

**Cultural and Linguistic Competency  
Planning Guide  
March 2010**



**Prepared by the Statewide Cultural and Linguistic Steering  
Committee of the Office of Cultural and Linguistic Competence**

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## **Office of Cultural and Linguistic Competency**

The Office of Cultural and Linguistic Competency (OCLC) has been formed in response to the demographic changes among racially, ethnically, culturally and linguistically diverse populations within the Commonwealth of Virginia.

As Virginia's population diversifies, its overall behavioral health care system must be ready to provide effective culturally and linguistically competent care.

### **VISION**

The Department of Behavioral Health and Developmental Supports (BHDS) vision for culturally competent care is:

- Care that is given with understanding of and respect for the consumer's health-related beliefs and cultural values
- Staff that respect health related beliefs, interpersonal styles, and attitudes and behaviors of the consumers, families, and communities they serve
- Leadership from administrative, management and clinical operations that includes individualized assessments; and processes that result in leadership and clinical workforce who are culturally and linguistically competent.

### **OBJECTIVES**

- Establish a system that delivers services in a culturally sensitive manner to consumers that are receiving service in Virginia's mental health, intellectual disabilities, and substance use disorder system.
- Coordinate the development of an Agency Cultural Competence Plan and its integration into agency policies, systems, program requirements and regulations.
- Provide resources and support for the implementation of cultural competence requirements of providers.
- Support development of guidelines for linguistic standards and a "needs assessment" for linguistic services.
- Identify and promote cultural competence training programs to enhance staff ability in providing culturally appropriate service.

## **Statewide Cultural and Linguistic Competency Steering Committee (CLCSC)**

The purpose of the CLCSC is to support the efforts of the Office of Cultural and Linguistic Competency in order to provide improved services to multicultural consumers and work toward eliminating disparities within the state's behavioral health, intellectual disability and substance-use disorder system. Specifically, the CLCSC assists the Office in strategic planning, establishing committees to accomplish the Office's activities, including financial, personnel, workforce development, fundraising and planning functions. Through such committees, the CLCSC assists the Office in policy formation, monitors the process of the strategic plan(s), and provides counsel.

CLCSC members are a group of stakeholders who represent diverse interests of the community that serve or advocate for persons with behavioral health, intellectual disability and substance abuse disorders.

The aim of the CLCSC is to analyze and make recommendations to the Director of the Office of Cultural and Linguistic competency regarding issues related to policies and procedures that will enhance the Department's ability to provide a culturally and linguistically competent system of care.

## **Office of Licensure Proposed Regulation**

*"The provider shall have a written plan on cultural and linguistic competency that assists the organization in delivering culturally competent services and use the National Standards on Culturally and Linguistically Appropriate Services (CLAS) as a primary guidance document"*

(Draft Rules and Regulations for Licensing Providers by the Department of Behavioral Health and Developmental Services)

## **Regulations, Policies, and Standards related to Cultural and Linguistic Competency**

Civil Rights Act of 1964

<http://www.usdoj.gov/crt/cor/coord/titlevi.htm>

Executive Order 13166

<http://www.usdoj.gov/crt/cor/Pubs/eolep.htm>

Mental Health: Culture, Race, Ethnicity Supplement to Mental Health: Report of the Surgeon General

<http://mentalhealth.samhsa.gov/cre/default.asp>

State Board Policy 1023 08-02

<http://www.DBHDS.virginia.gov/documents/adm-SBPolicies1023.PDF>

Presidential Executive Order 13166 -Limited English Proficiency (LEP)

[www.hhs.gov/ocr/lep](http://www.hhs.gov/ocr/lep)

DBHDS Position Statement on Culturally and Linguistically Appropriate Services

<http://www.dbhds.virginia.gov/documents/clc-DBHDS-PositionStatement.pdf>

## **Purpose:**

A recent report of the Surgeon General notes that, to maximize effectiveness, behavioral health care providers must understand better the culture of their patients, and the impact of cultural beliefs and practices on a patient's access and quality of care. Access and quality of care can be affected by the degree to which the behavioral health care system provides culturally and linguistically competent services. The concern is that because a person's cultural may be different or they may not be able to speak, read or understand English, persons with limited English proficiency, LEP, may be excluded from programs, experience delays, denied services or receive incomplete or inaccurate information related to available services.

