Introduction

In 1997, The U.S. Department of Health and Human Services (HHS), Office of Minority Health (OMH) asked Resources from Cross Cultural Health Care and the Center for the Advancement of Health to review and compare existing cultural and linguistic competence standards and measures in a national context, propose draft national standard language where appropriate, assess the information or research needed to relate these guidelines to outcomes, and develop an agenda for future work in this area. This resulted in recommendations for National Standards and an Out-come-Focused Research Agenda submitted to OMH in May 1999. The draft CLAS (cultural and linguistically appropriate services) standards were published in the Federal Register on December 15, 1999 (Volume 64, Number 240, pages 70042 – 70044), and full report for individual's and organizations review and comments from January 1 to April 30, 2000. The final report and standards by the Office of Minority Health, National Standards on Culturally and Linguistically Appropriate Services (CLAS) in Health Care were published in the Federal Register: December 22, 2000 (Volume 65, Number 247). The Final Report publication put out by the U.S. Department of Health and Human Services, dated March 2001, Washington D.C. sets forth 14 Standards. The 14 Standards are organized by themes: Cultural 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. Standards 4, 5, 6 and 7 are CLAS mandates that are current requirements for all recipients of Federal funds. Standards 1, 2, 3, 8, 9, 10, 11, 12, and 13 CLAS guidelines are activities recommended for adoptions as mandates by Federal, State, and national accrediting agencies. Standard 14 CLAS recommendation is suggested by Office of Minority Health (OMH) for voluntary adoption by health care organizations. Standards are attached as Attachment A to this plan.

Purpose

It is the responsibility of NCCMH – NMRE to ensure contracted providers take reasonable steps to facilitate appropriate cultural competence in the provision of mental health and substance abuse services.

The purpose of this plan is to clarify the responsibilities of NCCMH- NMRE in ensuring that people entering mental health and substance abuse services receive equitable treatment in a culturally and linguistically appropriate manner.

Application

North Country Community Mental Health is both a Medicaid specialty prepaid inpatient health plan (PIPH) and a service provider. This plan is intended to address both aspects of the organization's operations. It is the intent of NCCMH that the scope of the Cultural Competency Plan should promote equitable treatment in a culturally and linguistically appropriate manner.

The NMRE is a division of NCCMH that performs the managed care functions of the PIHP. NCCMH is authorized to perform these functions for a thirteen county area through an Intergovernmental Transfer of Functions and Responsibility ACT agreement. The NMRE's Cultural Competency Plan applies to all NCCMH services, providers, and subcontractors providing services under contract with NCCMH - NMRE.

General Overview

It is acknowledged that efforts to provide equitable mental health and substance abuse treatment in a culturally and linguistically appropriate manner to consumers must be organizational wide and must be ongoing. In order to assure that these efforts are sustained, compliance to Cultural Competency Plan is developed from the performance improvement perspective. Assuring this compliance, both prospectively and retrospectively, is best done through focus on improvement, utilizing objective data, systems analysis, and feedback.

Administrative Responsibilities

Primary responsibility for implementing and monitoring compliance to the NMRE's Cultural Competency Plan shall be assigned to the Regulatory Compliance Coordinator. The Compliance Coordinator will, with oversight of the Director of NMRE Services, perform the following activities:

- Review and amend the Cultural Competency Plan (CC Plan), as necessary, based on changes in the laws and regulations that govern cultural competency standards.
- Develop methods to ensure that employees and provider organization staff are aware of the CC Plan/policies, and are aware of the importance of ensuring equitable treatment in a culturally and linguistically appropriate manner.
- Ensure that employees and provider organization staff are educated and trained in the cultural competence standards.
- Monitor at least annually for appropriate training of staff, and that appropriate data gathering is occurring.
- Initiate corrective actions for identified deficiencies in implementation and maintenance of cultural competence standards.
- Develop processes to identify the number or proportion of culturally diverse persons in the population to be served or likely to be encountered by the provider or service.
- Develop processes for identifying and reporting data pertinent to tracking cultural diverse person's needs and future needs.

Administrative Plan

Each provider operation shall appoint a representative to serve as the Cultural Competency (CC) leader for that organization's activity. The CC leaders will coordinate cultural competency activities. (See NMRE Manual, 6/18/02 Operations Committee approved *"Policy Regarding Cultural Sensitivity*") The Regulatory Compliance Coordinator will have regular contact with the CC leaders about matters of common interest.

