

Office of Minority Health Publishes Final Standards for Cultural and Linguistic Competence

By Houkje Ross

Closing the Gap, Cultural Competency Part II • February/March 2001

In late December 2000, the Office of Minority Health (OMH), U.S. Department of Health and Human Services, published the final recommendations on national standards for culturally and linguistically appropriate services (CLAS) in health care. Federal and state health agencies, policy makers, and national organizations now have a blueprint to follow for building culturally competent health care organizations and workers.

The 14 standards are based on an analytical review of key laws, regulations, contracts, and standards currently in use by federal and state agencies and other national organizations. The standards were developed with input from a national project advisory committee composed of individuals representing State and Federal agencies, health care organizations and professionals, consumers, unions, and health care accrediting agencies. OMH conducted a four-month public comment period and held three regional meetings in early 2000 to solicit testimony and advice for the first draft of the standards.

Although many excellent standards do exist, many are limited in their scope—they address only a specific issue, geographic area, or subfield of health care such as mental health, according to OMH's final report.

Four of the standards (4-7) reflect existing federal guidance that address language assistance services for people with limited-English proficiency (LEP). Language barriers are a problem for many Hispanic and Asian Americans with limited English proficiencies. Take for example, a recent Asian American or Hispanic immigrant who speaks little or no English. The person may live a block from the local hospital, but be unable to receive adequate medical care if there are no interpreters available. Accessing health care is an issue that appears over and over in literature, research, and studies that examine the lowered health status of our nation's minority populations.

The CLAS standards that deal with language assistance services are consistent with HHS' Office of Civil Rights (OCR) written policy guidance to help ensure that LEPs can effectively access critical health and social services. The OCR standards were introduced in August 2000 (See story, page 4). The remaining CLAS Standards are recommendations suggested by OMH for voluntary adoption by health care organizations (Standard 14) and guidelines or activities recommended by OMH for adoption by federal, state, and national accrediting agencies (Standards 1-3; 8-13).

Leveling the Playing Field

"At a very basic level these standards are about ensuring that all persons entering the health care system, regardless of race or ethnicity, receive equal, fair, and quality treatment," said Guadalupe Pacheco, project officer at OMH. According to OMH's final report, the CLAS standards are 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 and consumers. "The standards are also a

way for providers, policymakers, and others in the health care community, to create accountability within their organizations for providing equitable, quality services," he said.

When it comes to treating minority patients and consumers, what is fair and equal treatment needs to be looked at closely. Current research and literature point to overwhelming disparities in health status of minorities when compared to whites. Minorities have higher prevalence and mortality rates of diseases like cancer, diabetes, and cardiovascular diseases. For example, African American men have some of the highest incidences and mortality rates of cancer. And in many American Indian and Alaska Native communities, diabetes is rampant.

Wilbur Woodis, management analyst and a behavioral health specialist for the Indian Health Service, noted that acknowledging the problems of minority populations is only the first step to eliminating health disparities. It has long been known that American Indians and Alaska Natives (AI/ANs) have high incidences of behavioral health issues such as suicide, substance abuse, and mental health problems. "It is easy to acknowledge the problems and the government programs that work to address these problems. What is harder, however, is acknowledging how culture influences the health of AI/AN and other minority populations," said Woodis.

"Culture and language are an integral part of how we define who we are. The CLAS standards bring attention to the need and importance of culture and language for people of color," said Woodis, who also served on the CLAS advisory committee that helped review draft standards.

Under the CLAS standards (see page 3), health care organizations are encouraged to ensure that patients receive understandable and respectful care that is compatible with their cultural health beliefs, practices, and preferred language. This may mean providing an environment in which patients from diverse cultural backgrounds feel comfortable discussing cultural health beliefs or practices; using community workers as a check on the effectiveness of communication and care; or encouraging patients to express their spiritual beliefs and cultural practices, according to OMH.

Data Issues And Discrimination Also Addressed

Ensuring that our minority populations receive culturally appropriate care is only one of a handful of problems addressed by the CLAS standards. For some minority groups like Asian Americans and Pacific Islanders and American Indians and Alaska Natives, statistical data on disease mortality and prevalence are either not available or limited. Limited data on racial and ethnic minority health can make it difficult for agencies to identify health disparities, justify the need for special initiatives, or measure progress made by state initiatives.



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To gain a better understanding of the health problems that exist in minority populations, CLAS Standard 10 recommends that health care organizations collect data on an individual patient's race, ethnicity, and spoken and written language. CLAS guidelines also recommend that organizations 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 a service area.

Unfortunately, discrimination is still a factor in the quality of health care services some minorities receive. A recent study from the Kaiser Family Foundation, *Perceptions of How Race & Ethnic Background Affect Medical Care*, found that minority patients are often distrustful of the U.S. health care system. Reasons cited for the lack of trust included lack of time and attention given to patients by health care professionals and the perception that health care professionals hold negative stereotypes of minority patients.

To help curb discrimination, the CLAS standards recommend that health care organizations develop participatory, collaborative partnerships with minority and ethnically diverse communities. There are many formal and informal mechanisms available for this, including participation in governing boards, developing community advisory

committees and ad hoc advisory groups, or conducting interviews or focus groups, according to OMH. Health care organizations are also encouraged to develop culturally and linguistically sensitive grievance resolution processes for resolving cross-cultural conflicts or complaints by patients and consumers.

A 1999 study conducted by the Oregon Office of Multicultural Health, *Strategies in Collaboration*, supports the CLAS recommendation for including minorities in health care organizations. The study notes that central to beginning the process of gaining trust from ethnic minorities is finding 'natural leaders' from within the minority communities. "Mainstream agencies need to foster opportunities for ethnic community leaders to meet within and across communities. This will help clarify needs, including how services need to be adapted to fit each community," said the study.

The CLAS standards and the final report documenting all phases of the project issues related to the standards are available online at <http://www.omhrc.gov/CLAS>. A hard copy can also be requested by writing: Attn: CLAS/Guadalupe Pacheco, Office of Minority Health, 5515 Security Lane, Suite 1000, Rockville, MD, 20852. Or e-mail gpacheco@osophs.dhhs.gov. ❖



Revised CLAS Standards From the Office of Minority Health

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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.
 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.
 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.
 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.
 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.
 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).
 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.
 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.
 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.
 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.
 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.
 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.
 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.
 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.
- *Note: The standards are organized by three themes.*
1. *Culturally Competent Care (Standards 1-3)*
 2. *Language Access Services (Standards 4-7)*
 3. *Organizational Supports for Cultural Competence (Standards 8-14).*

