcomes-related research, and could make recommendations to key stakeholders that would further the CLAS standards development and implementation agenda.

¹ For additional recommendations suitable for state and local organizations and funders, readers are directed to the summary of recommendations contained in the Multicultural Health Best Practices Overview prepared by Resources for Cross Cultural Health Care for The California Endowment and available online at [www.diversityrx.org/best].

PART II: INDIVIDUAL STANDARDS WITH DISCUSSION

INDIVIDUAL STANDARDS WITH DISCUSSION

INTRODUCTION

Part II presents the final national standards on culturally and linguistically appropriate services (CLAS) in health care as they appeared in the Federal Register on December 22, 2000 (Volume 65, No. 247, pages 80865 to 80879). Each standard is accompanied by a brief commentary (also published in the Federal Register) that provides additional clarification of key issues or requirements. Because these commentaries are crucial to the understanding of their respective standards, it is intended that they not be separated from the CLAS standards in executive summaries or other abbreviations of the full CLAS report.

In addition, Part II includes discussion sections that further explicate the intent, current practice and research, and/or potential implementation strategies or issues for each standard. Some of the material in the discussions has been gleaned from the public comment and NPAC review processes, which produced a rich store of information, suggestions, and opinions about the context, implementation, and implications of the CLAS standards¹. Also included is material that was originally reported in *Assessing Cultural Competence in Health Care: Recommendations for National Standards and an Outcomes-Focused Research Agenda* (Fortier and Taylor, 1999), which was published at the end of the first phase of the CLAS standards project. The length of each discussion section reflects the availability of relevant research, policy, public comments, and reported practices and, thus, should not be construed as indicative of the relative importance of a particular standard.

¹ The full complement of public comments on the CLAS standards is available on the OMH Resource Center Web site [<http://www.omhrc/clas>].

STANDARD 1

CULTURALLY COMPETENT HEALTH CARE (GUIDELINE)

Standard and Commentary

1. Health care organizations should ensure that patients/consumers receive from all staff members effective, understandable, and respectful care that is provided in a manner compatible with their cultural health beliefs and practices and preferred language

This standard constitutes the fundamental requirement on which all activities specified in the other CLAS standards are based. Its intent is to ensure that all patients/consumers receiving health care services experience culturally and linguistically competent encounters with an organization's staff. The standard is relevant not only to staff, who ultimately are responsible for the kinds of interactions they have with patients, but also to their organizations, which must provide the managers, policies, and systems that support the realities of culturally competent encounters.

Respectful care includes taking into consideration the values, preferences, and expressed needs of the patient/consumer. Understandable care involves communicating in the preferred language of patients/consumers and ensuring that they understand all clinical and administrative information. Effective care results in positive outcomes for patients/consumers, including satisfaction; appropriate preventive services, diagnosis, and treatment; adherence; and improved health status.

Cultural competence includes being able to recognize and respond to health-related beliefs and cultural values, disease incidence and prevalence, and treatment efficacy. Examples of culturally competent care include striving to overcome cultural, language, and communications barriers; providing an environment in which patients/consumers from diverse cultural backgrounds feel comfortable discussing their cultural health beliefs and practices in the context of negotiating treatment options; using community workers as a check on the effectiveness of communication and care; encouraging patients/consumers to express their spiritual beliefs and cultural practices; and being familiar with and respectful of various traditional healing systems and beliefs and, where appropriate, integrating these approaches into treatment plans. When individuals need additional assistance, it may be appropriate to involve a patient advocate, case manager, or ombudsperson with special expertise in cross-cultural issues.

Ways to operationalize this standard include implementing all the other CLAS standards. For example, in accordance with Standard 3, ensure that staff and other personnel receive cross-cultural education and training, and that their skills in providing culturally competent care are assessed through testing, direct observation, and monitoring of patient/consumer satisfaction with individual staff/personnel encounters. Assessment of staff and other personnel could also be done in the context of regular staff performance reviews or other evaluations that could be included in the organizational self-assessment called for in Standard 9. Health care organizations should provide patients/consumers with information regarding existing laws and policies prohibiting disrespectful or discriminatory treatment or marketing/enrollment practices.

Discussion

Intent of the Standard

Although the fourteen CLAS standards as a whole articulate the many different activities that constitute an organization's cultural and linguistic competence, this first standard focuses on the heart of the issue—ensuring that all staff interact with patients/consumers in a way that is culturally appropriate. The standard is inextricably linked to Standards 2 and 3 because the two principal actions an organization can take to foster culturally competent interactions are to recruit and retain a diverse staff and to ensure that all staff members receive ongoing education and training in CLAS delivery. The National Health Law Program emphasized the intent of this standard in its public comments, noting that “this overarching and comprehensive standard is crucial to creating a safe and welcoming environment for the entire patient population and sending a message of appreciation for the diversity of patients, as well as setting an appropriate tone for the organization. If the patient feels comfortable with the provider, she or he will more freely communicate with the provider and, consequently, be a more informed patient.” One physician commented that by increasing their cultural diversity and competence and making their patients feel comfortable about receiving health care, providers would be able to focus better on health disparities in minority populations and thus decrease a major health economic issue in the United States.

Definition and Assessment of Individual Cultural and Linguistic Competence

There are many definitions of cultural competence, and several similar terms that are used in the literature, including cultural appropriateness, cultural awareness, cultural responsiveness, and cultural sensitivity. The various definitions of cultural competence that are articulated by laws, organizations, and academics represent diverse perspectives and address different needs. A broad vision is offered by Lavizzo-Mourey and Mackenzie and includes being able to recognize and respond to health-related beliefs and cultural practices, disparities in disease incidence and prevalence, and differences in treatment efficacy. The meaning of cultural and linguistic competence that is stated in the preamble constituted the working definition used in the development of the CLAS standards and is adapted from definitions developed by Cross et al (1989). This definition was chosen because it is the most broadly applicable across all of an organization's staff. Providing care in a manner that is compatible with the patient's/consumer's cultural health beliefs and practices and preferred language, as stated in the standard itself, is a distillation of key elements of cultural and linguistic competence that apply to all members of an organization's staff.

Although there is no universal agreement on what specifically constitutes cultural and linguistic competence in an individual or how it is best measured, there are many guides and tools available to assist health care providers. These are discussed in more detail in the discussion section of Standard 3. In general, practitioners must strive to develop the following:

- attitudes that are open-minded and tolerant of social and cultural differences;
- interpersonal behaviors that convey concern and respect, in spite of any differences;
- a commitment to continually increase personal knowledge of the impact of culture on health, in addition to specific knowledge about the communities being served; and

- skills that allow providers to respectfully elicit and respond constructively to relevant personal and cultural issues from patients/consumers during the clinical interview.

Individuals should also strive to deepen their own cultural self awareness as well as their knowledge of and sensitivity to the historical/collective experiences of racial and ethnic groups that have experienced racism, prejudice, bias, and other forms of discrimination in the health care system and society in general.

Effective, Understandable, and Respectful Care

Effective health care is care that successfully restores the patient/consumer to the desired health status and takes steps to protect future health by incorporating health promotion, disease prevention, and wellness interventions. According to one health services researcher, “not only would it predictably and reliably cure the patient and increase his or her wellbeing, but it would be available, acceptable, affordable, free of adverse effects, easy to administer, readily amenable to quality control measures, compatible with other necessary health and social interventions, and, for good measure, it would increase job satisfaction in the health professional who delivers and monitors it” (Greenhalgh, 1998). In order for health services to have a chance of being effective in a patient, the clinician must accurately diagnose the illness, discern the correct treatment for that individual, and negotiate the treatment regimen successfully with the patient. These steps can all be affected by linguistically and culturally mediated factors that have an impact on trust, open communication, and adherence to treatment plans. There is also an increasing evidence base that suggests that ethnic, racial, and ethnopharmacological differences in how patients respond to treatments may vary the effectiveness of one approach over another.

Understandable care focuses on the need for patients/consumers to fully comprehend questions, instructions, and explanations from clinical, administrative, and other staff. It relates to populations that have limited proficiency in English as well as diverse English-speaking groups who may still have problems understanding the health care system and medical terminology. Understandable care encompasses not only addressing language differences and ensuring linguistic comprehension but also explaining technical or specialized terminology and concepts and verifying that the patient/consumer understands the content of what is being said.

Respect may appear to be implied by cultural competence, but it does not always appear in the literature as an essential component of culturally competent care. However, respectful care is an important factor in creating an environment in which patients/consumers from diverse backgrounds feel comfortable discussing their specific needs with any member of an organization’s staff. The Consumer Bill of Rights and Responsibilities states that “Consumers have the right to considerate, respectful care from all members of the health care system at all times and under all circumstances. The Bill of Rights cites one definition of respect (Faden and Beauchamp, 1986) as recognizing “a person’s capacities and perspectives, including his or her right to hold certain views, to make certain choices, and to take certain actions based on personal values and beliefs.” An environment of mutual respect is essential to maintain a quality health care system. The American Nurses Association’s Nursing’s Code of Ethics sets the goal of providing services with “respect for human dignity and the uniqueness of the client, unrestricted by considerations of social or economic status, personal attributes, or the nature of health problems.” Along with being nonjudgmental and sensitive to the needs of

each individual, staff and organizations can provide respectful care by treating patients/consumers as full partners in the planning and delivery of health care services, as stated in Standard 12. Other actions that communicate respect include preserving patients'/consumers' dignity during physical examinations, giving emotional support to alleviate their fears and anxieties, taking their complaints seriously, and respecting their time by avoiding lengthy waiting room delays and inadequate time with doctors.

Traditional Healing Systems and Beliefs

Integral to the provision of culturally competent health care services is familiarity with and respect for the traditional healing systems and beliefs of diverse cultural groups. The World Health Organization defines traditional medicine as approaches to protecting and restoring health that existed before the arrival of modern medicine. Traditional systems generally have had to meet the needs of local communities for many centuries. Many of the complementary and alternative medical practices that are becoming more popular in the United States—including acupuncture, botanicals, and massage and therapeutic touch—have their roots in traditional medicine. Culturally competent providers ask about and understand the traditional healing practices used by their patients/consumers and integrate these traditional approaches into treatment plans when appropriate. Staff and organizational openness toward and respect for traditional healing practices and traditional healers is an important element in making patients/consumers from culturally diverse backgrounds feel comfortable within a western medical setting and may contribute toward better adherence to treatment plans.

Cultural and Linguistic Competence Among All Staff

Although cultural and linguistic competence measures and training often focus on clinicians, the intent of this standard is to ensure that all members of an organization's staff exhibit the set of behaviors, skills, and attitudes that enables effective work in cross-cultural situations. Having staff members who are not culturally and linguistically sensitive at initial points of contact (e.g., admissions) could result in culturally diverse patients/consumers being excluded from services or feeling unwelcome and leaving the facility before they can be seen by clinical staff. Public comments provided many examples of caregivers who do not consider themselves "staff" and thus not subject to the terms of such a standard; staff members who self-identify themselves as culturally competent without understanding the criteria for this quality; and staff or administrators who believe that treating all patients/consumers alike, or "equally," constitutes cultural competence. Organizations should recognize that although hiring community workers and cultural brokers can be an important way to enhance culturally competent care, it does not diminish the responsibility of all providers and other staff members to be culturally competent. Finally, this standard applies not only to staff providing services in direct medical care settings but also to staff in all care settings, including those who serve people seeking public health or preventive services.

Organizational Role in Ensuring Culturally Competent Encounters

Although the nature of interactions with patients/consumers ultimately depends on staff members, organizations must support culturally and linguistically competent encounters by providing the necessary supervision and infrastructure. Organizations must become familiar with the communities they serve and understand the characteristics and specific perspectives of the cultural groups represented (see Standard 11). Organizations must use this information about the communities to design services that meet the unique and general health care needs of their service area. The organizational role includes working with physicians and other care providers to build cultural information into day-to-day interactions with patients/consumers; making available culturally appropriate diagnostic tools, clinical guidelines, and health education materials; and requiring ongoing education and training on CLAS delivery (see Standard 3). Organizations also need to design services that are accessible to diverse populations (e.g., by staffing and scheduling bilingual and culturally knowledgeable nurses to give advice on call centers, considering longer visits for patients/consumers who have complex linguistic or cultural needs; and building larger exam and waiting rooms in facilities where multiple family members are involved in supporting patients seeking health care). The organization's management should be responsible for assessing the cultural and linguistic competence skills of staff members in performance evaluations and monitoring patient satisfaction with staff encounters.

STANDARD 2

STAFF DIVERSITY (GUIDELINE)

Standard and Commentary

2. Health care organizations should implement strategies to recruit, retain, and promote at all levels of the organization a diverse staff and leadership that are representative of the demographic characteristics of the service area.

The diversity of an organization's staff is a necessary, but not sufficient, condition for providing culturally and linguistically appropriate health care services. Although hiring bilingual individuals from different cultures does not in itself ensure that the staff is culturally competent and sensitive, this practice is a critical component to the delivery of relevant and effective services for all patients/consumers. Diverse staff is defined in the standard as being representative of the diverse demographic population of the service area and includes the leadership of the organization as well as its governing boards, clinicians, and administrative personnel. Building staff that adequately mirrors the diversity of the patient/consumer population should be based on continual assessment of staff demographics (collected as part of organizational self-assessment in accordance with Standard 9) as well as demographic data from the community maintained in accordance with Standard 11. Staff refers not only to personnel employed by the health care organization but also its subcontracted and affiliated personnel.

Staff diversity at all levels of an organization can play an important role in considering the needs of patients/consumers from various cultural and linguistic backgrounds in the decisions and structures of the organization. Examples of the types of staff members whose backgrounds should reflect the community's diversity include clinical staff such as doctors, nurses, and allied health professionals; support staff such as receptionists; administrative staff such as individuals in the billing department; clergy and lay volunteers; and high-level decisionmakers such as senior managers, corporate executives, and governing bodies such as boards of directors.

Acknowledging the practical difficulties in achieving full racial, ethnic, and cultural parity within the workforce, this standard emphasizes commitment and a good-faith effort rather than specific outcomes. It focuses not on numerical goals or quotas, but rather on the continuing efforts of an organization to design, implement, and evaluate strategies for recruiting and retaining a diverse staff as well as continual quality evaluation of improvements in this area. The goal of staff diversity should be incorporated into organizations' mission statements, strategic plans, and goals. Organizations should use proactive strategies, such as incentives, mentoring programs, and partnerships with local schools and employment programs, to build diverse workforce capacity. Organizations should encourage the retention of diverse staff by fostering a culture of responsiveness toward the ideas and challenges that a culturally diverse staff offers.

Discussion

The Value of Diversity in an Organization

There is research evidence that suggests that many culturally diverse patients/consumers frequently prefer to choose providers of the same gender, racial or ethnic background, and language. Some managed care Medicare/Medicaid contracts address this issue of provider choice by calling for two providers from the racial or ethnic background of the patient. Comments on the CLAS standards included a description of one organization's market survey, which found that language is more important to its patients/consumers than ethnicity. In either case, a bilingual, bicultural staff is more likely to be sensitive to cultural issues, and be better able to facilitate direct communication with patients/consumers in whose language staff members are proficient. On an organizational level, it is easier to understand and address the needs of the diverse population groups being served when staff includes members who come from those groups. Moreover, a culturally and linguistically diverse staff can help create an environment that can make patients/consumers feel more comfortable and welcome.

Yet the value of diversity goes beyond the potential benefits of "like serving like." Diversity facilitates the development and maintenance of a culturally and linguistically competent organization, a more complex and far-reaching goal. To accomplish this goal, diversity needs to be embraced consistently throughout the organization, with each person at every level of the organization understanding it as a philosophy and a required practice. Diversity needs to be grounded in the organization's identity and addressed in its strategic plan and mission statement. Staff members with different cultural backgrounds can yield a variety of ideas and decisions that are attuned to the perceptions, motivations, and needs of patients/consumers and can help translate the needs of increasingly diverse communities into effective messages, educational materials, programs, and services. Staff diversity also enhances an organization's ability to attract, retain, educate, and motivate employees. Valuing staff diversity can enable an organization to deliver better services to its patients/consumers and, hopefully, contribute to the eventual elimination of racial and ethnic disparities in health.

Importance of Diversity Among All Staff

Being responsive to the needs of diverse patients/consumers is essential not only at the service level but also at the strategic planning, evaluation, and decision-making levels. Thus, cultural diversity must exist throughout the entire staff of an organization. If most of the staff reflecting diverse populations in the community is employed only in lower level positions, an organization may meet certain state or contractual requirements but not be truly diverse. Diversity among staff providing direct services in support, outreach, or clinical roles is important but not sufficient. Diversity is needed throughout the hierarchy of an organization, including leadership levels such as senior management, chief executives, and board of directors. This can promote strategic planning, as well as policy and decision making, that are inclusive of the cultural and linguistic needs of all patient/consumer populations. Bicultural and bilingual staff at all levels is both a sign of an organization's cultural and linguistic competence, and a motivating force to make the organization's services increasingly relevant and effective for its patients/consumers.

In addition to applying vertically throughout the hierarchies of an organization's staff, this standard also must be applied horizontally across various contractual relationships. Many health care organizations use networks or affiliated providers to deliver services to their patients/consumers. A hospital clinic may subcontract with a group of critical care physicians to provide emergency services. Because such situations are becoming more prevalent, it is important that staff diversity encompass all individuals involved in health care delivery, whatever their contractual or subcontractual relationship with the organization.

Strategies to Build Workforce Capacity

One of the major challenges to building a staff that truly reflects the community being served at all levels is the shortage of diverse capacity within the workforce of health professionals, particularly clinical staff. Students from diverse cultural groups remain dramatically underrepresented among enrollees and graduates of schools of medicine, public health, nursing, and other health professions. Culturally and linguistically diverse health professionals who earned their degrees abroad often face difficulties obtaining licensure and certification in this country. The health care industry is facing increasing shortages of bilingual, bicultural professionals in the available workforce, and health care organizations must compete not only among themselves but also with other industries. This trend makes it difficult to build a staff that adequately mirrors the cultural diversity and broad range of languages that could be encountered within a patient/consumer population. Nevertheless, organizations can design, implement, and evaluate strategies that will help them recruit and retain a more diverse staff.

Recruitment

Collaborations are an important aspect of strategies to recruit diverse staff and build workforce capacities. Improved linkages between academic and service settings can help identify potential recruits already in the educational "pipeline." For example, organizations can work with local universities, medical and allied health schools and federally qualified health centers to provide community-based internships, residencies, rotations, and fellowships that focus on preparation for serving culturally diverse populations. Organizations could become involved with summer employment, college recruitment, or mentoring programs to provide direct learning experiences for younger students who may be interested in health careers or working with diverse populations. Public comments on the CLAS standards emphasized the need for health care organizations to learn about existing grassroots efforts and to build partnerships with community-based organizations, including organizations that provide services to immigrants and refugees. Because true organizational commitment to diversity is a major incentive for bilingual and bicultural job applicants, a genuine commitment to, and active participation in, partnership activities are crucial to attracting candidates.