The Department of Behavioral Health and Developmental Supports (BHDS) calls for increased cultural and linguistic competence in Virginia's behavioral health care system. It is essential that all aspects of (BHDS) reflect the diversity of the communities we serve and that system stakeholders strive to be culturally and linguistically competent.

This requires incorporating skills, attitudes, and policies to ensure that the system is effectively addressing the needs of individuals and families with diverse values, beliefs, and sexual orientations, in addition to backgrounds that vary by race, ethnicity, religion, and language.

All health care organizations to include mental health care organizations that receive any federal funds are required to demonstrate their ability to provide culturally and linguistically appropriate services.

For more specific information regarding these see Executive Order 13166 signed in 2000, the Civil Rights Restoration Act of 1987 (CRRA) and Section 601 of Title VI of the Civil Rights Act of 1964, 42 U.S.C. Section 2000d *et seq.* states; " No person in the United States shall on the ground of race, color or national origin, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving Federal financial assistance." The U.S. Department of Health and Human Services, Office of Civil Rights (OCR) is the enforcing department and conducts investigations and completes compliance reviews.

## **Definitions:**

**CLAS Standards** - The collective set of culturally and linguistically appropriate services (CLAS) mandates, guidelines, and recommendations issued by the United States Department of Health and Human Services Office of Minority Health intended to inform, guide, and facilitate required and recommended practices related to culturally and linguistically appropriate health services (National Standards for Culturally and Linguistically Appropriate Services in Health Care Final Report, OMH, 2001).

### **Community Engagement -**

- Cultural competence extends the concept of self-determination to the community.
- Cultural competence involves working in conjunction with natural, informal support and helping networks within culturally diverse communities (e.g. neighborhood, civic and advocacy associations; local/neighborhood merchants and alliance groups; ethnic, social, and religious organizations; and spiritual leaders and healers).
- Communities determine their own needs.
- Community members are full partners in decision making.
- Communities should economically benefit from collaboration
- Community engagement should result in the reciprocal transfer of knowledge and skills among all collaborators and partners.

**Cross-Cultural** - Processes, communication, etc., which involves two or more cultural groups; often implies the bridging of a gap between the groups.

**Cultural Awareness** - The sensitivity, understanding and acceptance of differences. It is a first step in moving toward cultural competence.

**Cultural Competence** - Understanding and appreciating the differences in individuals, families, and communities, which can include: thoughts, speech, actions, customary beliefs, social forms and material traits of a racial, religious or social group, and the ability to effectively operate within these different cultural contexts. It also affects age, national origin, gender, sexual orientation or physical disability.

**Culturally and Linguistically Appropriate Services** - Health care services that are respectful of and responsive to cultural and linguistic needs (National Standards for Culturally and Linguistically Appropriate Services in Health Care Final Report, OMH, 2001).

**Culturally Competent Organizations** – Are organizations that:

- have a defined set of values and principles, and demonstrate behaviors, attitudes, policies and structures that enable them to work effectively cross-culturally.
- have the capacity to (1) value diversity, (2) conduct self-assessment, (3) manage the dynamics of difference, (4) acquire and institutionalize cultural knowledge and (5) adapt to diversity and the cultural contexts of the communities they serve.
- incorporate the above in all aspects of policy making, administration, practice, service delivery and involve systematically consumers, key stakeholders and communities.

**Cultural Sensitivity** - The recognition that the experiences of all people include aspects similar and different to our own, and that our actions affect other people. It involves getting to know and understand other cultures and perspectives. Culturally sensitive approaches acknowledge that difference is important and must be respected.

**Culture** - A shared, learned symbolic system of values, beliefs, and attitudes that shapes and influences human perception and behavior. It includes the thoughts, communications, actions, customs, language, skills, knowledge, symbols, motives, and institutions of racial, ethnic, religious, or social groups. DBHDS defines culture in the broad sense, as there are other things in addition to race, language, and ethnicity that contribute to a person's sense of self. These may be more specific or more general subgroups based on attributes (such as gender or sexual orientation), or shared life experiences (such as survival of violence and/or trauma, education, or homelessness). Multiple memberships in subgroups contribute to an individual's personal identity and sense of "culture". Understanding how these factors affect a person is important to providing culturally competent care.