Each provider organization is responsible for the development and implementation of a plan to address Cultural Competency compliance efforts. These plans shall, at a minimum include the following features:

- Written policies and procedures for operational activities undertaken by the organization personnel, including any specialty specific standards that may be relevant;
- Education and training programs to ensure staff have a working knowledge of cultural competency standards;
- A system ensuring and documenting that all new personnel receive training regarding cultural competency standards;
- A system ensuring and documenting that staff receive annual cultural competency training;
- A process for routine "spot checks" of cultural competency activities, with the results of such review being reported to the CC leader and the NMRE's Compliance Coordinator;
- A system that tracks the cultural diversity in service requests and provision of services, as well as issues that have been raised within the organization and the resolution of those issues;
- A process to assess and analyze community need, and implementation of policy/procedure to meet needs identified.
- A process for availability of interpreter services when needed.

Policy Guidelines

The Cultural Competency Plan will be reviewed annually, and revised as necessary. Cultural Competency training will be a part of new employee orientation and staff annual training.

Definitions

Definitions used here can be found in: Cross T., Bazron, B., Dennis, K., & Isaacs, M. (1989). Towards a Culturally Competent system of Care, Volume I. Washington, D.C.: Georgetown University Child Development Center, CASSP Technical Assistance Center.

The idea of more effective cross-cultural capabilities is captured in many terms similar to cultural competence. Cultural knowledge, cultural awareness, and cultural sensitivity all convey the idea of improving cross-cultural capacity, as illustrated in the following definitions:

Cultural Knowledge: Familiarization with selected cultural characteristics, history, values, belief systems, and behaviors of the members of another ethnic group (Adams, 1995).

Cultural Awareness: Developing sensitivity and understanding of another ethnic group. This usually involves internal changes in terms of attitudes and values. Awareness and sensitivity also refer to the qualities of openness and flexibility that people develop in relation to others. Cultural awareness must be supplemented with cultural knowledge (Adams, 1995).

Cultural Sensitivity: Knowing that cultural differences as well as similarities exist, without assigning values, i.e., better or worse, right or wrong, to those cultural differences (National Maternal and Child Health Center on Cultural Competency, 1997).

However, cultural competence, is defined as a set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among professionals and enables that system, agency, or those professionals to work effectively in cross-cultural situations (Cross, Bazron, Dennis, & Isaacs, 1989). Operationally defined, cultural competence is the integration and transformation of knowledge about individuals and groups of people into specific standards, policies, practices, and attitudes used in appropriate cultural settings to increase the quality of health care; thereby producing better health outcomes (Davis, 1997). Cultural competency emphasizes the idea of *effectively* operating in different cultural contexts. Knowledge, sensitivity, and awareness do not include this concept. "This is beyond awareness or sensitivity," says Marva Benjamin of the Georgetown Technical Assistance Center for Children's Mental Health.

REFERENCES

U.S. Department of Health and Human Services, OPHS – Office of Minority Health; "National Standards for Culturally and Linguistically Appropriate Services in Health Care" FINAL REPORT, March 2001, Washington, D.C.

The Office of Minority Health, Public Health Services, U.S. Department of Health and Human Services – Cultural Competence Standards, "Assuring Cultural Competence in Health Care", Summary

SAMHSA'S National Mental Health Information Center; Cultural Competence Standards in Managed Care Mental Health Services, Section II – Overall System Standards and Implementation Guidelines

Federal Register: December 22, 2000 (Volume 65, Number 247); Notices: Page 80865 – 80879

Federal/National Partnership Cultural Competency Task Force, Center for Mental Health Services, Meeting Summary Report Dated April 29, 1998, Washington, D.C.

Newsletter of the Office of Minority Health, Mental Health and Minorities, September 1997

Cultural Competence web site: www.air-dc.orgcecp/cultural/
"How is this different than Cultural Sensitivity or Awareness?" Definitions
"Who should be involved?" Clarifies not just an issue for mental health service providers
"How Do I start?" Checklist

Developing Cross-Cultural Competence, authors Eleanor W. Lynch and Marci J. Hanson – Chapters 1, 2, and 3

Attachment A

Excerpted From - National Standards for CLAS in Health Car e, Office of Minority Health, U.S. Department of Health and Human Services, March 2001, And Final Report – "National Standards for Culturally and Linguistically Appropriate Services in Health Care.

Standard 1. Health care organizations should ensure that patients/consumers receive from all staff members effective e, 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 decision makers 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 are 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 pro c e d u res, 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 pro c e d u re s;

- 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 socio-cultural 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 o f 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, and 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 non-written 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 o f 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