Incentives are another approach to recruiting bilingual, bicultural staff. Comments suggested that organizations offer salary bonuses or differentials to staff who are bilingual; provide incentives such as salary bonuses to staff who achieve cultural competence or interpreter certification; and support programs such as the National Health Service Corps, which provides incentives to primary care physicians who practice in underserved communities.

Organizations attempting to reach a more diverse group of candidates need to find alternatives to generic newspaper advertisements, search firms, and other mainstream recruiting methods. Community-based and national ethnic health organizations and networks as well as

publications and search firms that target diverse populations may provide better channels for recruiting and advertising vacancies.

“Grow Your Own” Staff

Although community members can add valuable knowledge about language and culture to clinical expertise, they often are asked to do so on a volunteer basis. Organizations can build their staff diversity by helping people from various cultural backgrounds complete preliminary and advanced training for positions at many different levels. “Grow your own” programs hire individuals from the community and provide them with training to act as interpreters and cultural brokers. These liaison staff members are encouraged to pursue formal training for a health profession or other important roles in the organization. This approach helps advance the careers of workers who already are committed to their community. The role of community health workers also can be expanded, with proper training, to include multifunctional roles in bridging the gap between mainstream organizations and ethnic and other cultural communities. For example, community advisors selected as representatives of the various cultural groups served by an organization can educate staff about the needs and concerns of their communities, in addition to acting as interpreters, translators, health educators or case managers.

Many health care organizations sponsor bilingual and bicultural individuals for training to interpret in clinic settings and act as outreach workers in the community. The health promoters (“promotores”) model has been used successfully, especially in the Latino community, to create a pool of fluent and knowledgeable bilingual health workers in their own community. Structured training, internships, and apprenticeships can help community members with little or no knowledge of health issues learn communication and leadership skills and build careers in bilingual outreach and education. One potential source of interpreters suggested in public comments is the recipients of Temporary Aid for Needy Families (“TANF”), who could be trained by county job training programs to be bilingual interpreters as a step towards self-sufficiency.

Retention

Recruiting staff from different cultural and linguistic backgrounds is only one step toward the goal of staff diversity. Retention of staff with bilingual or bicultural skills is another major challenge for organizations, which frequently experience high turnover of diverse staff. Organizations need to monitor work assignments and hire sufficient personnel to ensure that bilingual/bicultural staff members are not “burnt out” by inappropriate or excessive demands. For example, employees who can speak a foreign language of a predominant ethnic group should not be overburdened with demands for interpretation services if not explicitly a part of their job description and responsibilities. Organizations should also avoid using non-clinical support staff inappropriately in cultural broker positions without sufficient training. Organizations need to guard against having a “glass ceiling” by ensuring that diverse staff members get promoted into administrative or managerial positions where their cultural and linguistic capabilities can make unique contributions to planning as well as policy and decision making. In academic settings, an institution’s system of merit raises and promotions should not penalize staff whose involvement with cultural competence activities such as mentoring or

community liaison programs reduce their availability for traditionally valued work such as research. Organizations also need to foster an environment that respects the differences and is responsive to the challenges that a culturally diverse staff brings into the workplace.

STANDARD 3

STAFF EDUCATION AND TRAINING (GUIDELINE)

Standard and Commentary

3. Health care organizations should ensure that staff at all levels and across all disciplines receive ongoing education and training in culturally and linguistically appropriate service delivery.

Hiring a diverse staff does not automatically guarantee the provision of culturally competent care. Staff education and training are also crucial to ensuring CLAS delivery because all staff will interact with patients/consumers representing different countries of origin, acculturation levels, and social and economic standing. Staff refers not only to personnel employed by the health care organization but also its subcontracted and affiliated personnel.

Health care organizations should either verify that staff at all levels and in all disciplines participate in ongoing CME- or CEU-accredited education or other training in CLAS delivery, or arrange for such education and training to be made available to staff. This training should be based on sound educational (i.e., adult learning) principles, include pre- and post-training assessments, and be conducted by appropriately qualified individuals. Training objectives should be tailored for relevance to the particular functions of the trainees and the needs of the specific populations served, and over time should include the following topics:

- Effects of differences in the cultures of staff and patients/consumers on clinical and other workforce encounters, including effects of the culture of American medicine and clinical training;
- elements of effective communication among staff and patients/consumers of different cultures and different languages, including how to work with interpreters and telephone language services;
- strategies and techniques for the resolution of racial, ethnic, or cultural conflicts between staff and patients/consumers;
- health care organizations' written language access policies and procedures, including how to access interpreters and translated written materials;
- applicable provisions of Title VI of the Civil Rights Act of 1964, 42 U.S.C. §2000d, 45 C.F.R. §80.1 et seq. (including Office for Civil Rights Guidance on Title VI of the Civil Rights Act of 1964, with respect to services for (LEP) individuals (65 Fed. Reg. 52762-52774, August 30, 2000);
- health care organizations' complaint/grievance procedures;
- effects of cultural differences on health promotion and disease prevention, diagnosis and treatment, and supportive, rehabilitative, and end-of-life care;
- impact of poverty and socioeconomic status, race and racism, ethnicity, and sociocultural factors on access to care, service utilization, quality of care, and health outcomes;
- differences in the clinical management of preventable and chronic diseases and conditions indicated by differences in the race or ethnicity of patients/consumers; and

- effects of cultural differences among patients/consumers and staff upon health outcomes, patient satisfaction, and clinical management of preventable and chronic diseases and conditions.

Organizations that conduct the trainings should involve community representatives in the development of CLAS education and training programs, in accordance with Standard 12.

Discussion

Education and Training in CLAS

Staff education and training may be the single most important element of assuring the cultural and linguistic competence of an organization and is closely related to improving clinical care and outcomes as addressed in Standard 1. The Consumer Bill of Rights and Responsibilities suggests that organizations can enhance patient participation in treatment by arranging for “continuing education courses for providers to assure cultural and language competency,” and that patients’ right to respect and nondiscrimination can be fostered by developing education and training programs that address “the significance of cultural attitudes on the effectiveness of health care.” The Association of American Medical Colleges (AAMC) has approved mandatory diversity accreditation requirements, and legislation is being proposed in some states to require questions related to cultural competence on board examinations. It was suggested in one public comment that cultural competence training should be viewed as an essential part of patient care, on par in importance with training in treatment methods for medical care.

Currently, there is no consensus on the definition of cultural competence in individuals nor what constitutes a culturally competent health professional. Moreover, there are no standard curricula or universally accepted certification or credentialing for cultural competence, and no standardized measures for evaluating the effectiveness of cultural competence trainings. But there are many options available for organizations to ensure that their staff receives cultural competence training. Some organizations may find it easier to verify staff compliance by offering or arranging for the training themselves. Organizations may hire an external consultant to conduct in-service training or use in-house personnel who have sufficient expertise in developing and delivering cultural competence curricula. Smaller community organizations might be able to pool resources with neighboring organizations to conduct joint trainings. This standard deliberately allows organizations flexibility in how they ensure the ongoing education and training of their staff in CLAS delivery.

Recipients of Training

As one public comment noted, hiring a diverse staff may increase trust in a health care organization, but it does not automatically establish cultural competence. Commenters gave many examples of how similar ethnicity or language alone does not equate with being culturally competent. A hospital in a primarily African-American community in Baltimore might think it sufficient to have African-American doctors on staff. However, within the African-American community there are many different subcommunities. An African-American doctor who sees a Haitian patient may not understand many of the cultural beliefs and traditional medical practices within the Haitian community. All staff, regardless of cultural background, need to receive training in cultural competence. Every staff member will

encounter individuals whose age, cultural traditions, religious and health beliefs, and educational and socioeconomic status differ from his or her own.

For the same reasons that diversity is needed at all levels of an organization to foster cultural competence, staff members from managerial to front-line personnel also need ongoing training in CLAS delivery. All providers—including physicians, nurses, psychiatrists, nutritionists, and social workers—should receive basic and continuing education in cultural competence. This includes providers in training, who can be targeted for cultural competence education in academic settings, as well as more established providers, who received their health professions training when there was little awareness of CLAS. Thus, continuing education courses that train currently practicing providers should be emphasized. Nonclinical staff members for whom continuing education courses are not required still need to receive basic and ongoing training in cultural competence issues to improve their ability to interact sensitively and respectfully with patients/clients of different cultures.

Curricula and Training Programs

In the absence of a standard curriculum for cultural competence, widely varying training programs and curricula abound. This lack of uniformity makes it difficult to evaluate or make recommendations about existing programs or to develop replicable model curricula. Ideally, training and skills assessment should be integrated from the earliest phases of health professions training through the professional licensing process. Several public comments cited the need to incorporate cultural competence training into curriculum and continuing education requirements and for agencies such as the Office of Minority Health to collaborate with health professions schools, state licensure bodies, and accreditation agencies on this issue. Currently, cultural competence education in academic settings ranges from semester-long courses to discrete components that are part of a broader course outline. One public comment reported that many nursing and medical schools currently have no more than a 2- or 3-hour segment of their entire training devoted to cultural competence. However, in addition to the new AAMC requirement, other steps are being taken to address the issue. Curriculum guidelines for teaching culturally sensitive and competent health care to primary health care residents have been developed by the Society of Teachers of Family Medicine and several schools of nursing have developed cross-cultural nursing programs.

Outside academic settings, cultural competence may be addressed in continuing education courses for staff that range from a few hours to a few days. Public comments emphasized that cultural competence education and training should be ongoing to counter the effects of staff turnover and the natural tendency for new behaviors to be extinguished when not reinforced. Ongoing training also recognizes that cultural competence is a process in which staff members are made aware of their limitations, given knowledge and skills, and then provided with opportunities to practice what they have learned by interacting with people of different cultures. Some comments suggested that training programs should be CME- and/or CEU-accredited whenever possible. Such accreditation will help assure that the training program meets applicable minimum requirements by state medical associations regarding content, hours, and trainer credentials. CME- and CEU-accredited training also requires records of attendance and each participant's evaluation of the program. Organizations have found that clinical attendance increases when training programs are CME- and CEU-accredited because such trainings assist clinicians in meeting their licensure or relicensure requirements.

Conferences and workshops on cultural competence topics offer supplemental ways to convey skills, resources, and training. For example, meetings could be designed to address cultural competence issues related to a particular health care setting (e.g., community health clinic), ethnic group (e.g., Hmong women), or health disparity (e.g., diabetes in Native Americans). Public comments provided examples of approaches to teaching cultural competence that use community-based organizations, hands-on experiences, and opportunities for learning from patients as well as other staff members.

Curricula content and approach usually depend on the preferences of the trainer and, thus, vary widely. Whereas some trainings focus on how to eliminate prejudice or value differences, others present theories of cross-cultural health, or general information on specific cultural groups. For example, a common method of teaching cultural competence is to provide a general overview of the role of culture in health service delivery, and then to spend time focusing on the health beliefs and behaviors of specific ethnic groups. While this approach has the effect of increasing general knowledge about an ethnic population, it can lead to facile stereotyping if improperly conducted or understood. It has been debated that incorporating a more universal skills approach to cultural competence allows practitioners to use general questioning and medical history-taking techniques on any individual from any ethnic background (e.g., Kleinman, 1978; Berlin, 1982). This approach could be more useful in health facilities that see a wide diversity of clientele and could be combined with intensive education about specific ethnic groups.

Several comments emphasized the importance of conducting staff training needs assessments, and one recommendation called for focus groups to uncover specific issues that affect how staff members interact with different patient groups. Some comments indicated that providers prefer training that is customized to their specific responsibilities, issues, organization, and patient/consumer populations. Thus, training for a children's hospital in a Latino community should target Latino pediatric issues. Along with credentialing requirements, customized content and the provision of practical tools are key strategies to encourage staff to participate in cultural competence education and training. Although organizations that conduct their own trainings will have control over content and approach, all organizations should ensure that key topics are addressed over the course of ongoing trainings. Not every element of cultural competence education and training can be prescribed, but the topics suggested in the standard's commentary focus on a set of knowledge and skills that will enable staff to deliver basic CLAS within the organizational setting.

Cultural Competence Trainers

Although trainers and consultants play a major role in educating and training health professionals in CLAS delivery, their credentials in this area may vary widely. Some individuals have completed doctoral level research and academic training on cross-cultural issues such as medical anthropology or transcultural psychology; others rely on previous experience in human resources diversity training; and others have no formal training at all. Public comments suggested that some well-meaning cultural competence trainers are teaching their own biases and that it is important to assure that curriculum developers and trainers have sound credentials and relevant experience. However, there is no national consensus on what these credentials and experience should be, although there are increasing numbers of degrees, courses, and programs specifically designed to qualify individuals to be cultural

competence trainers. At least one state university has begun offering a master's degree program in diversity training, and some organizations are "growing" their own trainers by supporting this kind of graduate education for their employees. Until credentials or certification programs for cultural competence trainers are established, an organization can try to identify qualified individuals by checking their references, observing them conduct a training session, and reviewing any evaluative information on the short- and long-term impact of their training. Comments also suggested that using CME-accredited trainings is one way to hold trainers to a standard.

Assessment of the Impact and Validity of Trainings

Several comments recommended pre- and post-training self-assessments of trainees as one means to evaluate the impact of cultural competence trainings. However, neither comments nor the literature present any consensus on what constitute valid and appropriate self-assessment tools and performance measures. At the least, pre- and post- training self-assessments should indicate whether an individual has absorbed the content of the training. It is more useful to know, in the short term, whether participants have incorporated knowledge and skills from the trainings into their daily practice and, in the long term, whether such behavior changes have affected patient/consumer satisfaction or outcomes. Harvard Pilgrim Health Care uses post-training videotapes of model patient-provider interactions to assist with the behavioral interpretation of how well clinicians have incorporated their training. Comments also suggested that linking the demonstration of cultural and linguistic competence skills and behaviors to performance evaluations and pay increases could help reward staff for their development in this area.

Many assessment tools have been developed and reviewed by researchers and agencies, but they have not been rated against each other or validated. A review of the measurement and assessment literature conducted by Estrada (1999) indicated that many available tools are questionnaires that presumably ask valid and representative questions about cultural competence and solicit answers that presumably reflect reliable and accurate information about respondents' assessment of cultural competence services. Yet no empirical evidence shows whether these measures are valid (i.e., representative of the construct of cultural competence) or reliable (i.e., provide accurate information about cultural competence). Moreover, it remains difficult and time-consuming to find assessment tools that are appropriate for particular organizations or circumstances. Independent and objective analyses of such resources are difficult to find because information is often spread by word-of-mouth, and organizations tend to promote their own tools and approaches. Researchers continue to develop and test new tools that are promising but not without limitations. Until self-assessment tools are adequately validated, it will remain difficult to determine and compare the effectiveness of cultural competence education and training programs.

Community Involvement in Training

Although input from public comments generally favored basic standards for curricula and trainers, there were many reminders that cultural competence trainings ultimately must fit the needs of the community. Consequently, an important aspect of cultural competence training is considering the role that local communities will have in training activities. For organizations that conduct their own trainings, the involvement of community representatives from the earliest stages of planning will help curriculum developers and trainers understand the needs,

culture, and views of people the organization is serving. Community input can serve a dual purpose in strengthening training programs. First, it can provide information such as specifics about relevant health issues, language nuances, and health beliefs and practices. Just as important, it can provide concrete feedback on how patients/consumers perceive and react to the organization and its staff. Comments suggested that involving community organizations in the development of training programs also could help identify local funding sources and facilitate any data collection (e.g., patient satisfaction surveys) that the organization intends to link to the trainings.

STANDARD 4

QUALIFIED LANGUAGE ASSISTANCE SERVICES (MANDATE)

Standard and Commentary

4. Health care organizations must offer and provide language assistance services, including bilingual staff and interpreter services, at no cost to each patient/consumer with limited English proficiency at all points of contact, in a timely manner during all hours of operation.

Standards 4, 5, 6, and 7 are based on Title VI of the Civil Rights Act of 1964 (Title VI) with respect to services for limited English proficient (LEP) individuals. Title VI requires all entities receiving Federal financial assistance, including health care organizations, take steps to ensure that LEP persons have meaningful access to the health services that they provide. The key to providing meaningful access for LEP persons is to ensure effective communication between the entity and the LEP person. For complete details on compliance with these requirements, consult the HHS guidance on Title VI with respect to services for (LEP) individuals (65 Fed. Reg. 52762-52774, August 30, 2000) at [www.hhs.gov/ocr/lep].

Language services, as described below, must be made available to each individual with limited English proficiency who seeks services, regardless of the size of the individual's language group in that community. Such an individual cannot speak, read, or understand the English language at a level that permits him or her to interact effectively with clinical or nonclinical staff at a health care organization. (Patients needing services in American Sign Language would also be covered by this standard, although other Federal laws and regulations apply and should be consulted separately.)

Language services include, as a first preference, the availability of bilingual staff who can communicate directly with patients/consumers in their preferred language. When such staff members are not available, face-to-face interpretation provided by trained staff, or contract or volunteer interpreters, is the next preference. Telephone interpreter services should be used as a supplemental system when an interpreter is needed instantly, or when services are needed in an unusual or infrequently encountered language. The competence and qualifications of individuals providing language services are discussed in Standard 6.

Discussion

There have been numerous anecdotal and research-based accounts of how language barriers negatively affect the ability of a person with limited English proficiency to benefit from health care services. When these barriers go unaddressed, patients can be harmed because critical health information was not properly communicated. By contrast, research evidence demonstrates that patients are more satisfied and adhere better to treatment when language assistance is provided. In addition to these clinical and ethical reasons for providing language assistance, the Office for Civil Rights (OCR) guidance on persons with LEP thoroughly states the civil rights case for doing so.

Language assistance strategies and model programs

Health care organizations may use a wide spectrum of strategies for overcoming linguistic barriers to health care. These strategies include the use of bilingual providers, bilingual/bicultural community health workers, and interpreters (onsite and telephone). Certain strategies may work best in a particular health care setting, while others have wide application and can be useful in all settings—the best programs frequently use a combination of approaches. An overview of these strategies can be found in “Overview of Models and Strategies for Overcoming Linguistic and Cultural Barriers to Health Care” [<http://www.diversityrx.org/HTML/MODELS.htm>]. Despite concerns from many health care providers that addressing language barriers is difficult and expensive, there are many model programs nationwide at community health centers, health departments, hospitals, and managed care organizations. A few examples of some of these programs should give a sense of the approaches a health care institution can take.