**Diversity** - The wide range of national, ethnic, racial and other backgrounds of U.S. citizens and immigrants as social groupings, co-existing in American culture. The term is often used to include aspects of race, ethnicity, gender, sexual orientation, class and much more. (Institute for Democratic Renewal and Project Change Anti-Racism Initiative.)

**Ethnicity** - Races or large groups of people classed according to common traits, customs, language and social views.

**Ethnic Group** - A group of people bound together by common traits which include either or both: shared history and understandings and similar physical characteristics.

**Family & Consumers** -

- Family is defined differently by different cultures.

- Family as defined by each culture is usually the primary system of support and preferred intervention.
- Family/consumers are the ultimate decision makers for services and supports for their children and/or themselves.

**Family of Choice** - Persons forming an individual's social support network and often fulfilling the obligations of blood relatives. Many lesbian, gay, bisexual and transgender people are rejected when their families learn of their sexual orientation, or remain closeted to their biological relatives (family of origin). In such cases, it is their partner or significant other and close friends who will be called on in times of illness and personal crisis.

**Linguistic competence** - The capacity of an organization and its personnel to communicate effectively, and convey information in a manner that is easily understood by diverse audiences including persons of limited English proficiency, those who have low literacy skills or are not literate, and individuals with disabilities. Linguistic competency requires organizational and provider capacity to respond effectively to the health literacy needs of populations served. The organization must have policy, structures, practices, procedures, and dedicated resources to support this capacity. This may include, but is not limited to, the use of:

- Bilingual/bicultural or multilingual/multicultural staff;
- Cross-cultural communication approaches
- Cultural brokers;
- Foreign language interpretation services including distance technologies;
- A sign language interpretation services;
- Multilingual telecommunication systems;
- Videoconferencing and telehealth technologies;
- TTY and other assistive technology devices;
- Computer assisted real time translation (CART) or viable real time transcriptions (VRT);
- print materials in easy to read, low literacy, picture and symbol formats;
- Materials in alternative formats (e.g., audiotape, Braille, enlarged print);
- varied approaches to share information with individuals who experience cognitive disabilities;
- Materials developed and tested for specific cultural, ethnic and linguistic groups;
- Translation services including those of:
  - legally binding documents (e.g., consent forms, confidentiality and patient rights statements, release of information, applications)
  - signage
  - health education materials
  - public awareness materials and campaigns; and
  - Use of ethnic media for promotion of activities and recruitment of diverse staff.

*This information is adapted from the National Center for Cultural Competence at <http://www11.georgetown.edu/research/gucchd/nccc/index.html>*

**Multicultural** - Refers to a state of racial, cultural and ethnic diversity within the demographics of a specified place, usually at the scale of an organization such as a school, business, neighborhood, city or nation. Some countries have official, or de jure policies of multiculturalism aimed at recognizing, celebrating and maintaining the different cultures or cultural identities within that society to promote social cohesion. In this context, multiculturalism advocates a society that extends equitable status to distinct cultural and religious groups, with no one culture predominating.

**Race** - A socially constructed phenomenon based on the erroneous assumption that physical differences such as skin color, hair color, and texture, and facial features are related to intellectual, moral or cultural superiority. The concept of race has no basis in biological reality and as such has no meaning independent of its social definitions. Race may also be defined as: Classification of humans

based on genetic characteristics. 2. Classification of people based on common nationality, history, or experiences (University of Maryland).

**Refugee** - A person who, because of fear of being persecuted for reasons of race, religion, nationality, or political opinion, is residing outside the country of his or her nationality and is unable or unwilling to avail himself or herself of the protection of that country; also, a person who, not having a nationality and being outside the country of his or her former habitual residence, is unable or unwilling to return to that country.

