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

National Standards for Culturally and Linguistically Appropriate Services in Health Care

EXECUTIVE SUMMARY

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

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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.

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 that $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 recommendation is 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 profile 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].

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.