Among smaller volume health care organizations, such as community health centers and health departments, the most frequently used options are bilingual staff, and staff or volunteer interpreters who may also have other job responsibilities. Many of these organizations also use or run community interpreter services, which can offer a wide variety of different languages to many providers in a community at competitive rates. It is essentially a shared resource that allows many providers to access contract interpreters, especially from small language groups, when hiring them individually would be prohibitively expensive. Many Seattle area hospitals turned to a community-based interpreter service for their initial response to language discrimination complaints, and inaugurated the Hospital Interpreter Program. Similar community services have been started by university-based programs (e.g. Language Link of Worcester, Massachusetts and Community Health Connect of Northern Virginia), immigrant services agencies (e.g. Catholic Charities of San Diego, California, and the Heartland Alliance of Chicago, Illinois), health departments, and community clinics (e.g. Asian Health Services of Oakland, California). These programs have a qualitative advantage over telephone interpreter services in that they offer in-person, local ethnic community expertise at lower rates, and their interpreters are trained specifically for medical settings. These programs have the added bonus of creating jobs and career paths for immigrants and refugees.

Some of the most exciting and sophisticated programs of interpreter services in health care settings exist at a select group of hospitals and health care systems in different parts of the country. Massachusetts and the Seattle area are noted for having the highest density of interpreter services among hospitals in their regions. Exceptional model programs also are

found at the University of California-Davis, Stanford University Hospital, Santa Clara Valley Medical Center, and Cedars-Sinai Medical Center in California. Other notable programs have been developed in Oregon, Minnesota, Illinois, and Florida. Characteristics of these model programs (which may provide more than 50,000 interpreted encounters per year) include: an organization-wide commitment to develop, staff, and fund formal interpreter programs with administrative staff and in-house or contract interpreters; 24-hour access to onsite interpreters or telephone backup services; computerized tracking of patient language characteristics (as called for in Standard 10), interpreter scheduling, and utilization; formal assessment of interpreter skills and/or training; program evaluation; and advocacy from clinical staff to administrators on the need to maintain a trained interpretation staff adequate to meet patient demand.

Perhaps the most challenging setting in which to successfully bridge language barriers is the network or multi-facility managed care organization (MCO). The sheer numbers of providers and facilities, combined with an ethnically diverse and geographically dispersed client base, makes the replication of other model practices or programs organizationally challenging. Nevertheless, many MCOs are attempting to tackle the problem in a variety of ways:

- Alameda Alliance for Health(AAH) is a network public Medicaid managed care plan that was developed to serve Alameda County, California. It provides interpreter services for clinical visits through a community language bank that trains and certifies interpreters, with a telephone language line back-up. The plan uses its provider newsletters to promote the use of interpreters. To overcome provider resistance to using interpreters, AAH is planning to pay an increment for visits for which interpreters are used. This policy has been budgeted, but was not yet implemented as of August, 2000.
- Amerigroup Corporation is a plan that serves only urban populations in New Jersey, Illinois, Texas, Maryland, and Washington, DC. It uses a network of interpreters credentialed through a process similar to the one used to credential its provider network. To minimize the amount of wait time, the plan uses two (rather than one) telephone language lines as back-up. Every provider goes through an orientation which includes information on how to access free interpreter services. Amerigroup also gives providers a card with the number to access interpreter services 24-hours a day/seven days a week, and publishes information in a newsletter on interpreter availability. Amerigroup arranges and pays for the interpreter services used by providers. Usually the enrollee calls member services, and the plan arranges for the interpreter services in advance of the provider appointment.
- Kaiser Permanente (KP)-Southern California actively recruits and attempts to deploy bilingual health professionals at facilities where demand is greatest. It also offers a pay differential for bilingual staff who serve as interpreters and have passed a proficiency exam. The KP-San Francisco medical center offers interpretation and translation in 37 languages and dialects. The majority of the 20,000 per year face-to-face interpreter appointments are prescheduled, and 95 percent of interpreter staff are trained through a community college health care interpreter certificate program. KP-San Francisco has also implemented language preference fields in their member database, and established a Chinese interpreter call center to support the Northern California region's appointments and advice call center with more than 45,000 telephone interpreting encounters per year.

These organizations each take a slightly different approach to meeting language needs, and it is likely that a combination of strategies would be the most flexible and comprehensive solution. This combination could include: a bilingual provider roster; in-house or contract interpreters who could be deployed for appointments with specialists or other non-bilingual providers; bilingual/bicultural “case managers” to handle member services calls, appointments, health education visits, and other non-clinical encounters; and network agreements with hospitals and other facilities that have in-house language capacity. The greatest difficulty would probably remain with free-standing contract pharmacy, laboratory and other diagnostic facilities that typically do not offer language services. These institutions could use the MCO’s contract telephone interpreter services.

Telephone Interpreter Services

As noted in the discussion of Standard 6, both the OCR guidance and the National Health Law Program (NHeLP) report speak to using telephone interpreter services as a supplemental system, because such services may not always have readily available interpreters who are familiar with medical terminology or concepts. Nevertheless, telephone interpretation may be the only option in facilities that are very decentralized (such as plans based on an independent physician network), or must deal with a large number (25 or more) of languages, for which it would be difficult to maintain an adequate staff. In general, face-to-face encounters between patients/consumers and clinicians that involve diagnosis, treatment, and education may benefit from an on-site interpreter and, if lengthy, may be significantly cheaper than using a phone service. On-site interpreters are also able to observe and raise issues indicated by demeanor or body language from the patient—an especially critical ability when sensitive information is being communicated. Telephone interpretation may be appropriate for nonclinical interactions, emergency situations when waiting for an in-person interpreter may compromise patient outcomes, or situations requiring very uncommon languages. Staff should have clear written policies on when it is acceptable to use telephone interpreter services, and when in-person interpretation is necessary. Health care organizations should have standards by which they evaluate the quality of the services received, and have criteria to select high quality vendors. They should evaluate the recruitment and training programs used to select and train phone interpreters. If phone interpreters are used at all, procedures and policies should be in place to facilitate the use of these phone lines, and staff should be trained in their use.

Cost of Interpreter Services

There were a significant number of comments expressing concern about the financial implications of needing to provide language assistance services, especially interpretation. Comments representing home health agencies and small practice physicians receiving Medicare or Medicaid reimbursement felt that the cost of telephone or in-person interpretation services was frequently more expensive than the reimbursement they received for the office visit. Small community clinics and larger institutions are also concerned about the costs of interpreter programs, either because their overall budgets are fairly restricted, or the potential volume of demand is so large and diverse. These concerns have considerable merit, and reimbursement for interpretation and translation is an issue that Federal, state, and private insurance purchasers need to take seriously. As one doctor noted, interpretation for a non-English speaking patient/consumer is as important a diagnostic tool, or more so, than any blood test or x-ray. If medical diagnostic procedures are paid for, then interpretation services

should be similarly reimbursable. Washington State is one of the few States to reimburse for interpreter services under Medicaid. The Health Care Financing Administration in August 2000 sent a letter to state Medicaid directors advising them that under both the State Child Health Insurance Program (SCHIP) and Medicaid programs, “Federal matching funds are available for States’ expenditures related to the provision of oral and written translation administrative activities and services provided for SCHIP or Medicaid recipients. Federal financial participation is available in state expenditures for such activities or services whether provided by staff interpreters, contract interpreters, or through a telephone service” [<http://www.hcfa.gov/medicaid/smd83100.htm>].

In the absence of reimbursement, all health care providers and organizations should consider the hidden costs of not bridging language barriers for patients. Individual physicians should consider the ethical and malpractice risks of treating patients/consumers with whom they cannot communicate. Health care organizations should also consider these issues, and should examine the costs of many ad hoc approaches, such as taking highly paid bilingual professionals away from clinical work to do interpretation, canceling scheduled surgical procedures because a patient did not understand the pre-operative instructions, or caring for much sicker individuals in the emergency room because patients had been unable to communicate with the appointments clerk in the primary care department. Jacobs found that the implementation of interpreter services at a New England health organization increased the use of preventive and other clinical services, such as the number of office visits, prescriptions written and filled, and receipt of flu shots, rectal exams, and fecal occult blood testing (Jacobs, 2000).

In light of cost-related concerns, it is interesting to note that the model programs described above were not spontaneously conceived, accepted, or maintained. Almost all these programs were started in response to Title VI discrimination complaints filed by LEP individuals that led to reviews and corrective consent agreements between the HHS Office for Civil Rights and the facility. Language services can be increasingly expensive to maintain as ethnic diversity in a community increases. Nevertheless, attempts to cut back programs are frequently met with vocal resistance from clinical staff who have come to rely on and respect trained interpreter assistance, and are unwilling to risk treating patients without it.

STANDARD 5

NOTICES TO PATIENTS/CONSUMERS OF THE RIGHT TO LANGUAGE ASSISTANCE SERVICES (MANDATE)

Standard and Commentary

5. Health care organizations must provide to patients/consumers in their preferred language both verbal offers and written notices informing them of their right to receive language assistance services.

LEP individuals should be informed—in a language they can understand—that they have the right to free language services and that such services are readily available. At all points of contact, health care organizations should also distribute written notices with this information and post translated signage. Health care organizations should explicitly inquire about the preferred language of each patient/consumer and record this information in all records. The preferred language of each patient/consumer is the language in which he or she feels most comfortable in a clinical or nonclinical encounter.

Some successful methods of informing patients/consumers about language assistance services include: a) using language identification or “I speak . . .” cards; b) posting and maintaining signs in regularly encountered languages at all points of entry; c) creating uniform procedures for timely and effective telephone communication between staff and LEP persons; and d) including statements about the services available and the right to free language assistance services in appropriate non-English languages in brochures, booklets, outreach materials, and other materials that are routinely distributed to the public.

Discussion

Notices of Rights to Language Assistance

It is frequently a challenge for individuals with LEP to access interpreter/bilingual services, even when an institution organizes and offers the services. One large hospital in California with a million dollar interpreter services program and more than 30,000 encounters per year still only serves a portion of the population that needs language assistance. A former interpreter services coordinator estimated that perhaps 30 percent of all patients who needed an interpreter did not get one, most likely because staff were too busy to make a request to the interpreter services office. This hospital’s experience shows that the availability of services is no guarantee that they will actually be used when the need arises. And without information about such services, many LEP individuals would not think or would be hesitant to ask a provider to supply an interpreter.

Facilities around the country have developed innovative ways to publicize the availability of bilingual/interpreter services. At the University of Massachusetts Medical Center in Worcester, the staff at the main informational kiosk direct incoming LEP patients to a sign on the wall that has tear-off cards in many different languages. The patients select the appropriate card for their language and hand it to the staff person, who then contacts interpreter services. At the Pacific Medical Center Clinics in Seattle, Washington, all new patients are automatically assigned an interpreter in their birth language. The interpreter

appears at each visit unless the first visit reveals that interpreter services are unnecessary. In general, health care organizations should make available signs and notices about language assistance services at all major points of entry and discharge in a facility. They should also be present at different stations, departments, or offices where patients/consumers must regularly interact with staff, such as the pharmacy, laboratories, emergency room triage, and billing offices.

Several community-based organizations publish bilingual wallet cards that inform the holder and any provider who receives it that the bearer of the card is LEP and entitled to interpreter services under state and Federal laws. The cards are distributed to individuals through community-based organizations and the carriers are instructed to present the card when seeking health services. The National Health Law Program reports that OCR voluntary compliance agreements with health care providers have required outreach to communities to publicize the availability of no-cost programs and services in non-English community newspapers and on radio and television stations, and to give notice to community agencies and referral sources about the facility's language access policies and services (Perkins, 1998). Many providers, especially managed care organizations, have found that advertising the availability of bilingual services can increase enrollment from targeted communities.

State and Federal laws, regulations, and contracts with health providers should reiterate, in detail, the Title VI provider obligation to inform recipients of their right to receive no-cost interpreter/bilingual services. Accreditation standards and measures should reflect and refer to relevant Federal laws, including Title VI. Oversight agencies and advocates can check compliance by entering facilities to see whether appropriate signage and notices are posted, and by calling facilities to inquire about availability of interpreters/bilingual staff. Staff should be instructed in the organization's Title VI and other legal responsibilities and institutional procedures for securing interpreter/bilingual assistance so that they can respond promptly to a need for language assistance that might be generated by signage or notices to patients/consumers.

STANDARD 6

QUALIFICATIONS FOR BILINGUAL AND INTERPRETER SERVICES (MANDATE)

Standard and Commentary

6. Health care organizations must assure the competence of language assistance provided to limited English proficient patients/consumers by interpreters and bilingual staff. Family and friends should not be used to provide interpretation services (except on request by the patient/consumer).

Accurate and effective communication between patients/consumers and clinicians is the most essential component of the health care encounter. Patients/consumers cannot fully utilize or negotiate other important services if they cannot communicate with the nonclinical staff of health care organizations. When language barriers exist, relying on staff who are not fully bilingual or lack interpreter training frequently leads to misunderstanding, dissatisfaction, omission of vital information, misdiagnoses, inappropriate treatment, and lack of compliance. It is insufficient for health care organizations to use any apparently bilingual person for delivering language services—they must assess and ensure the training and competency of individuals who deliver such services.

Bilingual clinicians and other staff who communicate directly with patients/consumers in their preferred language must demonstrate a command of both English and the target language that includes knowledge and facility with the terms and concepts relevant to the type of encounter. Ideally, this should be verified by formal testing. Research has shown that individuals with exposure to a second language, even those raised in bilingual homes, frequently overestimate their ability to communicate in that language, and make errors that could affect complete and accurate communication and comprehension.

Prospective and working interpreters must demonstrate a similar level of bilingual proficiency. Health care organizations should verify the completion of, or arrange for, formal training in the techniques, ethics, and cross-cultural issues related to medical interpreting (a minimum of 40 hours is recommended by the National Council on Interpretation in Health Care). Interpreters must be assessed for their ability to convey information accurately in both languages before they are allowed to interpret in a health care setting.

In order to ensure complete, accurate, impartial, and confidential communication, family, friends or other individuals, should not be required, suggested, or used as interpreters. A patient/consumer may choose to use a family member or friend as an interpreter after being informed of the availability of free interpreter services unless the effectiveness of services is compromised or the LEP person's confidentiality is violated. The health care organization's staff should suggest that a trained interpreter be present during the encounter to ensure accurate interpretation and should document the offer and declination in the LEP person's file. Minor children should never be used as interpreters, nor be allowed to interpret for their parents when they are the patients/consumers.

Discussion

Qualified versus Unqualified Interpretation

The provision of medical interpretation services in the United States is marked by contrasts: highly trained and well-paid professional interpreters deliver services in some communities, whereas other institutions use housekeeping staff who barely understand English or call ethnic restaurants for free, ad hoc "interpretation." A number of comments, including those received from major health care organizations, demonstrated a lack of understanding about the critical importance of competence and training in medical interpretation. Competence in medical interpretation means different things to different people. "Professional" can simply mean "paid." "Trained" and "certified" may not mean trained or certified in medical interpretation, which requires a different set of skills, ethical considerations and, most importantly, technical language, than court or conference interpretation (which are the focus of the majority of training/certification programs).

The research of Downing and others on the impact of using untrained interpreters makes clear that the error rate of untrained "interpreters" (including family and friends) is sufficiently high as to make their use more dangerous in some circumstances than no interpreter at all. Using untrained interpreters lends a false sense of security to both provider and client that accurate communication is actually taking place. In a close analysis of one encounter between a nurse practitioner, a Russian-speaking patient, and his son acting as interpreter, Downing uncovered 49 miscommunications by the "interpreter" in a conversation of only 25 exchanges of information. For example,

- the interpreter misinterpreted (five times) because of lack of understanding of particular words and idioms;
- the interpreter's failure to interpret the question led the patient to try to guess what the question was and attempt an answer (four times);
- the interpreter failed to interpret an answer offered by the patient (six times);
- the interpreter seriously distorted the message in the process of interpreting it, by adding information (twice), omitting information (four times), or changing the meaning (seven times);
- the reply that the nurse practitioner received from the patient through the interpreter was the answer to a different question than the one she had asked, but she did not know it (two times).

This example dramatically illustrates the potential of misdiagnosis, inappropriate treatment, and liability when using unqualified individuals to interpret. (Downing, 1991)

Interpreter Role, Skills Assessment, and Certification

Assuring quality in an interpreted encounter depends on using commonly accepted definitions of role, interpreter training, and competency. Health care organizations need to use clear and consistent role definitions and practice standards to ensure the harmonious integration of interpreters into a clinical or administrative encounter. Staff members who work with interpreters need to know what interpreters do, what they do not do, and where responsibility

lies for different aspects of communication (this information is an essential training topic discussed in Standard 3 and a requirement of the OCR guidance). Medical interpreters are now working to clarify the definition of the medical interpreter role and to specify practice standards and codes of ethics. Pioneering work by the Massachusetts Medical Interpreter Association (MMIA) on practice standards for medical interpreters has provided a foundation for discussion and adoption of standards by other interpreter groups nationally. The MMIA standards address issues of interpreter skill, behavior, linguistic and cultural knowledge, and ethics. These standards of practice were based on extensive research, focus groups with working interpreters, and a formal analysis of a wide sample of practicing interpreter job responsibilities. The National Council on Interpretation in Health Care (NCIHC), which has been meeting since 1994 to discuss and move towards consensus on role and practice issues, has formally endorsed the MMIA standards. Another group, organized through the American Society for Testing and Materials, will soon release national standards for general interpretation, including specific guidelines for medical interpretation.

Because the practice of using interpreters is still largely ad hoc in many settings, health care organizations frequently pay little attention to the skills and competency of any given individual called on to interpret. Because there are so few “formally” trained medical interpreters, the issues of skills assessment and training are often addressed simultaneously. When skills and competency are addressed, each organization typically uses its own instrument to test individuals who may be selected or hired as interpreters. Assessing competency is critical to assuring quality, and standardized tests for medical interpreting skill and language competency can give providers a necessary tool in this process.

Developing standard tools for assessing basic medical interpreter skills is one component of implementing certification for interpreters. There has been increasing interest in developing both national and state level certification programs; in fact, the MMIA is developing a certification process for Massachusetts, and working collaboratively with other organizations to develop certification programs in California and New York, and nationally with NCIHC. Washington State already uses a certification process for medical and social service programs.

Certification is ideally an endpoint in a continuum that includes widespread consensus about role definition, practice standards, standardized curriculum elements, and standardized competency assessments. While much progress has been made in each of these areas, additional development and dissemination, and the convening of a national discussion to seek consensus is necessary. Some medical interpreters propose addressing these issues on a state-by-state basis. But given the intensive effort needed to properly develop these elements of the continuum, this process could be inefficiently replicated without much standardization for many years. One possibility is to define a minimum level of language proficiency and basic interpreter skills necessary to not compromise patient care. Additional roles and levels of responsibility could be added with additional training and achievement in higher levels of testing. This graduated approach would address some of the concerns expressed on behalf of community-based interpreters from smaller ethnic groups (i.e. Cambodian, Hmong, Somali) that may have few potential interpreter candidates, many of them without formal education or training opportunities.