## **National Standards for Culturally and Linguistically Appropriate Services in Health Care (CLAS)**

The following national standards issued by the U.S. Department of Health and Human Services' (HHS) Office of Minority Health (OMH) help ensure all people entering the health care system receive equitable and effective treatment in a culturally and linguistically appropriate manner. Standards for culturally and linguistically appropriate services (CLAS) are proposed to correct inequities that may currently exist in the provision of health services and developed to make these services more responsive to the individual needs of all patients/consumers. Below are annotated interpretations of CLAS Standards based on documented resources. Each standard listed has the following format; an introduction, definition, discussion and resources as available.

### **CLAS Standard 1:**

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***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.***

#### **Introduction and Definition:**

This standard is the basis for all of the other standards. It is the responsibility of the organization to provide the policies, procedures, systems and structure that support the individual staff to client provision of culturally competent services.

"Its intent is to ensure that all patients/consumers receiving health care services experience culturally and linguistically competent encounters with an organization's staff", (U.S Department, 2001).

#### **Discussion:**

Providing cultural competent services and creating a cultural inclusive organization is not a separate activity or process, it is one that is incorporated and integrated into the mission and operating principles of the organization.

The Office of Minority Health responds to standard in terms of providing respectful and understandable care. "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. 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 and integrating these approaches into treatment plans. Implementing the other CLAS standards will help in meeting this standard". (U.S Department, 2001).

### **Suggested Resources:**

#### **TAP Partnership-**

Cultural and Linguistic Competence Implementation Guide

<http://tapartnership.org/COP/CLC/implementationGuide.php>

### **CLAS Standard 2:**

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*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.*

#### **Introduction and Definition:**

The intent of this standard is that all levels within the organization are representative of the persons served. Creating a diverse staff provides a good foundation for the organization to understand the needs of the persons served and help assist and shape services so that they can be culturally sensitive.

“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. Staff refers not only to personnel employed by the health care organization but also its subcontracted and affiliated personnel”. (U.S. Department, 2001)

#### **Discussion**

Continuous assessment of the demographics of the staff at all levels compared to the demographic data of the persons served and community demographic data provides an analysis for possible organizational objectives regarding recruitment, retention and promotion.

“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. (U.S. Department, 2001).

The opportunity to hire a diverse workforce begins with the recruitment process. Organizations may put processes in place broaden the notification of available positions. Providing a supportive and open environment can assist in the retention of staff. Additionally, organizations can develop creative approaches to assist staff expand their abilities that may result in promotion opportunities.

#### **Suggested Resources**

Diversity Central- Resource for Cultural Diversity at Work

<http://www.diversitycentral.com/>

Diversity Officer Magazine

[http://diversityofficermagazine.com/magazine/?page\\_id=391](http://diversityofficermagazine.com/magazine/?page_id=391)

### **CLAS Standard 3:**

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***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.***

### **Introduction and Definition:**

Creating a culturally competent organization is an ongoing and changing process. Training and educating staff on the cultural and linguistic needs of the persons served is a continuous process and should be relative to the population served and the services they receive. The training of staff includes contractors, students and volunteers, anyone that has contact with the persons served.

### **Discussion:**

The organization based on assessments of their needs and population served provides for and clearly documents ongoing culturally and linguistic educational and training opportunities for all staff. The manner in which this is provided shall vary with each organization. The Office of Minority health has suggested training areas for organizations to include in their education and training programs over time and suggests the inclusion of the community in the development of organizational training programs. "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". (U.S. Department, 2001)

### **Suggested Resources**

For specific recommended topics suggested by the Office of Minority Health see page nine at <http://www.omhrc.gov/assets/pdf/checked/finalreport.pdf>.

### **CLAS Standard 4:**

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***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.***

### **Introduction and Definition**

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.

Health Care organizations which include Behavioral Health Organizations that receive federal funding must provide language assistance to persons served that have limited English proficiency in a timely manner at no cost to the client. Language assistance including sign language assistance. The organization must develop procedures for obtaining and providing trained and competent interpreters and other language assistance services.

### **Discussion:**

Offering language assistance to persons served will vary from organization to organization. It depends on the needs of the community and the abilities of the organization.