Medical Interpreter Training

If potential candidates for interpreter positions are not certified or do not pass a basic skills assessment, some health care organizations may test individuals for the ability to successfully complete interpreter training and then send them for training. Some health care institutions sponsor interpreter assessment and training services in-house; others collaborate with or refer to programs at local colleges or community organizations. Training programs can be difficult to initiate if qualified trainers are not available locally. In such cases, it is often advantageous for several institutions to pool resources and collaboratively establish a local or regional training program, using one of the many models of training already in existence. This collaborative structure can also be expanded over time to house a community-based pool of interpreters who could be shared and deployed among many provider organizations. A 1998 document available online [<http://www.ahschc.org/traindir2.htm>] catalogues selected interpreter training programs in the U.S. and Canada that take a variety of approaches. The NCIHC has written that 40 hours of basic training seem to be average among well-regarded training programs. Essential topics include instruction in interpretation skills and techniques; ethics of interpreting in health care encounters; a review of key medical terminology, basic clinical concepts, and the workings of the American medical system; an overview of the role of culture and how to manage cultural issues; and professional interpretation issues.

Bilingual Staff

With respect to using bilingual staff as interpreters, it can not be assumed that a nurse, medical student, or other staff (clinical or not) who speaks two languages will be sufficiently familiar with medical terms and concepts in both languages. Bilingual individuals, unless they were trained as health professionals in another country, generally only have conversational skills in the target language, and medical terminology would need to be specifically acquired through a course of study. In addition, a bilingual individual may not have had formal training in medical interpreting skills, and may risk making the kinds of mistakes identified by Downing.

These concerns can also arise when assumptions are made about “bilingual” staff or health professionals who communicate directly with LEP patients. These individuals may have learned the language conversationally at home, in high school, or in college, but lack training in medical terminology and concepts. Almost universally, the level of true bilingual ability is never ascertained. Kaiser Permanente of Southern California has instituted competency testing for staff who wish to operate in a bilingual or interpreter capacity. But many provider organizations rely heavily on lists of untested bilingual staff for both direct patient care and interpreting, and increasing numbers of managed care organizations market their services to LEP communities by highlighting their lists of bilingual health professionals. The presence of these lists may not be indicative of true language access because the individuals on them may not always be available or qualified to act in a bilingual or interpreter capacity.

The notion of teaching health professionals another language for the purposes of diagnosis and treatment is controversial. Health care organizations and health professions training programs often encourage “survival Spanish” or other quick and/or intensive language courses as a means of preparing for, or coping with, the increasing numbers of LEP patients/consumers. While these courses may enhance basic communication and rapport with LEP individuals, they pose a serious danger by leading clinicians to believe they can

adequately communicate through the breadth and depth required of complex clinical encounters. A study conducted at Stanford University found that medical residents who took a 45-hour course in medical Spanish still made a considerable number of mistakes in communicating with patients who only spoke Spanish. Many of the mistakes could have had an impact on diagnosis or treatment (Prince, 1995). Linda Haffner, in her 1992 article *Translation is Not Enough*, reports many instances of physicians who thought they had a sufficient command of the language but, in fact, understood their patients incorrectly or made replies that were confusing, incorrect, or insulting (Haffner, 1992). The Downing research also suggests that using insufficiently bilingual health professionals can have the same negative impact as using interpreters of unknown skill.

Nevertheless, language training programs for medical/social service staff are proliferating. Given the potential for errors, health care organizations should not offer or suggest these courses as sufficient to communicate with LEP patients/consumers in clinical encounters. It can only be misleading to market 8-hour courses in “survival Spanish” to clinicians or health care administrators. Still, many medical schools offer or encourage students to take semester long (or shorter) courses in “medical Spanish.”

Family and Friends as Interpreters

The issue of limiting the role of family and friends as interpreters generated both considerable support and dissent from the public comments. This standard in no way contemplates the exclusion of family or other companions in the health care encounter; in fact, family and others should be present and actively involved in health care delivery, as desired by the patient/consumer. But the evidence presented by Downing on interpretation errors when untrained individuals are used is too compelling to ignore, and some health care institutions have been sued for malpractice related to significant injury and death when family members were involved in interpretations. Moreover, family and friends may be able to be more involved in patient support and decisionmaking if they do not have the additional burden and risk of interpretation. As suggested by the OCR guidance, the best approach with patients who have brought their own interpreter is to stress that a trained staff interpreter is being provided for their safety and confidentiality, and that if they would still like to use their own interpreter, the staff interpreter will remain present to ensure that both the patient and clinician are receiving accurate information. As stated in the commentary, minors should never be used to interpret, either on behalf of other patients/consumers, or for their parents when they are the patient/consumer. An excellent discussion of the potential errors and conflicts raised by using children as interpreters can be found online at [<http://www.nhelp.org/pubs/19990720LEPGuidance.html>].

STANDARD 7

TRANSLATED MATERIALS (MANDATE)

Standard and Commentary

7. Health care organizations must make available easily understood patient-related materials and post signage in the languages of the commonly encountered groups and/or groups represented in the service area.

An effective language assistance program ensures that written materials routinely provided in English to applicants, patients/consumers, and the public are available in commonly encountered languages other than English. It is important to translate materials that are essential to patients/consumers accessing and making educated decisions about health care. Examples of relevant patient-related materials include applications, consent forms, and medical or treatment instructions; however, health care organizations should consult OCR guidance on Title VI for more information on what the Office considers to be “vital” documents that are particularly important to ensure translation (65 Fed. Reg. 52762-52774, August 30, 2000) at [www.hhs.gov/ocr/lep].

Commonly encountered languages are languages that are used by a significant number or percentage of the population in the service area. Consult the OCR guidance for guidelines regarding the LEP language groups for which translated written materials should be provided. Persons in language groups that do not fall within these guidelines should be notified of their right to receive oral translation of written materials.

Signage in commonly encountered languages should provide notices of a variety of patient rights, the availability of conflict and grievance resolution processes, and directions to facility services. Way-finding signage should identify or label the location of specific services (e.g., admissions, pediatrics, emergency room). Written notices about patient/consumer rights to receive language assistance services are discussed in Standard 5.

Materials in commonly encountered languages should be responsive to the cultures as well as the levels of literacy of patients/consumers. Organizations should provide notice of the availability of oral translation of written materials to LEP individuals who cannot read or who speak nonwritten languages. Materials in alternative formats should be developed for these individuals as well as for people with sensory, developmental, and/or cognitive impairments.

The obligation to provide meaningful access is not limited to written translations. Oral communication often is a necessary part of the exchange of information, and written materials should never be used as substitutes for oral interpreters. A health care organization that limits its language services to the provision of written materials may not be allowing LEP persons equal access to programs and services available to persons who speak English.

Organizations should develop policies and procedures to ensure development of quality non-English signage and patient-related materials that are appropriate for their target audiences. At a minimum, the translation process should include translation by a trained individual, back translation and/or review by target audience groups, and periodic updates.

It is important to note that in some circumstances verbatim translation may not accurately or

appropriately convey the substance of what is contained in materials written in English. Additionally, health care organizations should be aware of and comply with existing State or local nondiscrimination laws that are not superceded by Federal requirements.

Discussion

The Importance of Translated Materials

Written materials offer an effective way of communicating with large numbers of people, supplementing or further explaining information provided by clinicians and other staff, and reinforcing key messages that can be forgotten in the plethora of facts and advice that are conveyed during a health care encounter. However, the potential benefits of these documents are lost if patients/consumers cannot understand the language in which the materials are written. Without understandable written materials, patients/consumers have limited access to health information and are thus at risk for not following medical directions or health plan requirements. A health care organization can help ensure that its LEP patients/consumers have equal access to its services by including in its language assistance program translated materials that are written in commonly encountered non-English languages and are consistent with the culture and literacy levels of target language groups. Providing oral interpretation or information in alternative formats is an important step toward mitigating the disadvantages faced by LEP individuals who have no written language or are unable to read.

Materials for Translation

Two important issues related to the provision of translated materials are what types of materials should be translated and for which language groups should translations be provided. Both issues are addressed in part by the OCR guidance on Title VI. The guidance provides numerous examples of what the Office considers to be “vital” documents warranting translation, including applications; consent forms; letters containing important information about participation in a program; and notices about the reduction, denial, or termination of services or benefits. However, the guidance recognizes that the unique characteristics of each federally funded health and social service program are considerations in determining which documents and information are considered vital.

Public comments generated numerous suggestions on the issue of which documents should be translated, ranging from “essential or critical documents” to “all needed materials...if it is important enough for English-speaking people to have it, everyone should have it.” Commenters generally agreed that materials necessary for patients/consumers to access and make educated decisions about their health care should be translated. Comments proved a rich source of ideas on the types of patient-related written materials that, if translated, would be valuable to LEP individuals. Suggestions are highlighted below.

- **Administrative and legal documents**—materials requiring informed consent, obligation, or acknowledgement of certain legal or financial rights and responsibilities; waivers of rights; living wills and advanced directives; emergency room, release, and discharge forms; marketing materials; documents establishing and maintaining eligibility for services; explanations of benefit coverage packages; evidence of coverage cards and notices of noncoverage; information on patient/consumer services and rights; health plan member handbooks or critical portions thereof; and appointment slips

- **Clinical information**—prevention and treatment instructions, including how to prevent transmission of a contagious disease, what to do before, during, and after a procedure or treatment (e.g., surgery, chemotherapy), how to take medications, and how to perform routine self-care or self-monitoring
- **Patient education, health prevention and promotion, and outreach materials**—brochures, fact sheets, pamphlets, promotional flyers and posters, health warnings, immunization notices, and other materials that support treatment programs (e.g., for chronic disease or reproductive health) and prevention activities (e.g., cancer or high blood pressure screenings).

Languages for Translation

The OCR guidance calls for translation of written materials in instances when there are a significant number or percentage of the population that needs information in a language other than English. OCR provides guidelines for determining whether the number or percentage of a population is significant. Health care organizations should be familiar with any national, state, or local regulations related to the provision of language assistance services and ensure that information about these requirements are disseminated to staff members who should know about them. This staff includes personnel in member services, member communications, health education, outreach, advertising, and public relations as well as direct service providers.

OCR recognizes that it would be unduly burdensome to require translations in all written materials in all of the dozens of different languages that are encountered in certain areas, such as large cities. Moreover, several public comments observed that the languages that are most commonly encountered shift with population changes over time, particularly among migrant populations. However, commenters provided ideas on how organizations can be responsive to multiple non-English language groups as well as shifts in commonly encountered languages. For example, one county medical center recently implemented a new set of criteria for deciding what materials are translated. The hospital used to translate all of its documents to the seven most commonly used languages, but its top seven languages kept changing. The hospital now matches the types of translated materials to the specific needs of the top language groups. For example, because most of the hospital's Russian population is elderly, it no longer automatically translates pregnancy information into Russian.

Translation Methodologies and Protocols

In many health care organizations translation of written materials is done on an ad hoc basis and without the benefit of guidelines to ensure accuracy and appropriateness for the patient/consumer. Organizations may use in-house bilingual individuals who may have no background in translation, community-based ethnic organizations that do some translation but may lack training or sufficient command of both languages, commercial translation services, and translated materials produced by other organizations. However, organizations should attempt to use explicit policies and procedures to ensure the quality of translators and the translation process.

Some agencies and organizations have developed protocols for how written materials should be translated. For example, the Canadian Multilingual Health Education Net has a Web site [<http://www.healthtrans.org>] that provides guidelines for translating English health education materials. A translation task force committee developed such protocols for organizations

participating in the California Medicaid (Medi-Cal) managed care program. The University of Minnesota Translation Laboratory has developed extensive translation protocols for the Minnesota Department of Health. Other agencies are developing glossaries and dictionaries in a wide variety of languages. The latter resources would facilitate the work of translators and help standardize the vocabulary used for medical terms, especially in the languages of more recent immigrant populations that may not have Western medical concepts in their native languages.

The development and use of translation tools can help organizations improve the quality of translated written materials they make available. Professionally accepted standards currently include, at a minimum, translation by a trained individual, back translation and/or review by target audience groups, and periodic updates. These minimum standards call for a deconstruction approach to translating complicated jargon and concepts that are essentially untranslatable or require further explanation. The translation guidelines disseminated by the Multilingual Health Education Net emphasize the importance of beginning with an English version that is written at a grade 4 to 6 literacy level and using a two-tiered testing system that includes review by health care practitioners (for accuracy of medical information) and the community (for understandability, cultural context, and accessibility).

The use of qualified translators is crucial to ensuring the accuracy of translated written materials. Organizations should have written criteria for selecting translators and translation vendors. At a minimum, organizations should ensure that translators have 1) previous experience, education, and training in translation; 2) command of both English and the language into which the material will be translated; and 3) familiarity with medical terminology. Criteria for selecting translation vendors should include a review of 1) translation methods and procedures used, from submission of English copy to printing of finished materials; 2) recruitment and training of translators; and 3) procedures for reviewing translated materials. Organizations also should have in place knowledgeable people to work with translators or vendors during the translation and review process and to determine the quality of purchased translations. Public comments emphasized the need to avoid “wildcat” translation (e.g. the doctor’s sister who took Spanish in college), however tempting the financial advantages.

Community Involvement

Ideally, translated written materials should reflect the dialectic and cultural nuances as well as the acculturation, educational, and literacy levels of the local target population. Public comments emphasized that documents that reflect an awareness of these details demand a more sensitive approach than mere literal translation of text. Many experts believe that even with translation standards, many documents are better approached through a method of developing original written material in the target language that includes collaboration with the target community and the writer of the substantive material. For example, focus groups discussions with members of the target population can identify any suggestions or instructions in the translated material that might be embarrassing or offensive, suggest cultural practices that provide more appropriate examples (e.g., eating rice instead of pasta), and check whether graphics reflect the diversity of the target community (e.g., facial features, clothing and hair styles). This process is especially important for health education and disease prevention materials that are intended to motivate behavior change. Because many communities are

repeatedly tapped for translation and review services without receiving any reimbursement, organizations should consider providing financial compensation or in-kind services.

Translation of Technical Information

Many public comments addressed concerns related to translating highly technical medical and legal language into consumer-oriented and easily understood language, whether it be English or another language. The need to balance medical and legal accuracy with the language, culture, and literacy levels of patients/consumers is a complicated issue that involves considerable risks for organizations and providers. The difficulties of translating highly technical language that is far from consumer-friendly in English are multiple, as the public comments indicated. Literal translations can be incomprehensible, irrelevant, or culturally insensitive, and poor translations can provide inaccurate information. The challenge of addressing the patient's level of literacy is complicated by the issue of determining and being responsive to the person's level of acculturation and health and legal literacy.

Some organizations and providers seek legal protection through precise and "watertight" wording in informed consent and other standard forms. However, as one person commented, in lawsuits, lawyers can target the issue of whether a patient with LEP had true informed consent. Several approaches to addressing these difficulties were proposed in the public comments. For example, one translator at a hospital meets with doctors or nurses for help with the translation of highly technical materials. Another hospital has a separate set of criteria for translating forms because they are more specialized than educational materials and involve legal issues. One project found it helpful as a first step to get permission to revise and simplify the state health department's standard consent forms in English before undertaking translation. Another approach is to produce translated explanatory documents that clarify concepts, such as "advanced directives," that are used on the forms. One language access project that encountered difficulties translating concepts into certain languages decided that it needed interpreters to explain consent forms and other standardized forms. The danger of this approach is that patients/consumers who are not offered interpreters may sign forms without understanding the document.

New Technologies and Alternative Formats

New technologies offer timesaving alternatives for translation, but not without drawbacks. Computers provide a way to store translated documents such as forms and fact sheets that can be easily printed and updated, thus allowing organizations to stock less inventory of these items. Some organizations may be tempted to use translation software programs to speed the process of translating material from English to the target language, but these programs are very rudimentary and frequently introduce inaccuracies, particularly when technical language is used. Consequently, bilingual staff are required to identify and correct these inaccuracies and to add any adaptations for the target community. The Internet offers a useful medium for establishing a centralized database/repository of commonly used translated documents and glossaries that could be downloaded and customized by anyone with a computer and appropriate software. An Internet-based repository would also facilitate ongoing review and updates of translated documents—a necessary process to ensure that materials remain current with scientific and methodological advances. Multilingual Health Education Net and the Multicultural Health Communications Service, Health Department, New South Wales, Australia [<http://www.mchs.health.nsw.gov/au/>] have large collections of online translated

health materials in a number of languages.

Several public comments called attention to the need for alternative formats to address the needs of people who cannot read or lack a written language and persons with sensory, developmental, and/or cognitive impairments. Community-based organizations have a long history of working with people who cannot read and have developed a variety of formats that communicate ideas and reinforce important concepts. For example, one center developed a video that shows a Haitian woman going through a grocery store and touching indigenous food groups that are important for a healthy diet. Radio and audiotapes also are useful for people who cannot read. An issue of *The Pfizer Journal* on health literacy (Giorgianni, 1998) gives many examples of how to use pictures to illustrate medical procedures or concepts. Photographs or drawings showing the dosage of medications and a clock face with the times to take the drugs can help increase adherence to prescription regimens among patients who cannot read labels. A photoessay on early cancer detection can explain a screening technique with minimal words by showing women going through the steps of getting a mammogram. Photo-novellas and comic books rely primarily on pictures to deliver health messages through a story format. Storytelling and drama have been used effectively to communicate with people who do not have a written language. Large-print, Braille, and audio materials are alternatives for people with visual impairments, whereas interpreters who can use American Sign Language are needed for persons who are deaf or hard of hearing.

Need for Oral Interpretation

Whatever the technology and formats used, translation of written materials should not be interpreted as a way to replace oral interpretation. Oral communication is a critical part of the exchange of information between a health care organization or provider and patients/consumers. Thus, an organization that limits its language services to the provision of written materials is, by definition, limiting LEP persons equal access to services. In determining how best to provide access to LEP individuals, organizations need to address the appropriate mix of written and oral language assistance.

STANDARD 8

ORGANIZATIONAL FRAMEWORK FOR CULTURAL COMPETENCE (GUIDELINE)

Standard and Commentary

8. Health care organizations should develop, implement, and promote a written strategic plan that outlines clear goals, policies, operational plans, and management accountability/oversight mechanisms to provide culturally and linguistically appropriate services.

Successful implementation of the CLAS standards depends on an organization's ability to target attention and resources on the needs of culturally diverse populations. The purpose of strategic planning is to help the organization define and structure activities, policy development, and goal setting relevant to culturally and linguistically appropriate services. It also allows the agency to identify, monitor, and evaluate system features that may warrant implementing new policies or programs consistent with the overall mission.

The attainment of cultural competence depends on the willingness of the organization to learn and adapt values that are explicitly articulated in its guiding mission. A sound strategic plan for CLAS is integrally tied to the organization's mission, operating principles, and service focus. Accountability for CLAS activities must reside at the highest levels of leadership including the governing body of the organization. Without the strategic plan, the organization may be at a disadvantage to identify and prioritize patient/consumer service need priorities.

Designated personnel or departments should have authority to implement CLAS-specific activities as well as to monitor the responsiveness of the whole organization to the cultural and linguistic needs of patients/consumers.

Consistent with Standard 12, the strategic plan should be developed with the participation of consumers, community, and staff who can convey the needs and concerns of all communities and all parts of the organization affected by the strategy. And, consistent with Standards 9, 10, and 11, the results of data gathering and self-assessment processes should inform the development and refinement of goals, plans, and policies.

Discussion

Policy Basis for a CLAS Organizational Strategy

The need for a strategic and structured organizational approach to cultural competence was prominent in both the original source policy documents and the public comments. In the original analysis of policy documents used to develop the CLAS standards, many of these documents outlined the need for an organizational planning approach to implementing cultural and linguistic competence activities. Contract language used in California's Medicaid (Medi-Cal) managed care program contains the most extensive requirements for organizational process in the provision of culturally and linguistically appropriate services, including the development of a cultural and linguistic services plan, with activities, time lines, and milestones; identification of responsible individuals (including organizational charts, types and responsibilities of staff); the development and implementation of standards and performance requirements; performance monitoring; and protocols for appointment scheduling and system coordination.

The Department of Health and Human Services' (HHS) Office for Civil Rights (OCR) is similarly explicit about the need for policies and procedures on language assistance services, listing implementation of these components as one of the four key activities that will facilitate compliance with the Title VI. The Maine Medical Center compliance agreement, available online [<http://www.hhs.gov/ocr/mmc07172000.html>], outlines a model organizational structure and policies for achieving compliance with the OCR guidance. These two documents reflect OCR's recognition of the difficulties involved in delivering linguistic services to a diverse patient population according to the Federal standards of timeliness and appropriateness without a formal structure for organizing and accessing these services. For example, having qualified interpreters and translated materials available at the time of need is nearly impossible without designated staff who are responsible for organizing and dispatching the services.

A similar argument can be made for overall organizational cultural competence. The American Nurses Association noted in their written comments that without a formal structure in place, it is very difficult to provide culturally competent, linguistically appropriate services. "Frequently, a nurse may be placed in a compromised situation due to the lack of a clear commitment by the health care organization to provide her/him with adequate resources or support necessary to provide culturally competent, linguistically appropriate services. A standard which identifies the health organization's policies and procedures regarding CLAS would go a long way to assure that all health care providers would be informed of the expectation and support for the provision of these services." CLAS services would include both obvious and subtle indicators of a culturally competent environment: the inclusion of culturally appropriate magazines and health education materials in the waiting and treatment rooms, appropriate food choices in a hospital, the use of culturally appropriate artwork and posters, cultural competence training for all staff, as well as the other activities outlined in all the CLAS standards. The detail offered by the public comments reveals a rich breadth of wisdom and experience in the implementation of cultural competence activities, and this input is reflected in the discussion below.

Integration of CLAS throughout an Organization

Many comments described the delicate balancing act between the seamless integration of CLAS into the mission and activities of the organization, and the need for prominent goals and policies to focus attention on what may be new or undervalued activities. According to one comment, “Cultural competence should not be something ‘over there.’ The services, strategic goals, plans, policies, and staff designations should not be framed in a way that a department, initiative, or activities are set apart from the rest of the life of the organization. Cultural competency needs to be practiced in a way that is fully integrated into the life of an organization.” Another comment noted, “It is extremely important that a culturally competent organization have a philosophical and ethical basis, not just policies, rules, or strategies to address culturally and linguistically appropriate services. Cultural competency needs to be grounded in the organization’s identity—how it recruits and staffs employees, how it treats customers, how it conducts business. Cultural competency needs to flow both from the top down and from the bottom up.” Incorporating CLAS activities and values into the organization’s mission statement and comprehensive management strategy was frequently mentioned as a critical first step.

Accountability from the Top and throughout the Organization

Nearly half of the public comments on this standard addressed the issue of internal and external accountability for cultural competence in an organization. Some comments identified a bottom-up or front-line staff approach to initiating cultural competence activities. However, most comments recognized the need for top management support for cultural competence to assure accountability and longevity, as well as shared responsibility for implementation throughout the organization. Several comments suggested true accountability and authority for change lies at the governance level. One comment observed that a “comprehensive management strategy must come from the top of the hierarchy of the health care organization, which for most large organizations is the board of trustees. For example, at the Mount Sinai Hospital and Mount Sinai School of Medicine, the Board of Trustees has the capacity to effect change in the entire institution and impact all levels of staff more effectively than individual department chairs.” However, another comment noted that these leaders are not always ready to act on CLAS, and change can be initiated by others. “From our experience, we are seeing [the change come] from the providers. The providers are getting very frustrated with not being able to speak the [patient’s] language, of not being able to give clear guidance, of spending money on people who are coming back all of the time. So [the providers] are the ones that are starting their own... cultural competence teams.” Frequently, these staff-driven teams develop so much expertise and authority among their peers that they are invited by administrators to offer guidance on how to make changes across the organization.

Motivation for change is a first step; but accountability for implementing and sustaining the change is equally important. In general, it was observed that managers should not be any more responsible for change than other staff. As one comment stated, “Cultural competency policy needs to be followed consistently throughout the organization. Each person at every level of the organization needs to understand the philosophy and required practice.” But the need for designated staff who monitor the development and execution of policies and procedures is essential. This may involve creating an office of diversity, or charging a senior manager with cultural competence as part of his/her portfolio, or creating a team that works across an organization. One model described a cultural competency committee that worked with existing

departments. “The cultural competency committee did not do training; it worked with the training department on curriculum, infusion, and identifying speakers. Committee members met with supervisors about issues and problem solving, and then the supervisors would develop standards and tools. The committee was the impetus for the organization [to conduct CLAS activities] but not the doers. Committee members had accountability to senior management for their work, but lines of accountability within the organization stayed the same. The cultural competency “add-ons” became part of the ongoing chain of command and responsibility.”

Implementation of CLAS Activities

The strength and the challenge of the CLAS standards is that they attempt to be comprehensive in describing all the activities that an organization might undertake to be culturally competent. For an organization with little or no experience in delivering culturally and linguistically appropriate health services, the prospect of taking action on 14 different types of activities is understandably daunting. Many commentators observed the tension between specificity in the standards and the need for flexibility in implementation. “[The standards need] to be prescriptive but also incremental... if it is too overwhelming, people don’t want to do anything.” Another comment suggested that “striving for cultural competence within an organization is a developmental process and occurs over an extended period of time. Health care organizations should be encouraged to develop a comprehensive plan to incorporate values, structures, policies, practices, and procedures at all levels within the system. The plan needs to include incremental and measurable short-term and long-term outcomes.” Various comments called for a phased-in implementation process, step-by-step guidelines, and checklists. These tools could be developed by individual healthcare organizations or by the HHS Office of Minority Health as a follow-up to the CLAS standards development process. An Illinois organization, the Heartland Alliance, has developed one such guide, *Building Linguistic and Cultural Competency: a Toolkit for Managed Care Organizations and Provider Networks that Service the Foreign-Born* (1998). Although this manual does not track the CLAS standards explicitly, it includes many of the most important CLAS elements as well as resources for implementation. Whatever tool or guide is used, health care organizations could decide to focus their preliminary efforts on implementing one or two of the standards. Alternatively, organizations could determine a logical, standard-by-standard implementation process in which each step would build on the previous one. One potential implementation sequence could work as follows (the relevant CLAS standard number is in parenthesis):

Laying the groundwork:

- Internal assessment (9)
- Community profile (11)
- Community engagement (12)

Organizational supports:

- Plans and accountability structure (8)
- Data collection systems (10)

Services:

- Language assistance (4,5,6,7)
- Staff diversity and cultural competence training (2,3)
- Culturally sensitive care and environment (1)

Monitoring:

- Ongoing assessment: organization and staff (3, 9)
- Outcomes research and evaluation (9)

The complexity raised by a multi-stage implementation process obviously reinforces the need for Standard 8. It would be impossible to implement and manage new CLAS activities without a structured and strategic approach.

Involvement of Communities and Patient/Consumers

This standard's commentary mentions the importance of involving communities and patients/consumers in the development of an organization's management strategy on cultural competence, and this issue is more fully explored in Standard 12. In the context of Standard 8, it is useful not to overstate or understate the role of community in developing and executing the organizational framework for CLAS. With the exception of mandated consumer representation on the boards of directors of federally funded community health centers, few organizations have structures in place to involve community representatives (or even staff) at every stage of planning and implementation. But many health care organizations maintain very close ties and sponsor regular meetings with consumers and community leaders to test ideas and solicit feedback on services. The effort may seem considerable, but if services are ill-conceived or do not meet the true needs of the community, the authenticity of the health care organizations' commitment to cultural responsiveness will be questioned. The New York University New York Downtown Hospital has found that regular consultation with the Chinese community in their service area has resulted in health care services that community leaders support and local consumers use. Together, these leaders and consumers constitute an enthusiastic, informal referral system that brings Chinese patients/consumers from several surrounding States. Hospital leadership has recognized that developing close relationships with the community over many years has been instrumental in bringing the institution from the brink of closure to financial stability.

STANDARD 9

ORGANIZATIONAL SELF-ASSESSMENT (GUIDELINE AND RECOMMENDATION)

Standard and Commentary

9. Health care organizations should conduct initial and ongoing organizational self-assessments of CLAS-related activities and are encouraged to integrate cultural and linguistic competence-related measures into their internal audits, performance improvement programs, patient satisfaction assessments, and outcomes-based evaluations.

Ideally, these self-assessments should address all the activities called for in the 14 CLAS standards. Initial self-assessment, including an inventory of organizational policies, practices, and procedures, is a prerequisite to developing and implementing the strategic plan called for in Standard 8. Ongoing self-assessment is necessary to determine the degree to which the organization has made progress in implementing all CLAS standards. The purpose of ongoing organizational self-assessment is to obtain baseline and updated information that can be used to define service needs, identify opportunities for improvement, develop action plans, and design programs and activities. The self-assessment should focus on the capacities, strengths, and weaknesses of the organization in meeting the CLAS standards.

Integrating cultural and linguistic competence-related measures into existing quality improvement activities will also help institutionalize a focus on CLAS within the organization. Linking CLAS-related measures with routine quality and outcome efforts may help build the evidence base regarding the impact of CLAS interventions on access, patient satisfaction, quality, and clinical outcomes.

Patient/consumer and community surveys and other methods of obtaining input are important components of organizational quality improvement activities. But they should not constitute the only method of assessing quality with respect to CLAS. When used, such surveys should be culturally and linguistically appropriate.

Discussion

The Role of Organizational Self-Assessment

Ongoing organizational self-assessment is a process often used to examine factors that might be impeding a service delivery system's effectiveness and performance. It is essential for planning, implementing and evaluating the quality of any kind of service, including CLAS. Cultural audits are a specific form of organizational assessment that focus on identifying problems and developing strategies relevant and specific to developing CLAS. In the area of cultural and linguistic competence, many organizations remain largely unaware of structural and behavioral factors that create barriers to providing quality service for diverse populations. Although some health care organizations may attempt to provide CLAS through targeted programs, they seldom link these efforts with other organizational activities that focus on policy and decision-making related to outcomes accountability. The development of overall organizational cultural and linguistic competence will take both time and a better

understanding of the potential impact of CLAS on outcomes and satisfaction. However, there are steps organizations can take to assess their progress on the journey.

As a first step, organizations should conduct a cultural audit using existing cultural competence assessment tools to inventory structural policies, procedures, and practices. These tools provide general guidance to determine whether the core structure (e.g., management, governance, delivery systems, and customer relation functions) necessary for providing CLAS is in place. Results from this internal audit should then be used to identify assets (e.g., bilingual staff members who could be used as interpreters, existing relationships with community-based ethnic organizations) and weaknesses (e.g., no translated signage or cultural competence training), as well as opportunities to improve the structural framework (e.g., revise the mission statement or recruit people from diverse cultures into policy and management positions). Only after such a self-assessment can organizations prepare adequate strategic plans for developing CLAS (see Standard 8). Subsequent ongoing self-assessment helps organizations chart their progress in implementing the CLAS standards and refine their strategic plans.

Tools for Organizational Self-Assessment of Cultural Competence

Organizational self-assessment of cultural competence faces some of the same limitations as assessing the cultural competence of individuals. Although many tools for organizational self-assessment have been developed and cataloged, no one assessment instrument or process has been specifically validated against another. Moreover, some are suited to a particular type of institution (e.g., hospital, managed care organization), and none are based on the CLAS standards. Nevertheless, useful compilations of tools do exist. The Judge Baker Children's Center uses an analysis of organizational self-assessment tools as the foundation for an extensive manual describing how children's mental health providers can conduct and implement a culturally competent assessment process.

Other assessment tools/processes have been designed and field tested. The National Center for Cultural Competence developed a process that has been conducted with organizations in several states. Another process developed by the National Public Health and Hospital Institute was tested in hospitals and redesigned as an organizational self-assessment tool. Dr. Miguel Tirado at California State University Monterey Bay developed a cultural competence assessment tool for managed care organizations based on his previous assessment tool for individual health professionals (Tirado, 1996). The State of Massachusetts currently uses a tool to assess and rate the cultural competence of hospitals. This tool will eventually be modified for use with managed care organizations participating in Medicaid. Polaris Research in San Francisco has an assessment process for organizations that provide HIV services, and the Heartland Alliance of Illinois offers a cultural competence toolkit for managed care organizations that includes a blueprint of organizational competencies, assessment criteria, and best practices. Although several of these products and processes have built upon the approaches developed by previously published tools, each reflects the specific definitions, goals, and objectives of its developers rather than any universally accepted set of criteria.

CLAS-Related Measures in Performance Improvement and Outcomes Assessments

Integrating measures related to cultural and linguistic competence into existing quality improvement programs could help organizations learn whether CLAS delivery processes produce the desired results. Although organizational self-assessment (the first part of this

standard) is presented as a guideline, the current evidence base supports only the recommendation that organizations integrate CLAS-related measures into existing quality improvement activities (the second part of the standard). No consensus on state-of-the-art measures of quality, satisfaction, and outcomes related to CLAS currently exists. However, public comments suggest that there are many opportunities for organizations to collect basic data about ethnic clients and CLAS utilization, and to systematically examine the quality of these services as well as their impact on performance and outcomes. For example, the draft specifications by the Health Resources and Services Administration (HRSA) for Medicaid managed care contracts suggest that organizations could conduct focused studies that explore 1) accessibility of interpreter services; 2) the effectiveness of cultural competence training for providers and non-clinical staff; 3) differences in the use of services among different racial and ethnic minority groups; and 4) the impact of culturally competent service provision on the health outcomes, health status, and satisfaction of enrollees.

Another suggested approach was to include in performance improvement programs one or more evaluation questions that focus on whether there are differences among ethnic or language groups in service utilization (e.g., not appearing for appointments, termination of enrollments). Such data are useful in refining programs because they identify potential problems that are highly actionable. For example, an assessment of “no-show” data could reveal certain times of day at which patients/consumers from a particular group are more likely to break their appointments. Determining why these times are less convenient and adjusting appointment times for these individuals could increase access to services among the group.

The Center for Healthy Families and Cultural Diversity, University of Medicine and Dentistry of New Jersey-Robert Wood Johnson Medical School, has developed a Participatory Quality Improvement (PQI) model for systematically linking clinical quality improvement with measures of organizational, provider, and community/patient cultural competence. Now being tested, PQI offers a promising way for organizations to measure quality improvement in dimensions related to the elimination of racial and ethnic health disparities.

One relatively easy way to integrate cultural competence-related measures into performance improvement activities is to add a question about self-identified ethnicity to an organization’s existing patient surveys. These data can be segregated by ethnicity to compare patient/consumer satisfaction among ethnic groups and to identify any specific service-related differences. However, the data collection instrument must be culturally and linguistically appropriate, with translated questionnaires or bilingual interviewers for telephone surveys. Harvard Pilgrim Health Care, a managed care organization in Massachusetts, developed a patient cultural audit that is being pilot tested at three multi-specialty sites. Preliminary results indicate that the survey, which is available in seven languages, provides information that helps sites focus on what patients want, what is working well, and what needs additional attention.

It should be noted that although patient/consumer satisfaction surveys are one of the most frequently used methods of evaluating services, they might not yield a true picture of the quality of services. Research shows that it is particularly difficult to design patient satisfaction surveys to capture the patient’s complete view of quality and satisfaction. For example, neither patients nor physicians may truly be able to assess the quality of the language assistance services because neither has the linguistic capacity to verify the competency or accuracy of the

interpreter or translation. Additionally, cultural variations abound in how clients respond to satisfaction-related questions, especially when feedback might be negative.

Health care organizations that integrate queries related to race, ethnicity, and language into utilization or risk management systems may find trends that could be related to these factors or be affected by the presence or absence of cultural and linguistic services. For example, an analysis of patient records at two Midwestern hospitals preparing for a merger found that patients with certain conditions had shorter lengths of stay and lower rates of return for the same condition at one hospital. Although the sample was small, further analysis offered a statistically significant indication that the hospital's use of interpreters played a role in the better outcomes.

Assessing the effectiveness of CLAS in terms of health outcomes requires aggregate data on patient/consumer race and ethnicity. Until organizations implement Standard 10, which calls for the collection of such data, many may attempt data aggregation by ethnicity on the basis of last names. This approach is flawed by overlaps that occur between subpopulations (e.g., Cuban and Mexican Americans), the fact that immigrants often change the spelling of their last name, and the possibility that changes as a result of marriage may reduce the accuracy of last names as markers of ethnicity. Instituting collection of race, ethnicity, and language data is necessary to ensure appropriate monitoring of patient/consumer service needs and utilization, quality of care, and outcome patterns.

STANDARD 10

COLLECTION OF DATA ON INDIVIDUAL PATIENTS/CONSUMERS (GUIDELINE)

Standard and Commentary

10. Health care organizations should ensure that data on the individual patient's/consumer's race, ethnicity, and spoken and written language are collected in health records, integrated into the organization's management information systems, and periodically updated.

The purposes of collecting information on race, ethnicity, and language are to:

- Adequately identify population groups within a service area;
- ensure appropriate monitoring of patient/consumer needs, utilization, quality of care, and outcome patterns;
- prioritize allocation of organizational resources;
- improve service planning to enhance access and coordination of care; and
- assure that health care services are provided equitably.