The organization must have a plan to provide access to services to individuals with Limited English Proficiency, LEP. It is the organization that will ultimately need to assess the English proficiency of the individual and wrap a plan of services around the individual in a timely manner. The ability to provide language assistance must be available to implement during all hours of operation. The key is that there is effective communication that occurs between the organization and person served. The organization must ensure that the LEP person is provided with adequate information to understand the services available, the benefits of the services available and that they are able to receive the services they are eligible for.

The organization's plan could be a combination of approaches, for example combining written information, phone interpreter services, referring out to organization that have trained interpreters, but there will be points of encounters that the organization will need to provide language assistance.

Ultimately it is the enforcing agencies such as the Department of Justice or Court systems if there are lawsuits that determine if the organization provided sufficient language assistance to meet the intent of the law.

### **Suggested Resources**

Department of Justice

<http://www.usdoj.gov/crt/cor/Pubs/BoydLEPArt.php>

Hablamos Juntos – we speak

<http://hablamosjuntos.org/is/background/default.background.asp 2.26.2009>) and

<http://www.hablamosjuntos.org/is/default.index.asp>

### **CLAS Standard 5:**

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***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 services.***

#### **Introduction and Definition:**

The standard encourage organizations to take reasonable steps in providing verbal and written notices "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". (U.S. Department, 2001)

#### **Discussion:**

The HHS Office of Civil Rights (OCR) Guidance (2003) states that there are four factors to balance when assessing the obligation to provide language access services. The intent is "to suggest a balance that ensures meaningful access by LEP patients to critical services, while not imposing undue burdens on small businesses, small nonprofits, etc." (DHHS, 2003). These four areas to consider are number, frequency, nature and resources.

Number - Refers to the number of LEP persons you are likely to serve or may access a particular program.

Frequency – How often individuals come in contact with the program or service

Nature – The nature refers to the type of program and the importance of the service, program to life of the person seeking services.

Resources – This factor takes into account the resources available to the organization and consideration of the costs to organization.

It is important to remember while the organization is providing information in written form that the level of literacy in which it is written is reflective of the community served. It is suggested that the written material produced is reviewed by an interpreter to review for accuracy.

### **Suggested Resources:**

Office for Civil Rights

<http://www.hhs.gov/ocr/civilrights/resources/specialtopics/lep/policyguidancedocument.html>

Limited English Proficiency, A Federal Interagency Website

<http://www.archives.gov/eo/laws/title-vi.html>

### **CLAS Standard 6:**

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***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).***

### **Introduction and Definition:**

“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 non-clinical staff of health care organizations. When language barriers exist, relying on staff who are not fully bilingual or lack interpreter training frequently leads to misunderstanding, dissatisfaction, omission of vital information, misdiagnoses, inappropriate treatment, and lack of compliance. It is insufficient for health care organizations to use any apparently bilingual person for delivering language services—they must assess and ensure the training and competency of individuals who deliver such services. “

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

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

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

### **Discussion:**

Recommendations for Implementation include, but are not limited to the following:

- Offer and provide language assistance services; including bilingual staff, interpreters, and telephone interpretation services, at no cost to each behavioral health recipient with Limited English Proficiency (LEP) at all points of contact, in a timely manner during all hours of operation;
- Provide both verbal offers and written notices informing behavioral health recipients, and potential behavioral health recipients of their right to receive language assistance services in their preferred language;
- Ensure the quality of language assistance provided to LEP persons by interpreters and bilingual staff through certification or a similar process (i.e. training). Family and friends should not be used to provide interpretation services;
- 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

#### Practical Recommendations:

- Staff hired should reflect the patient population if possible. A diverse employee pool will be beneficial for meeting the immediate needs of the consumer.
- Survey your staff to see who are bilingual. If staff is being used to interpret, a training program should be developed to assist them with a test to indicate competency after completing the training.
- Identify certified interpreter or interpretation agencies that will be readily available over the telephone, in person and/or to assist with written translations. Have this information accessible to staff and patient at all times.

#### References:

U.S. Department of Health and Human Services, OMH, (2001). National standards for culturally and linguistically appropriate services in health care [:] Final report.