Collection of data on self-identified race/ethnicity should adhere to the standard procedures and racial and ethnic categories specified in the Office of Management and Budget's most current policy directive and adapted in the U.S. Census 2000. To improve the accuracy and reliability of race and ethnic identifier data, health care organizations should adapt intake and registration procedures to facilitate patient/consumer self-identification and avoid use of observational/visual assessment methods whenever possible. Individuals should be allowed to indicate all racial and ethnic categories that apply. Health care organizations can enhance their information on subpopulation differences by collecting additional identifiers such as self-identified country of origin, which provides information relevant to patient/consumer care that is unobtainable from other identifiers.

The purpose of collecting information on language is to enable staff to identify the preferred mode of spoken and written communication that a patient/consumer is most comfortable using in a health care encounter. Language data also can help organizations develop language services that facilitate LEP patients/consumers receiving care in a timely manner. To improve the accuracy and reliability of language data, health care organizations should adapt procedures to document patient/consumer preferred spoken and written language. Written language refers to the patient/consumer preference for receiving health-related materials. Data collected on language should include dialects and American Sign Language.

For health encounters that involve or require the presence of a legal parent or guardian who does not speak English (e.g., when the patient/consumer is a minor or severely disabled), the management information system record and chart should document the language not only of the patient/consumer but also of the accompanying adult(s).

Health care organizations should collect data from patients/consumers at the first point of contact using personnel who are trained to be culturally competent in the data collection

process. Health care organizations should inform patients/consumers about the purposes (as stated above) of collecting data on race, ethnicity, and language, and should emphasize that such data are confidential and will not be used for discriminatory purposes. No patient/consumer should be required to provide race, ethnicity, or language information, nor be denied care or services if he or she chooses not to provide such information. All patient/consumer data should be maintained according to the highest standards of ethics, confidentiality, and privacy, and should not be used for discriminatory purposes.

Discussion

Legality and Purposes of Collecting Data on Race, Ethnicity, and Language

Public comments on Standard 10 indicate that confusion remains as to whether the collection of data on race and ethnicity is permissible by law. Since 1997, the U.S. Department of Health and Human Services (HHS) has required the inclusion of information on race and ethnicity in HHS data collection systems (HHS, 1997). In recent correspondence with a national health care organization, the Office of Civil Rights (OCR) affirmed the legality and importance of collecting and analyzing these data to improve services. OCR considers collecting racial and ethnic data a critical part of any comprehensive strategy to eliminate health disparities. The Office strongly encourages collecting such data to help organizations focus care on health conditions prevalent in specific demographic groups and provide CLAS to its patients/consumers. Through analyses of race and ethnicity data, health care organizations can identify and track similarities and differences in plan performance and quality of care in ethnic, cultural, and geographic communities. OCR often requests race/ethnicity data on clients to assess whether programs receiving Federal funds are in compliance with Title VI (OCR, 2000). Massachusetts, California, and Arizona are among the States that collect race and ethnicity data in their Medicaid and State Children's Health Insurance Programs.

In addition to the purposes OCR cites for collecting race and ethnicity data, public comments suggested other compelling reasons. For example, clinicians can use these data to make more accurate assessments, diagnoses, and treatment evaluations and interventions, based on research findings about specific physical, biologic, and physiological variations (e.g., in disease and drug metabolism) found among different racial and ethnic groups. One commenter noted that race and ethnicity data could be used to identify and understand general patterns and trends in accessing care as well as cross-cultural differences in outcomes. However, needs assessments (as called for in Standard 11) are necessary to capture the details of a community's resources, assets, and needs.

Standardization of Data

Numerous public comments emphasized the need to standardize race/ethnicity data, noting that one of the difficulties in analyzing these data is the wide variation of classification and collection methodologies. Standardizing racial and ethnic categories was suggested as an important way to facilitate research and analysis. Collaborative efforts among local, state, and Federal agencies to collect the same type of information were recommended to foster the sharing and broader use of data. Yet it was also considered vital that the categories allow for a greater variety of self-identified ethnicity. The OMB guidance on the classification of Federal data on race and ethnicity provides an existing standard that is followed by all Federal agencies. The standard has five minimum categories for data on race (American Indian or

Alaska Native, Asian, Black or African American, Native Hawaiian or Other Pacific Islander, and White) and two categories for data on ethnicity (Hispanic or Latino and Not Hispanic or Latino). However, these categories were expanded for U.S. Census 2000 to include four Spanish/Hispanic/Latino, seven Asian, and four Pacific Islander categories. Census 2000 also allows for respondents to self-identify one or more races. Although organizations are urged to use this classification system as a base for data collection, gathering more detailed information on subpopulations, with linkages to these categories, also is encouraged

Additional Identifiers

In addition to standardized racial and ethnic categories, HHS encourages the collection of data on other variables, such as cultural background and socioeconomic status, that may be useful in assessing and improving health care (HHS, 1997). Public comments also suggested that health care organizations collect data on country of origin as a way to identify characteristics of subpopulations not necessarily revealed by self-identified race/ethnicity or preferred language. For example, the needs of a Somali refugee population are very different from those of third-generation African Americans. Similarly, one commenter reported that there are 36 different Asian communities in a San Francisco service area. Information on country of origin also can identify patients/consumers who may be at higher risk for illnesses such as hepatitis or tuberculosis, based on the results by international studies conducted by the Centers for Disease Control and Prevention. Acculturation data also might be important. For example, pregnancy outcomes might vary considerably between the first and second generation of immigrants from West Africa.

Commenters suggested that data on language be inclusive of diverse dialects and languages such as ASL. Because some languages have many distinct dialects (e.g., Cantonese and Mandarin Chinese), collecting specific data on the dialect of the patient's/consumer's spoken language is critical to ensuring linguistically appropriate care. Including a code for signing systems such as ASL will facilitate the availability of appropriate language services for deaf or hard-of-hearing individuals. It may also be important to distinguish between written and spoken communication because it cannot be assumed that individuals' primary written language are the same as their primary spoken language. For example, an LEP client may speak English well enough not to need an interpreter. However, that client may not be able to read English, and therefore would like to receive his or her correspondence in another language. A different individual may be fluent in speaking Cantonese Chinese but may not be able to understand written Chinese. Collecting data on both written and spoken communication preferences can help health care organizations provide appropriate interpretation and translation services.

Confidentiality Issues

Many diverse cultural groups may be afraid of negative reprisals for providing personal information such as race, ethnicity, and language. Undocumented populations may be unwilling to volunteer this information for fear that they will be reported to the U.S. Immigration and Naturalization Service. Other patients may believe that they will receive disparate medical services as a result of answering questions about race, ethnicity, or language in a medical encounter. Still others may worry about being asked to pay higher insurance premiums based on race or ethnicity. Public comments also indicate that some providers are concerned about collecting data from their patients because they have no way to ensure that the data will not be misused later.

Public comments emphasized the obligation of organizations to ensure that all patient/consumer data are maintained according to the highest standards of ethics, confidentiality, and privacy. Information on race, ethnicity, and language should never be used for discriminatory or profit-making purposes, and should never be required of patients/consumers who do not wish to provide it. Data collection should never compromise the relationship between patient and provider, and the client should never be put at risk to collect data. Just as important is the organization's obligation to inform patients/consumers, and, ideally, the community, about the purpose of collecting such data. Patients/consumers and the community need to be assured that the information is being gathered for their benefit. Health care organizations should follow the new Federal regulation concerning the privacy of patients' health information, if allowed to stand. The final rule, which is provided for under the Health Insurance Portability and Accountability Act of 1996, requires health care plans and providers to obtain their patients' consent for both routine and nonroutine use and disclosure of health records. The regulation also calls for plans and providers to give patients a clear written explanation of how their health information can be used, kept, and disclosed. (HHS, 2000)

Public comments provided practical suggestions for helping to ensure the confidentiality of individual data in management information systems (MIS). For example, systems could use codes for data such as race/ethnicity that would never be linked to patients'/consumers' names but used only in aggregate to track outcomes. Another comment suggested that organizations could design MIS that allow access to race/ethnicity data only to certain approved personnel. To determine which staff members are given access, it is important for organizations to clarify the purpose of the data and who needs to use them. Organizations should ensure that all staff members using MIS information regularly receive training on client record confidentiality. One commenter suggested that organizations should consider a system of consent and collaboration in which patients/consumers consent to have their needs (e.g., for language services) communicated, and those needs are respected throughout the various systems through which the patients/consumers travel.

Management Information Systems

Collecting data on race, ethnicity, and language is not yet a universal practice, and fields for such data are not part of every health care organization's existing MIS. However, one commenter noted that many managed care organizations and hospitals are in a phase of changing and upgrading their information technology systems, thus offering a window of opportunity for building databases that can collect information on race, ethnicity, and language. For example, health care organizations designing or upgrading their MIS could learn from Harvard Pilgrim Health Care and other organizations, which have found that they need to allow for coding of more than a dozen different languages.

The State of Washington's Department of Social and Health Services has an Automated Client Eligibility System (ACES) that goes even further in tracking the language of its clients. ACES currently has a primary language field that accepts 88 different language codes (listed on a help screen), including one for Sign Language. There is also code for "Other Language," the name of which can be typed on a narrative screen. ACES can also generate correspondence in 8 supported languages, whose basic text for all ACES letters is contained in the system; correspondence in the other languages is printed in English and sent to a contractor for

translation. Modification of ACES is underway to include two primary language fields—one for written communication and one for spoken communication. Each field will have its own help screen listing of valid codes. Staff will be required to provide a valid primary language code for each field. For example, one client may have Chinese as the primary written communication and Chiu Chow, a Chinese spoken dialect, as the spoken communication.

Public comments suggested that taking advantage of Web-based enrollment forms can make it easier to update and adjust data collection fields. Organizations also can consider building crosswalks between their main databases, which are usually written in difficult computer languages, and parallel systems with more user-friendly software (e.g., Microsoft Access) that allow easier access to data on race, ethnicity, and language. Kaiser Permanente of Northern California collects five data points related to language: primary and secondary spoken language, primary and secondary written language, and the need for an interpreter. Information to update these five language fields is collected during routine queries about the member's most current address and phone number (e.g., during calls to make appointments or check-ins with receptionists).

It is recognized that not all health care organizations have the advantages of Harvard Pilgrim Health Care and Kaiser Permanente, which have more control over their service delivery systems and providers than do most other plans. For many health care organizations, especially small practices, the addition of data fields to collect race/ethnicity and language data may create a considerable burden. One way to phase in the fulfillment of this standard would be to incorporate fields for the additional data in any future upgrades to an organization's MIS. States could help by requiring the collection of data on race, ethnicity, and language on their enrollment forms for Medicaid and the State Children's Health Insurance Program and sharing this information with health care organizations or plans to which enrollees are assigned. However, a State's failure to collect and share race, ethnicity, and language data does not absolve organizations and plans of the responsibility to do so. It is ultimately the organizations and plans that benefit from, and bear responsibility for, collecting the data. All organizations should capture race, ethnicity, and language information at least in the patient's chart and make it available to staff who schedule appointments. This minimal compliance is necessary to ensure that patients receive CLAS.

Data Collection at First Point of Contact

Public comments raised the important issue of the potential for variations in race, ethnicity, and language data, depending on when such data are collected (e.g. time of enrollment vs. time of service). There also may be multiple points of entry into a health care organization, and information collected at one point may not be routinely shared across other service components. Ideally, for programs requiring enrollment (i.e. managed care programs), the entity responsible for enrollment could collect these data at the time of enrollment, and then pass the information to the provider. In other cases, providers such as physicians or pharmacists could collect and record this information at the first point of contact. The information should be recorded not only in the patient record but also communicated to other departments that might have contact with the patient, such as billing or member services. One hospital in Seattle that uses a computer system for patient information and appointment scheduling has a non-optional field for querying the patient about primary language at the initial intake, and forwards this information automatically to the appropriate clinical

department and the interpreter services department for each appointment. An interpreter is automatically scheduled unless a subsequent evaluation reveals that such language services are not needed.

Some health plans that now collect data on race, ethnicity, and language from new members have devised plans to obtain this information from existing members. For example, Kaiser Permanente of Northern California began instructing personnel to collect missing language data from existing members when they called for appointments. A mandatory field ensures that language data is collected before the record is completed, and a script helps staff explain why members are being asked for this information. Contests across hospitals have resulted in some sites already gathering language data on 70 percent of their membership.

STANDARD 11

COLLECTION OF DATA ON COMMUNITIES (GUIDELINE)

Standard and Commentary

11. Health care organizations should maintain a current demographic, cultural, and epidemiological profile of the community as well as a needs assessment to accurately plan for and implement services that respond to the cultural and linguistic characteristics of the service area.

The purpose of this standard is to ensure that health care organizations obtain a variety of baseline data and update the data regularly to better understand their communities, and to accurately plan for and implement services that respond to the cultural and linguistic characteristics of the service area.

Health care organizations should regularly use a variety of methods and information sources to maintain data on racial and ethnic groups in the service area. It is important that health care organizations go beyond their own data, such as marketing, enrollment, and termination figures, which may provide an incomplete portrait of the potential patient/consumer population, many of whom may not be aware of or use the organization's services. A more useful and in-depth approach would use data sources such as census figures and/or adjustments, voter registration data, school enrollment profiles, county and State health status reports, and data from community agencies and organizations. Both quantitative and qualitative methods should be used to determine cultural factors related to patient/consumer needs, attitudes, behaviors, health practices, and concerns about using health care services as well as the surrounding community's resources, assets, and needs related to CLAS. Methods could include epidemiological and ethnographic profiles as well as focus groups, interviews, and surveys conducted in the appropriate languages spoken by the patient/consumer population. Health care organizations should not use the collected data for discriminatory purposes.

In accordance with Standard 12, health care organizations should involve the community in the design and implementation of the community profile and needs assessment.

Discussion

The Importance of Collecting Data on Communities

Social ecological theories suggest that health status is influenced not only by individual attributes such as genetics and health behaviors but also by the physical, social, and cultural, dimensions of a person's environment (Stokols, 1996). Consequently, health care organizations need to understand their communities as well as their patient/consumer populations to provide quality health care services. This standard focuses on two tools for helping organizations understand their communities—a demographic, cultural, and epidemiological profile of the community and a needs assessment. These tools can help providers and policymakers develop appropriate services and evaluate access to, and utilization of, those services.

Many people in a service area, especially individuals with limited English proficiency (LEP), may be unaware of an organization's services and never enroll in its programs. Consequently, it is important to collect data about potential as well as current patient populations and to use as many data sources as possible, including sources outside the organization itself. Because many characteristics of a community change over time, it is also critical that health care organizations ensure that data on their community is up to date. Although routine updates of community information should take place periodically, some organizations might consider an annual update too burdensome. To address this issue without being too prescriptive, the standard calls for organizations to maintain a current profile and needs assessment, and the commentary calls for organizations to obtain baseline data and update it regularly.

Types of Relevant Data

Health care organizations need to learn as much as possible about their communities using both qualitative and quantitative methods. This standard allows organizations flexibility in determining the types of data they collect. Relevant types of data have been suggested by the document review conducted for the CLAS standards project, draft Health Resources and Services Administration (HRSA) Medicaid contract language, and public comments. For example, data collection required by some source documents includes descriptions of geographic, demographic, and socioeconomic status; languages spoken in the community; population densities; ecological factors; and cultural needs. Other requirements in various source documents include an analysis of the cultural needs and health practices and behaviors of ethnic groups and the development of a database on ethnic/cultural needs of patients. Source documents also address documentation of requests for culture-specific services, data development of utilization trends and services in preferred languages, and documentation that all hospital data are analyzed by race and ethnicity.

Some source documents also require organizations to assess various factors related to the need for language access services. The types of data and analysis called for in this area include a report on the size and demographics of the population served, an analysis of LEP groups (including those who need interpreters) by zip code, the number of zip codes where a large percentage of residents are LEP, and a group needs assessment that identifies linguistic and cultural needs. The OCR guidance suggests that organizations identify non-English languages that are likely to be encountered by estimating the number of LEP persons that are eligible for services. To obtain this estimate, OCR recommends reviewing census data, client utilization data from client files, and data from schools systems and community agencies and organizations.

HRSA specifications for Medicaid managed care contracts suggest that organizations conduct an assessment of racial and ethnic minority groups that includes demographic data, including literacy and educational levels; epidemiological data; evidence of health disparities; health beliefs, including attitudes toward health and illness and traditional medical treatment; and health-related behaviors and practices, including the use of alternative medicine and practitioners (HRSA, 2000).

Public comments provided additional recommendations on the type of data that is helpful to understand a community and its patient/consumer population. For example, it is helpful to collect data on the specific health care needs of the community, such as the number of people with asthma or heart disease, or the number of teenagers committing suicide. Collecting data

about the cultural factors related to patient needs, attitudes, behaviors, and concerns about health and medical care can help organizations plan and implement services. One comment suggested that these factors might include the length of time patients/consumers have spent in the United States and the number of trips they have taken back to their country of origin. Several comments recommended the collection of outcome data, including patient satisfaction, access to services, and clinical outcomes such as quality of life and reduction of health disparities. Comments also recommended that data collection on racial and ethnic groups in the community be expanded to include other diverse cultural groups whose medical needs and concerns are not typically addressed by health care organizations. Examples of such groups include people with physical or mental disabilities and different sexual orientations.

To fully understand the surrounding community's resources, assets, and needs related to CLAS, organizations should become knowledgeable about the economic conditions (e.g., employment rates), social norms and values (e.g., the community's health decisionmaking process and behaviors), and political structures (e.g., neighborhood governances, planning councils) within the community. It is also helpful to identify the formal and informal leadership structure in the community; key organizations and institutions; and linkages among relevant systems, groups, and individuals (CDC/ATSDR, 1997). HRSA specifications for managed care contracts call for health care organizations to identify any public or private programs and facilities in the service area that furnish needed services such as health education and interpreter services (HRSA, 2000). Learning about community experiences dealing with cultural, linguistic, and health issues (e.g., existing coalitions focused on HIV/AIDS), as well as successes and failures associated with those experiences, may help organizations understand the extent to which the community is willing to become involved in other collaborations. It is also important to determine how the community views the health care organization and its staff. Understanding these perceptions can help identify problems that need to be addressed as well as strengths that can be used to improve services.

Community mapping is one way to understand and describe a community and its resources. This technique identifies human and material resources that can be used to address community issues and concerns. Community assets and capabilities might include public schools and higher education institutions, cultural organizations, individual businesses and business associations, public health agencies, religious organizations, and citizens associations, along with individual capacities (McKnight and Kretzmann, 1990). Mapping community assets can help health care organizations identify groups and individuals who may be potential partners in prioritizing and mobilizing a coordinated response to implement CLAS and improve other aspects of health care services. One comment noted that a children's mental health project in the Bronx identified more than 500 community organizations, including senior services, faith-based organizations, and schools, that were related in some way to the project's objectives.