Title VI of the Civil Rights Act of 1964

Executive Order No. 13166: Improving Access to Services for Persons with Limited English Proficiency

#### Suggested Resources:

**Executive Order No. 13166:** Improving Access to Services for Persons with Limited English Proficiency - The White House, Office of Management and Budget (OMB) Released the Benefit-Cost Report of Executive Order No.13166 (Improving Access to Services for Persons with Limited English Proficiency)(Aug.2000), designed to improve access to federally conducted programs and activities and programs and activities of recipients of Federal funding for persons, who as a result of national origin, are limited in their English proficiency (LEP).

**Title VI Prohibition Against National Origin Discrimination As It Affects Persons With Limited English Proficiency Policy Guidance** - Although Title VI of the Civil Rights Act of 1964 prohibits discrimination against persons with limited English proficiency, there are statutes in many states that have "English only" requirements. The use of state funds to provide linguistic access services is strictly prohibited by these states. There is a perception that even Federal funds cannot be used for the

provision of linguistic access services within English only states. This continues to be litigated at the state and Federal levels. English, Spanish, and Chinese languages versions are available

## **CLAS Standard 7:**

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***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.***

### **Introduction and Definition:**

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](http://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 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.

### **Discussion:**

#### **Recommended Development and Implementation**

- Assess the organization to determine what information is vital to translate (e.g. • Consent and complaint forms, information about free language assistance programs or services, intake forms that have the potential for important consequences, notices of eligibility criteria, rights and denial, loss, or decreases in benefits).
- Have translations of material available for patient who falls into the category of the most commonly used languages (5% or 1000 patients, whichever is less). However, if a patient does not fall into the most commonly used languages provisions should be made to provide them with

translation services. (Please refer to the Office of Civil Rights for “safe harbor” guidelines for translation).

- Make available easily understood recipient-related materials and post signage in the languages of the commonly encountered groups and/or groups represented in the service area in a conspicuous public area such as a facility waiting room.
- 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.
- Develop policies and procedures to ensure development of quality non-English signage and patient-related materials that are appropriate for their target audiences.
- Make available easily understood recipient-related materials and post signage in the languages of the commonly encountered groups and/or groups represented in the service area in a conspicuous public area such as a facility waiting room.
- Provide both verbal offers and written notices informing consumers of their right to receive language assistance services in their preferred language;

#### References:

Arizona Department of Health Services Division of Behavioral Health Services PROVIDER MANUAL. Revised 3/2007

Executive Order No. 13166: Improving Access to Services for Persons with Limited English Proficiency

65 Fed. Reg. 52762-52774, August 30, 2000) at [www.hhs.gov/ocr/lep].

Title VI of the Civil Rights Act of 1964

The Joint Commission at [www.jointcommission.org](http://www.jointcommission.org)

(12 U.S. Department of Health and Human Services STANDARDS 2001)

U.S. Department of Health and Human Services, OMH, (2001). National standards for culturally and linguistically appropriate services in health care [:] Final report.

#### **Suggested Resources:**

The California Endowment Language Access Resources

[http://www.calendow.org/Collection\\_Publications.aspx?coll\\_id=22&ItemID=312](http://www.calendow.org/Collection_Publications.aspx?coll_id=22&ItemID=312)

Symbol World

<http://www.symbolworld.org/index.htm>

Health Info Translations

<http://www.healthinfotranslations.com/hospital-signs.php#links>

#### **CLAS Standard 8:**

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***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.***

### **Introduction and Definition:**

Developing an organizational framework for cultural competence requires short and long range strategic planning. Inclusion of a strategic plan for the successful implementation of CLAS standards can help the “organization define and structure activities, policy development, and goal setting relevant to culturally and linguistically appropriate services” (U.S. Department, 2001). Organizational self-assessment (Standard 9) includes identifying, monitoring and evaluating internal organizational systems.

### **Discussion:**

The organizational framework for cultural competence consists of a comprehensive plan of clearly written and established values, policies, practices, structures, and procedures, which affect all levels within the organization. The discussion surrounding the need for an organizational framework and cultural competence includes justification based on policy, integration of CLAS and activities, accountability, and involvement of patient/consumers and communities.

#### **Policy**

The original analysis of policy documents to develop CLAS standards outlines an organizational planning approach to implementing cultural and linguistic competence activities (U.S. Department, 2001). Standard 8 supports the idea that organizational policies and procedures should employ written CLAS-related activities.