Collaboration to Develop Community Profiles and Needs Assessments

Many health care organizations have indicated that they have neither the in-house capacity to maintain a community profile/needs assessment nor the resources to hire a consultant to conduct this CLAS activity. Other organizations already have the framework to collect data and learn about their communities but do not yet collect data relevant to CLAS (e.g., immigrant and refugee census data). State or local health departments could consider

collaborating with health care organizations in their area to jointly develop community profiles/needs assessments. For example, health departments could collect quantitative data such as basic demographic information on diverse population groups in a specific geographic area. The centrally collected data could be made available to local health care organizations, which could work with their communities to gather supplemental information about local health care needs and assets (e.g., the identification of traditional healers in the community). This collaborative approach would avoid the need for organizations to expend limited resources in duplicative efforts to collect demographic data on the same populations, yet still involve the organizations in the educative process of learning about their patients/consumers.

Another critical collaboration is the involvement of the community in the design and implementation of the community profile and needs assessment. One public comment suggested that community partnerships could be useful in assessing the current status of existing data. Organizations also can learn from the community what issues it considers important and how to make data collection instruments and processes culturally sensitive. Another comment urged that people in the community be involved in data collection, whatever method is used. This involvement can help allay mistrust among groups in the community, such as undocumented immigrants, who may fear reprisals based on information collected by the organization. On a related issue, public comments suggested that the information collected in accordance with this standard should be shared with the community from which it was solicited (see Standard 14).

Potential Uses for Community Data

Organizations can use the data collected for community profiles and needs assessments in a variety of ways. The data can be useful for customizing services, as well as enhancing specific or general assessments of quality and outcomes. Epidemiological information about the surrounding community can assist health care organizations in planning for and implementing population-based interventions and health education campaigns. Cataloguing the cultural needs, resources, and assets of the surrounding community can help an organization plan and implement services and linkages with community-based ethnic organizations and private providers who can assist with outreach and service delivery to different ethnic groups.

The State of California requires its Medicaid (Medi-Cal) managed care plans to use information collected through group needs assessments to inform and direct both their health education and cultural/linguistic programs. This information also has to be integrated with the plans' quality improvement efforts. Thus, the group needs assessment helps create a road map for actions that will allow health care plans to meet the needs of their enrollees.

STANDARD 12

COMMUNITY PARTNERSHIPS FOR CLAS (GUIDELINE)

Standard and Commentary

12. Health care organizations should develop participatory, collaborative partnerships with communities and utilize a variety of formal and informal mechanisms to facilitate community and patient/consumer involvement in designing and implementing CLAS-related activities.

The culturally competent organization views responsive service delivery to a community as a collaborative process that is informed and influenced by community interests, expertise, and needs. Services that are designed and improved with attention to community needs and desires are more likely to be used by patients/consumers, thus leading to more acceptable, responsive, efficient, and effective care. As described below, this standard addresses two levels of consumer/patient and community involvement that are not token in nature, but involve working with the community in a mutual exchange of expertise that will help shape the direction and practices of the health care organization.

Patients/consumers and community representatives should be actively consulted and involved in a broad range of service design and delivery activities. In addition to providing input on the planning and implementation of CLAS activities, they should be solicited for input on broad organizational policies, evaluation mechanisms, marketing and communication strategies, staff training programs, and so forth. There are many formal and informal mechanisms available for this, including participation in governing boards, community advisory committees, ad hoc advisory groups, and community meetings as well as informal conversations, interviews, and focus groups.

Health care organizations should also collaborate and consult with community-based organizations, providers, and leaders for the purposes of partnering on outreach, building provider networks, providing service referrals, and enhancing public relations with the community being served.

Related to Standard 11, health care organizations should involve relevant community groups and patients/consumers in the implementation of the community profile and needs assessment.

Discussion

Most health care organizations include responsiveness to the community as a part of their mission statements, but many struggle with the means and rationale for true partnership development with patients/consumers and community representatives. Given the complexity of deciphering the cultural beliefs and mores of ethnic communities, health care organizations have the potential to benefit greatly from establishing ongoing links and opportunities for consultation with representatives from these communities. On the other hand, some organizations may fear that community collaboration may also open the door to painful criticism and unlimited or unachievable demands.

If an organization has as its goal the delivery of health services that are appreciated and appropriately used by its customers, then input from those individuals is essential to planning, implementing, and improving services. Community input provides health care organizations with the opportunity to view themselves as they are seen from the outside, and to plan service delivery according to the everyday realities of the community. “We all live in our own box,” noted one comment, “and we all make assumptions about people who do not live in our box because we are not familiar with their situation. We need to have our minds open enough to see outside our box and not make assumptions. [Patients/consumers] cannot follow through with [advice that is] outside their means, such as taking a daily walk when they live in a dangerous neighborhood. That is why community input is crucial, because people will stop listening if they hear messages that they ultimately cannot follow through with. Organizations will be more effective and will ultimately experience cost savings if they take community input into account.”

Challenges of Authentic Community Involvement

The challenges of involving consumers and community organizations in delivering health care services are both philosophical and practical. The health care organization has to decide whether it is developing mechanisms for partnership solely to comply with a requirement, or whether it is truly prepared to hear both positive constructive input and critical or angry views. Even when the organization’s commitment is authentic, the practical issues can be discouraging, especially for organizations that have not previously worked with culturally diverse communities.

In the initial CLAS standards report, the California Medicaid (Medi-Cal) managed care requirement for community advisory committees was used as an example of how to meaningfully involve consumers in the development and oversight of cultural competence activities. Over the years, managed care organizations (MCOs) participating in Medi-Cal have been challenged to find authentic ways of involving consumers in the process. While the requirements for process and participation are specific, making such advisory committees work is not always straightforward. One organization’s perception of success may not be viewed so favorably by the community. Consumer advocates have observed that the Medicaid population is often challenging to involve in long-term community partnership or planning processes. Participants in the Medicaid program frequently lack familiarity with the financial and management aspects of MCOs, may not stay on Medicaid very long (resulting in frequent turnover on advisory committees), or may not have sufficient time or resources to participate fully. On the other hand, several Federal programs have long histories of involving consumers in their governance structures and planning. These programs include community and migrant

health centers and Head Start, all of which have consumer profiles that are very similar to the Medicaid program.

Often, attention to the small details of support can enable consumers to effectively participate in community involvement processes. One comment described a 35-member regional advisory committee where Spanish is spoken at the meetings. Some committee participants have requested training on meeting protocol and other technical assistance to understand certain issues. It is also critical for organizations to provide incentives for patients/consumers to participate in community partnership activities. Many low-income working individuals feel their circumstances constrain their participation in community meetings. According to one comment, “There are many people who have nontraditional working hours, and sometimes lose a day of work (which translates into less income for their families) if they participate in formal processes for comment. Organizations seeking input should take that into consideration and compensate appropriately.” This could include providing monetary stipends, transportation reimbursement, childcare, and meals before or after meetings.

Public comments raised the issue of power imbalances between health care organizations and the community as well as between health care organizations and individual patients/consumers. Some comments fear that community-based organizations will be misused or tokenized by community input processes sponsored by health care organizations. With respect to individual patients/consumers, several comments pointed out that some members of certain ethnic, age, or gender groups are not always comfortable offering their opinions. Some individuals simply believe that they do not have a right to participate in communications with their physicians or other health care providers. Resolving these issues requires action on many fronts: community leaders can be approached to develop long-term advisory relationships; community members can be invited to discussions in which they feel safe to raise difficult issues without fear of anger or dismissal; and community and health care organizations can work together to educate patients/consumers about how to interact with the American health care system. As one comment noted, “There’s a need for a community liaison position in health care organizations that sits alongside the chief financial officer and other, more traditional keepers of power. We need to get the right people at the table, including people who are usually not invited to the table.”

Methods for Involving the Community

There are a number of other ways to involve community leaders and patients/consumers in partnerships to improve the cultural competence of health care services. For example, community leaders could be invited to participate in the ongoing planning and advisory groups that design and implement the strategic plan for cultural competence. Many comments pointed out that it is also important for health care organizations to go into the community to initiate its partnerships. Community leaders and other community-based organizations could use their facilities to co-sponsor with the health care organization community forums and conversations where patients/consumers can express needs and concerns about health care delivery in their area. Churches were frequently mentioned as good partners with which to sponsor interactions between health care organizations and the community. Many churches also provide social and health services that could be linked to, or supported by, the health care organization. In both large and small organizations, including small physician practices, individuals from the community who are knowledgeable about cultural health beliefs could

serve as advisers and trainers for staff cultural competence training. The health care organization or practice could train and hire community members to work as receptionists, community outreach workers, and interpreters. When patients/consumers come to the health care delivery site, they could be asked to complete short questionnaires about how their needs are being met, or they could participate in a semi-structured interview with staff before or after their encounters. See Standard 9 for further discussion related to patient surveys.

Several public comments raised the importance of the “giving back” as part of the process of working with the community. “Community members become frustrated when they are asked for their input and never hear back about how the input was used and if anything happened as a result,” one comment said. Some comments made clear that giving back to the community comes from ensuring that the input was used and responsive changes have been made. Others felt it important to simply report how the information was delivered and received. Sometimes the demonstration of partnership needs to be more creative. “Even if health care organizations ‘give back’ to their community by having representatives attend a rally to protest the proximity of the trash dump, it closes the loop. It demonstrates that the health care organization cares enough to prevent future health care problems [in the community].”

Community Referrals and Liaisons

Another important issue relates to the development of formal participation and referral linkages with ethnic and community-based providers. These types of collaborations may also have the effect of assisting mainstream providers with resources and expertise on linguistic and cultural competence that otherwise may be difficult and costly to successfully replicate in-house. Again, as a result of the Medicaid managed care rules in California, some health care plans and providers have realized that ongoing patient/consumer education and chronic disease or prenatal care management of non-English speaking patients can be difficult and time consuming for providers who are not from the patients’ ethnic groups. This realization has led to experimentation with the use of community health workers by both providers and plans. In light of the limited contact time between patients and clinical providers in most health care settings today, the development of community health worker programs may offer an effective means of educating and supporting the continuing health management needs of all patients (Coye, 1999).

STANDARD 13

COMPLAINT AND GRIEVANCE RESOLUTION (GUIDELINE)

Standard and Commentary

13. Health care organizations should ensure that conflict and grievance resolution processes are culturally and linguistically sensitive and capable of identifying, preventing, and resolving cross-cultural conflicts or complaints by patients/consumers.

This standard requires health care organizations to anticipate and be responsive to the inevitable cross-cultural differences that arise between patients/consumers and the organization and its staff. Ideally, this responsiveness may be achieved by integrating cultural sensitivity and staff diversity into existing complaint and grievance procedures as well as into policies, programs, offices or committees charged with responsibility for patient relations, and legal or ethical issues. When these existing structures are inadequate, new approaches may need to be developed.

Patients/consumers who bring racial, cultural, religious, or linguistic differences to the health care setting are particularly vulnerable to experiencing situations where those differences are not accommodated or respected by the health care institution or its staff. These situations may range from differences related to informed consent and advanced directives, to difficulty in accessing services or denial of services, to outright discriminatory treatment. Health care organizations should ensure that all staff members are trained to recognize and prevent these potential conflicts, and that patients are informed about and have access to complaint and grievance procedures that cover all aspects of their interaction with the organization. In anticipation of patients/consumers who are not comfortable with expressing or acting on their own concerns, the organization should have informal and formal procedures such as focus groups, staff-peer observation, and medical record review to identify and address potential conflicts.

Among the steps health care organizations can take to fulfill this standard are: providing cultural competence training to staff who handle complaints and grievances or other legal or ethical conflict issues; providing notice in other languages about the right of each patient/consumer to file a complaint or grievance; providing the contact name and number of the individual responsible for disposition of a grievance; and offering ombudsperson services. Health care organizations should include oversight and monitoring of these culturally or linguistically related complaints/grievances as part of the overall quality assurance program for the institution.

Discussion

It is important to recognize, as many comments noted, that this standard is linked to many existing legal requirements. Issues such as grievance procedures, ombudspersons, and discrimination policies and procedures are frequently regulated at the Federal and/or state level. Many of these policies, however, are designed to be “one size fits all,” and such programs may not be used by individuals for culture and language-related concerns or may not be

responsive to these issues. Title VI compliance calls for notices to limited English proficiency (LEP) patients/consumers about their right to complain about not receiving language assistance when needed, as well as their rights to have interpreters and translated materials available related to any complaint processes.

Recognition of Misunderstanding and Bias, and Organizational Solutions

Often the substance of complaints related to cultural misunderstanding is subtle, and many comments pointed out that most health care organizations still struggle with “systemic conscious or unconscious bias.” As one comment observed, “Sometimes discrimination happens because an organization does not have cultural competence and the necessary policies and procedures in place. So it is important to have lawyers involved when policies and procedures are being developed to define what is discrimination and violation of rights. Racism is still a problem, but it is not as well defined legally as is discrimination. White supremacy, black supremacy, and other types of supremacy also are real issues. If people do not know how to present themselves respectfully to certain people, the conversation is over. Respectful intake engagement needs to be put in procedures and implemented.”

Clearly, organizations need to address these issues systematically and draw on several types of structural and staff resources for assistance. Ideally, such resources would be used to help staff recognize and act on emerging cultural conflicts before they rise to the formal complaint level. One hospital in the Midwest was providing health care to a community of recent immigrants who would not sign informed consent forms because of cultural and religious issues about discussing death and dying. The hospital’s legal staff convened a community meeting to search for a compromise position that would meet the needs of the community and hospital. While the perfect solution was never achieved, the dialogue contributed to better relationships and understanding between patients and staff. Another comment recounted a case involving an Asian family in which a family member had died. For cultural reasons, the family expressed resistance to an autopsy and complained that staff had been rude in responding to the family’s concern. It may not always be clear whether such a situation is a complaint or a grievance or discrimination, but organizations can foster alternative scenarios that might involve calling in a patient advocate or ombudsperson or enlisting the assistance of an ethics committee at the first sign of disagreement or conflict.

Formal institutional policies and procedures to address complaints by patients about unfair or discriminatory treatment can provide direction for staff members in their efforts to achieve cultural competence. The previous example also highlights the critical role of cultural competence training to prepare staff to appropriately respond in the face of cultural differences. Procedural guidelines, courses and case study analysis can instruct staff on how to listen and respond respectfully when cultural differences arise, how to respond to patient complaints, and what cultural issues influence patient dissatisfaction. Organizations may also want (or be required) to create programs with an ombudsperson and an ethnically diverse staff to proactively address patients rights and protections. Such a program can also provide a quality feedback loop to the organization on the effectiveness of ongoing cultural and linguistic competency initiatives.

Patient Culture/Empowerment Issues

Health care organizations should not assume that a lack of complaints from patients/consumers means that cross-cultural conflict or discrimination is not occurring. Often patients/consumers may not recognize that they are being treated inappropriately, or they may have fears or cultural beliefs that inhibit complaining, or may not know that they have the right to complain. They may also believe that a complaint will be disregarded by the institution. Health care organizations need to communicate the concept of patients rights to their patient/consumers in a way that recognizes these potential barriers and reassures patients about the safety, importance, and validity of the process. The complaint/grievance process itself should be understandable, easily accessible, confidential, and transparent. As one comment noted, “Clients shouldn’t have to figure out where to go to file a complaint.” Linguistic accessibility to notices, forms, and processes is particularly crucial.

STANDARD 14

INFORMATION FOR THE PUBLIC (RECOMMENDATION)

Standard and Commentary

14. Health care organizations are encouraged to regularly make available to the public information about their progress and successful innovations in implementing the CLAS standards and to provide public notice in their communities about the availability of this information.

Sharing information with the public about a health care organization's efforts to implement the CLAS standards can serve many purposes. It is a way for the organization to communicate to communities and patients/consumers about its efforts and accomplishments in meeting the CLAS standards. It can help institutionalize the CLAS standards by prompting the organization to regularly focus on the extent to which it has implemented each standard. It also can be a mechanism for organizations to learn from each other about new ideas and successful approaches to implementing CLAS.

Health care organizations can exercise considerable latitude in both the information they make available and the means by which they report it to the public. For example, organizations can describe specific organizational changes or new programs that have been instituted in response to the standards, CLAS-related interventions or initiatives undertaken, and/or accomplishments made in meeting the needs of diverse populations. Organizations that wish to provide more in-depth information can report on the data collected about the populations and communities served in accordance with Standard 11 and the self-assessment results gathered from Standard 9. Organizations should not report scores or use data from self-assessment tools that have not been validated. However, as standard self-assessment instruments and performance measures are developed and validated, additional information gathered by using these tools could be made available to the public.

Health care organizations can use a variety of methods to communicate or report information about progress in implementing the CLAS standards, including publication of stand-alone documents focused specifically on cultural and linguistic competence or inclusion of CLAS components within existing organizational reports and documents. Other channels for sharing this information include the organization's member publications; newsletters targeting the communities being served; presentations at conferences; newspaper articles; television, radio, and other broadcast media; and postings on Web sites.

Discussion

Intent of the Standard

The recommended action in Standard 14 did not appear in any of the source documents for the original CLAS standards report. However, its inclusion as a CLAS standard was recommended and approved by the National Advisory Committee that met in July 1998. The original intent of the standard was to address the accountability of health care organizations to their patients/consumers and communities by calling for organizations to publish an annual report. In the report accompanying the draft CLAS standards it was noted that an annual

report would benefit the organization by providing a mechanism for reaching out to potential patients/consumers and educating providers and staff about the cultural competence goals of the organization. The community would benefit from such a document because it could allow community residents to understand and monitor the progress that organizations are making towards the goal of cultural competence. The idea for the report was stimulated by existing efforts such as Harvard Pilgrim Health Care's publication of a regular "Diversity Report" that reviews in a qualitative narrative the goals and progress of the organization related to serving diverse populations.

However, public comments differed on the need for this standard as well as on the purpose and nature of the annual report. The National Project Advisory Committee (NPAC) believed that the field could not yet support guidelines for formalized and standardized reporting or for methodologies that would allow comparisons of data. Nevertheless, the NPAC recognized the benefits that reporting on progress toward CLAS offers both the community and the organization. Consequently, Standard 14 was retained with a less prescriptive focus. It now encourages organizations to provide meaningful information to the public on an ongoing basis and gives considerable latitude on how the information is presented. Allowing organizations maximum flexibility in meeting this standard is intended to foster both innovation and accountability to the community. Although the standard's commentary emphasizes the positive aspects of sharing information, it cautions organizations against reporting scores from unvalidated tools that could misrepresent differences between health care organizations. As standard self-assessment instruments and performance measures are developed and validated, organizations are encouraged to use these tools to provide additional information to the public.