Health care organizations should clearly identify and define CLAS activities within its policies and procedures. A consistent following of policies and procedures throughout the entire organization is essential (U.S. Department, 2001). Timely examination of both for necessary revisions is part of strategic planning.

#### **Integration of CLAS**

Some recommendations regarding the organizational framework for inclusion of cultural competency is an adaption of learned values and strategic planning reflected in the mission statement, operating principals and service focus (U.S. Department, 2001). Demonstration of an integration of CLAS related activities within a health care organization is a reflection its quality of services, delivery of services, and best practices.

Integration of CLAS is: 1) conducted at the initial point of contact with patients/consumers at intake; 2) demonstrated during the professional’s one-to-one interaction with patients/consumers; and 3) an inclusion of culturally and linguistic questions on assessment forms and within documentation. A natural integration of CLAS and related activities within the entire daily operations of an organization is a goal.

#### **Implementing CLAS-Related Activities**

Organizations should determine the order to implement CLAS standards. The order should follow a logical systematic process and build on the previous standard(s), as shown in the example below, from the final report of National Standards for Culturally and Linguistically Appropriate Services in Health Care (U.S. Department, 2001):

##### **Step One: Groundwork**

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

##### **Step Two: Organizational Supports**

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

#### Step Three: Services

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

#### Step Four: Monitoring

- On-going assessment, organization and staff (Standards 3, 9)
- Outcomes research and evaluation (Standard 9)

An organization framework and strategic planning approach provides the support that an organization needs to implement CLAS activities.

#### Accountability

An internal and external structure for accountability includes designation of personnel, departments, and partnering organizations that will implement and monitor CLAS-specific activities for the organization. The initial point of motivation for change and initiation of CLAS-related activities can be different for each organization. Organizations should clearly define the accountability of monitoring and implementing CLAS activities on all levels.

#### Involvement of Patients/Consumers and Communities

Input from patients/consumers, the community, personnel and other stakeholders builds the strategic plan. Means to include their ideals will help to develop, implement and promote culturally competent activities within the health care organization. Maintaining a positive relationship with investors such as patients/consumers and communities is an opportunity to evaluate all aspects of the organization. Inclusion of patients/consumers and communities in the organizational framework is noted in other Standards such as 9, 10, 11, 12 and 14.

#### **Suggested Resources:**

The Providers Guide to Quality and Care  
Culturally Competent Organizations

<http://erc.msh.org/mainpage.cfm?file=9.0.htm&module=provider&language=English&ggroup=&mgroup=>

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The TAP Partnership

Plan Implementation Guide and Sample Plan

<http://tapartnership.org/COP/CLC/implementationGuide.php>

<http://tapartnership.org/docs/clcPlanTemplateFinal.doc>

Building Bridges: Tools for Developing an Organization's Cultural Competence

[http://www.lafrontera.org/assmnt\\_tools.htm](http://www.lafrontera.org/assmnt_tools.htm)

#### **CLAS 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 [CLC]-related measures into their internal audits, performance improvement programs, patient satisfaction assessments, and outcomes-based evaluations.***

#### **Introduction and Definition:**

Interpretation of Standard 9 is two-fold. First, this Standard addresses the development of ongoing organizational self-assessments of CLAS-related activities. Secondly, it focuses on the integration of CLAS-related measures into existing quality improvement activities, which could help organizations learn if CLAS delivery processes produce desired results (U.S. Department, 2001).

**Organizational Assessment and its Role:**

Organizational self-assessment is an established on-going process, which examines performance and quality of service delivery specifically targeting, implemented CLAS (Culturally and Linguistically Appropriate Services)-related activities within a health care organization. Self-assessments are vital to the overall daily operation of a health care organization despite its size and scope. Given the many benefits of a self-assessment, perhaps the most beneficial is the opportunity to identify both the effective and ineffective aspects of the organization’s program activities.