The Need for Reporting to the Public

A few commenters believed the annual report was redundant if organizations followed the first 13 CLAS standards, particularly Standard 9, which calls for organizational self-assessment. Concerns were raised about the administrative burden and unrealistic time frames of such reporting, and one commenter warned that organizations might put more effort into preparing a required report than trying to achieve the objectives of the CLAS standards. However, comments generally agreed that it was a good idea for organizations to share information about progress toward CLAS with the public. For example, it was suggested that public disclosure of CLAS-related activities would prompt health care organizations to make improvements in this area. It also supports a continuous quality improvement process by emphasizing the organization's ability to respond to patient/consumer needs. The development of an annual report could also benefit organizations by helping them learn how to reach out to diverse patient populations; communities could benefit from having organizations develop programs that match their needs. One commenters stated that the public is entitled to meaningful information about the ways that institutions used public funds to serve their communities. Other comments emphasized that reports to the public should be more than an advertisement for the organization and should include information that was relevant, useful, and understandable to the community.

Accountability as a Focus of Reporting

Comments from the public and the NPAC offered varying perspectives on the extent to which accountability should be the focus of organizations' reporting to the public. Although it was not the original intent of the draft standard, the call for an annual report raised some concerns that the document would become a mandated process that would be linked to reporting to a Federal agency. This scenario, in turn, generated fears that the report would be used as a tool to monitor for compliance and possible discontinuation of Federal funds. However, some commenters viewed accountability as the essence of this standard and saw a report to the public as an important tool for community-based organizations to push for change in institutions that are not meeting their needs.

If organizations were to provide the kinds of information that allow for true community accountability and informed consumer choice, they might include demographics of the patient population; statistics related to interpreter use and availability, translated materials, and staff training; and financial reports on CLAS-related expenditures. The National Health Law Program recommended that the annual report include self-assessment results gathered from Standard 9, community data collected in accordance with Standard 11, and the number of complaints and their resolution as collected pursuant to Standard 13. Various comments suggested that organizations report on performance measures such as patient satisfaction ratings, quality improvement and clinical outcome data, and a cost-effectiveness analysis.

Comparability as a Focus of Reporting

The usefulness of an annual report depends, in part, on the ability of patients/consumers to make decisions based on a comparison of reported results from various health care organizations. However, current questions about the availability and variability of measurement tools make comparability of such data problematic. Without standardized methodologies, data elements, and collection and evaluation processes, every organization could have its own approach to evaluating its progress toward what it has defined as CLAS. The resulting variability in reporting can be significant. One commenter related that the San Francisco Department of Health requests all providers to prepare an annual report on the recipients and costs of services, resulting in submitted reports that range in length from 2 to 65 pages. Until a common set of reporting requirements is developed, organizations could explore other ways to enhance the comparability of reported information. For example, certain States such as Maryland publish report cards. Health care organizations could request that CLAS-related questions be added to this reporting mechanism.

PART III: METHODOLOGY AND ANALYSIS

Introduction

The CLAS standards were developed over three years in a two-stage process sponsored by the HHS Office of Minority Health (OMH). The following discussion will briefly review stage one of the process, describe in more detail stage two of the process, and summarize the changes made to individual standards as a result of public comments received.

Development of the Draft CLAS Standards: Stage One

In 1997, the U.S. Department of Health and Human Services' (HHS) Office of Minority Health (OMH) asked Resources for Cross Cultural Health Care and the Center for the Advancement of Health to review and compare existing cultural and linguistic competence standards and measures in a national context, propose draft national standard language where appropriate, assess the information or research needed to relate these guidelines to outcomes, and develop an agenda for future work in this area.

The project methodology for stage one described below was guided by the key tasks and questions as requested by OMH. The study objectives that guided this project were as follows:

- Where are we now in the process of developing cultural and linguistic competence standards or performance indicators?
- Do current attempts converge around common themes and elements and can a consensus be developed around draft standards to inform performance indicators?
- What areas require further investigation and/or additional information to develop a consensus?

The project research questions sought to investigate whether there is sufficient knowledge and experience within the health care system in developing cultural and linguistic competence standards to form a basis for developing national standards. The following questions served to guide the analysis process:

- What are the common categories of cultural and linguistic competence in existing federal and state and other national policy documents?
- How are performance requirements for cultural and linguistic competence described in each category?
- How do performance requirements compare across similar types of standards (e.g., among OCR consent decrees, or Medicaid contracts)? How do they compare across all types of standards?
- Are there discrete elements that appear repeatedly? How frequently for each category?
- Which elements are the minimum performance requirements in each category? Which are the most comprehensive?
- Do the elements converge around particular performance requirements?

The types of written documents reviewed for this stage one included both technical and policy literature. Technical literature, including reports on research studies, and philosophical and disciplinary papers served as background materials for guiding the coding of cultural and

linguistic competence elements; these sources are listed in the Bibliography. The policy literature included legal reports, federal and state statutory and regulatory documents, accreditation guidelines, reports on cultural competence standards or measures, and provider contract documents from select state managed care providers.

In order to address the study questions, 30 policy documents representative of national, federal and state agencies that made specific reference to cultural and linguistic competence activities were selected for review and analysis. The 30 policy documents were identified from various sources including:

- The National Health Law Program's (NHLP) 1998 Ensuring Linguistic Access in Health Care Settings: Legal Rights and Responsibilities and included all Medicaid managed care contract language and the summaries of state law requirements addressing language and cultural needs from ten regionally representative states. We also conducted a separate review of the original contracts selected for inclusion, which are on file in the NHLP-North Carolina office.
- The Center for Health Policy Research's 1997 publication, Negotiating the New Health System: A Nationwide Study of Medicaid Managed Care Contracts
- The document entitled "The Office for Civil Rights' 'Bottom Lines' for Linguistic Accessibility," based on NHLP's review and synthesis of more than 100 compliance agreements or communications from the HHS Office for Civil Rights to health care organizations that are recipients of federal funds. As such, we considered it a de facto operating standard with respect to the enforcement of Title VI of the Civil Rights Act of 1964.

All the policy source documents are listed in an addendum to the Bibliography contained in Part IV of this final report.

Data analysis methods employed both quantitative and qualitative techniques. The quantitative methods were driven by content analysis techniques to establish discrete measurable units for collating frequency of items within the study documents. The qualitative analysis was guided by a content coding process to identify the common categories and an initial list of areas judged to be important for inclusion under the cultural and linguistic competence thematic clusters.

A matrix analysis format was used to collate information from the source documents. The matrix collated data into two thematic clusters to correspond to (1) linguistic competence (covering the area of language access, interpreter and translation services) and (2) cultural competence (covering the area of patient, staff and organizational cultural diversity management). Originally, each topic area contained twenty elements, which formed the vertical axis of the matrix. Each source document was reviewed and details pertaining to relevant elements were placed in a cell along the horizontal axis. After revisions, the list of elements in each area was reduced to ten and 13, respectively.

Based on the analysis of data in the matrix, the initial report offered a discussion of the frequency and substance pertaining to the final list of elements. The first group of recommended standards (21 in all) had cultural and linguistic competence activities as two separate categories. The report and first set of recommendations for standards were reviewed by a national advisory committee composed of representatives from Federal and state health

agencies, provider groups, and academic research, which met in Washington, D.C., in July 1998. The advisory committee made recommendations for consolidation of the number of standards and making the language of each standard more concise, with policy and practice implications to be discussed in an accompanying commentary. It also recommended changing the terminology for the draft standards to culturally and linguistically appropriate services (CLAS) in health care.

With input gathered from the meeting, a revision of the first set of standards, now reduced to 14, was presented to a focus group convened at the October 1998 national conference, Quality Health Care for Diverse Populations, held in New York City. This version was also distributed for limited public comment on the DiversityRx listserv, from which a dozen comments were received. A second version was drafted in January 1999, and revised four times between February and April 1999 with additional comments from members of the advisory committee. The final product, *Assuring Cultural Competence in Health Care: Recommendations for National Standards and an Outcomes-Focused Research Agenda* was submitted to OMH in May 1999.

Public Comment on and Revision of the CLAS Standards: Stage Two

OMH determined that the appropriate next step for the draft CLAS standards was to undergo a national process of public comment that would result in a broader awareness of HHS interest in CLAS in health care, significant input from stakeholder groups on the draft standards, and a final revision of the standards and accompanying commentary supported by the expertise of a National Project Advisory Committee. To complete this task, OMH contracted with IQ Solutions, Inc. and Resources for Cross Cultural Health Care.

The draft CLAS standards were published in the Federal Register on December 15, 1999 (Volume 64, Number 240, pages 70042-70044), and the full report was made available for review online at [www.omhrc.gov/CLAS]. Individuals and organizations desiring to comment on the standards were encouraged to read the standards and full report, and to send comments during the public comment period, which ran from January 1 to April 30, 2000. During this period, written comments sent by e-mail and regular mail were received from 104 individuals and organizations.

Individuals also had the opportunity to participate in one of three regional meetings on the CLAS standards. The purpose of these one-day meetings was to present information on the standards' development process, and for participants to discuss and provide feedback on issues related to the standards themselves or their implementation. Meetings were publicized in the Federal Register notice, on the website, and in letters mailed to more than 3,000 stakeholders. The meetings were held on January 21, 2000, in San Francisco, California; March 10, 2000, in Baltimore, Maryland; and April 7, 2000, in Chicago, Illinois. More than 309 individuals, representing themselves or their organizations, participated in the three meetings. All sessions of each meeting were audiotaped and transcribed for inclusion in the analysis of public comments.

Following the closure of the public comment period on April 30, 2000, the project team (consisting of staff members of OMH, IQ Solutions, Inc., and its subcontractor Resources for Cross Cultural Health Care) implemented the following steps to analyze the public comments on the CLAS standards received through the three regional meetings, mail, and e-mail.

The public comments received from all sources were organized according to the following

categories (the numbers used to identify the standards pertain to the numbering system of the draft standards. The standards have been reordered in the final revision):

- General Comments (made on the overall report)
- Diverse and Culturally Competent Staff (Standards 1, 4, and 5)
- Consumer and Community Input (Standard 3)
- Bilingual/Interpreter Services (Standards 6, 7, and 9)
- Translated Written Materials (Standard 8)
- The Culturally Competent Organization (Standards 2 and 13)
- Data Collection and Performance Evaluation (Standards 10, 11, 12, and 14)

Within these categories, comments were organized by individual standards and within standards by major identified themes. Staff reviewed the compilations of comments to identify issues and controversies for each standard, and the original comments were organized topically for each standard and for the General Comments. The project team then conducted a series of meetings to discuss comments on topically grouped sets of standards. Deliberations on the CLAS Standards addressed the following set of questions:

- Is there a powerful consensus from public comments to change the standard in any way? If so, what are the issues?
- Are there any meaningful secondary issues that are so compelling or sensible that they need to be considered in terms of changes to the standard?
- Are there any other issues that should be addressed (e.g., controversies raised by the standard) by the CLAS Standards National Project Advisory Committee (NPAC)?

Deliberations on the general comments addressed the following set of questions:

- What are the major themes or issues related to the previous process of developing the standards, and how should these issues be addressed in the final CLAS standards report?
- What are major themes related to contextual issues, and how should these themes be addressed in the final CLAS standards report?
- What are major issues related to the subsequent standards development process, and how should these themes be addressed?

National Project Advisory Committee

Based on the discussions related to these questions, the project team prepared a deliberation report for the NPAC that included an analysis of comments on the general comments and each standard. Each analysis:

- Makes recommendations for changes to the standards when clearly indicated by a consensus in either public comments or project team deliberations;
- identifies key themes, issues, and controversies; and
- provides rationales for changes or controversies that the NPAC is being asked to consider.

The CLAS Standards National Project Advisory Committee was composed of 27 individuals representing State and Federal agencies, health care organizations, health care professionals, consumers, unions, and health care accrediting agencies. A complete list of NPAC members is available at [www.omhrc.gov/CLAS] and in the Appendix of this report. The NPAC met with the project team in Washington, DC, on July 21-22, 2000. Together, the group:

- Considered the recommendations proposed in the deliberation report and either concurred on the suggested changes to the standard or offered an alternative approach to responding to public comments on the issues;
- examined key issues for which recommendations were not presented in the analysis (due to a lack of clear consensus) and, when possible, recommended changes to the standards that were responsive to public comments;
- identified and addressed other issues not raised in the deliberation report; and
- made recommendations for next steps.

Following the meeting the project team revised the standards based on the public comments and the deliberations of the NPAC, whose members were given the opportunity to review and comment on subsequent revisions. No formal consensus was obtained from the NPAC after the meeting, although most comments were integrated into the final standards by the project team, and the NPAC was given the opportunity to review and comment on the final revisions. The final revisions were published in the Federal Register on December 22, 2000 (Volume 65, No. 247, pages 80865 to 80879) as recommended national standards for adoption or adaptation by stakeholder organizations and agencies.

PART IV: BIBLIOGRAPHY AND GLOSSARY

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Addendum: Source Document Master List

Thirty source documents were reviewed and analyzed for language on linguistic and cultural competence standards or measures. Twenty of these documents were accessed from the National Health Law Program's (NHeLP) 1998 publication, *Ensuring Linguistic Access in Health Care Settings: Legal Rights and Responsibilities* and included all Medicaid managed care contract language and the summaries of state law requirements addressing language and cultural needs from ten regionally representative states. We also conducted a separate review of the original contracts selected for inclusion, which are on file in the NHeLP-North Carolina office. Medicaid managed care language was also partly culled from the Center for Health Policy Research's 1997 publication, *Negotiating the New Health System: A Nationwide Study of Medicaid Managed Care Contracts*. The document entitled "The Office of Civil Rights' 'Bottom Lines' for Linguistic Accessibility" is based on NHeLP's review and summary of more than 100 compliance agreements or communications from the HHS Office for Civil Rights to providers who are recipients of federal funds. The Consumer Bill of Rights, contained in *Quality First: Better Health Care for All Americans. Final Report to the President of the United States from The President's Advisory Commission on Consumer Protection and Quality in the Health Care Industry*, has been adopted as policy guidance for all Federal health care programs.

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- (4) Substance Abuse and Mental Health Services Administration, Center for Mental Health Services. Cultural Competence Standards in Managed Mental Health Care for Four Underserved/Underrepresented Racial/Ethnic Groups (1997).
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- (7) National Health Law Program. *Ensuring Linguistic Access in Health Care Settings: Legal Rights and Responsibilities*, "Office of Civil Right's Bottom Lines for Linguistic Accessibility," 1998.

Medicaid managed care contract language for

- (8) California; (9) Colorado; (10) Florida; (11) Hawaii; (12) Massachusetts; (13) Nebraska; (14) Pennsylvania; (15) Texas; (16) Vermont; (17) Washington.

Summary of state law requirements addressing language and cultural needs for

(18) California; (19) Colorado; (20) Hawaii; (21) Massachusetts; (22) Florida; (23) Pennsylvania; (24) Texas; (25) Vermont; (26) Washington.

(27) The Commonwealth of Massachusetts, Division of Medical Assistance. Contract Requirements for Cultural Competence (1997).

(28) Joint Commission on Accreditation of Health Care Organizations' Comprehensive Accreditation Manuals for: Ambulatory Care, Behavioral Health Care, Health Care Networks, Home Care, Hospitals, and Long Term Care (selections).

(29) The Consumer Bill of Rights, contained in Quality First: Better Health Care for All Americans. Final Report to the President of the United States. The President's Advisory Commission on Consumer Protection and Quality in the Health Care Industry, November 1997.

(30) Medicare+ Choice regulations.

GLOSSARY

CLAS standards The collective set of CLAS mandates, guidelines, and recommendations issued by the HHS Office of Minority Health intended to inform, guide, and facilitate required and recommended practices related to culturally and linguistically appropriate health services.

community Any set of persons within the society that differs from other sets due to demographic, economic or social characteristics such as age, sex, education level, race, religion, income level, lifestyle, beliefs, etc.

cultural competence Having the capacity to function effectively as an individual and an organization within the context of the cultural beliefs, behaviors and needs presented by consumers and their communities.

culture “The thoughts, communications, actions, customs, beliefs, values, and institutions of racial, ethnic, religious, or social groups. Culture defines how health care information is received, how rights and protections are exercised, what is considered to be a health problem, how symptoms and concerns about the problem are expressed, who should provide treatment for the problem, and what type of treatment should be given. In sum, because health care is a cultural construct, arising from beliefs about the nature of disease and the human body, cultural issues are actually central in the delivery of health services treatment and preventive interventions. By understanding, valuing, and incorporating the cultural differences of America’s diverse population and examining one’s own health-related values and beliefs, health care organizations, practitioners, and others can support a health care system that responds appropriately to, and directly serves the unique needs of populations whose cultures may be different from the prevailing culture” (Katz, Michael. Personal communication, November 1998).

culturally and linguistically appropriate services Health care services that are respectful of and responsive to cultural and linguistic needs.

cultural and linguistic competence “Cultural and linguistic competence is a set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among professionals that enables effective work in cross-cultural situations. ‘Culture’ refers to integrated patterns of human behavior that include the language, thoughts, communications, actions, customs, beliefs, values, and institutions of racial, ethnic, religious, or social groups. ‘Competence’ implies having the capacity to function effectively as an individual and an organization within the context of the cultural beliefs, behaviors, and needs presented by consumers and their communities” (Based on Cross, T., Bazron, B., Dennis, K., & Isaacs, M., (1989). *Towards A Culturally Competent System of Care* Volume Washington, DC: Georgetown University Child Development Center, CASSP Technical Assistance Center).

cultural sensitivity The ability to be appropriately responsive to the attitudes, feelings, or circumstances of groups of people that share a common and distinctive racial, national, religious, linguistic or cultural heritage.

discrimination Treatment or consideration based on class or category rather than individual merit.

ethnicity The characteristic of a group of people that share a common and distinctive racial national, religious, linguistic or cultural heritage.

health care organization Any public or private institution involved in any aspect of delivering health care services.

health disparities Differences in health across individuals in the population.

health maintenance organization (HMO) A type of managed care organization that provides comprehensive medical care for a predetermined annual fee per enrollee.

Interpreter A person who translates orally from one language to another.

ombudsperson A person who investigates complaints, reports findings, and mediates fair settlements, especially between aggrieved parties.

patients/consumers Individuals, including accompanying family members, guardians, or companions, seeking physical or mental health care services, or other health-related services.

quality of life Factors that are considered important by patients such as environmental comfort, security, interpersonal relations, and autonomy of making decisions.

race A local geographic or global human population distinguished as a more or less distinct group by genetically transmitted physical characteristics. A group of people united or classified together on the basis of common history, nationality, or geographic distribution.

religion A set of beliefs, values and practices based on the teachings of a spiritual leader.

sexual orientation The direction of one's sexual interest toward members of the same, opposite, or both sexes.

staff Individuals employed directly by a health care organization, as well as those subcontracted or affiliated with the organization.

strategic plan An approach that incorporates elements of all kinds of planning, helps respond to questions and helps to identify potential problems that may arise over time.

training to make proficient with specialized instruction and practice.

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