The Office of Minority Health (OMH) recommends activities, as related to Standard nine for health organizations, to adopt as a mandate for Federal, State and national accrediting agencies. Given the diversity of health care organizations, at minimum assessments should:

- address the individual fourteen CLAS standards issued by the (OMH) under the U.S. Department of Health and Human Services (HHS);
- complement applicable health care regulations imposed by local, State, Federal entities;
- be inclusive of the needs of the target population and community served;
- represent the stakeholders who support the organization;
- be built into all facets of the organization from individual patient service delivery, policies, practices to procedures;
- include frequencies of initial and on-going assessments; and
- a format, which focuses on the capacities, strengths, and weakness of the organization in implementing CLAS standards (U.S. Department, 2001).

**Tools for Organizational Self-Assessment of Cultural Competence:**

Hospitals, managed care and other health care organizations in varying states and locations have developed assessment tools, which are inclusive of cultural and linguistic competency. It is important to utilize tools and approaches, which are applicable to the organization. Specifically self-assessments should be reflective of the goals, objectives, staff, consumers, and all other aspects of the organization.

**Discussion:**

**CLAS-Related Measures in Performance Improvement Measures and Outcome Assessments:**

Organizational use of compatible integration is vital (part II Standard 9). Tailored methods of performance measures and outcome assessments should be program specific. An organization may choose to adopt other established methods; however in doing so achieving desired results and designed tools may not be appropriate.

The following are examples of models of health organizations who have implemented CLAS-related measures into their programs, and other activities:

Organization	focus	CLAS-Related measure Approaches and/or Recommendations
Health Resources and Services Administration	Medicaid managed care.	A focus study that examines interpreter

(HRSA) www.hrsa.gov/medicaidprimer		accessible services; effective cultural competence training for providers and non-clinical staff; utilization of services by race and ethnic minority groups; and impact of culturally competent service provision on health outcomes, health status, and satisfaction of enrollees (U.S., 2001).
Center for Healthy Families and Cultural Diversity, University of Medicine and Dentistry of New Jersey-Robert Wood Johnson Medical School www.rwjms.umdj.edu	Participatory Quality Improvement (PQI) model.  Focus on race and health disparities.	Links clinical quality improvement with measures of organizational, provider, and community/patient cultural competence (U.S., 2001).
Harvard Pilgrim Health Care www.harvardpilgrim.org	Managed Care Organization	Survey of patient needs evaluation of services and additional input. Available in seven languages
Non-specific	Consumer/patient use of services.	Evaluation of utilization of services by ethnic or language groups (U.S., 2001).
Non-specific	Consumer/patient satisfaction surveys.	To compare consumer/patient satisfaction of services by ethnic groups. Provision of translation services and other services

Recommendations for Implementation (Part I and II of Standard 9) include, but are not limited to the following:

- Be specific in your self-assessment and focus on primary and vital areas of your organization. Build your assessments and CLAS-related activities around existing program activities, policies and procedures.
- Effective data collection (refer to Standard 10) methods can help to avoid duplication, provide information, which is applicable to other areas, target desired results, and demonstrate efficient use of time to name just a few benefits.
- Build within your self-assessment a plan to review your overall assessment activities in a timely manner so that you are aware of any limitations, risks, and pitfalls. Schedule self-audits.
- Be aware of assessment limitations and founded results. For example, patient or consumer driven satisfaction surveys may not be realistically representative of quality of services.
- Set reasonable timeframes and measurable goals and objectives.
- Research and be aware of the characteristics of your service area, population, needs, resources, stakeholders and other aspects. This would also include such areas as race, ethnicity, gender, age groups, language, cultures and religion.
- Present consistency in all activities.

- Define and designate tasks such as monitoring and other activities.

### **Suggested Resources**

U.S. Department of Health and Human Services, OMH, (2001). National standards for culturally and linguistically appropriate services in health care [:] Final report. Retrieved February 4, 2009 from [www.vdh.state.va.us/ohpp](http://www.vdh.state.va.us/ohpp)

### **CLAS Standard 10:**

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***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.***

#### **Introduction and Definition:**

Standardized methods, which are inclusive of actions that are representative of the individuals, groups and communities served, help to achieve the provision of health care services to diverse populations. Uniform methods, when implementing CLAS-related activities within a health care organization, play a significant role in the collection of data regarding the racial, ethnic, and linguistic characteristics of patients/customers. These methods should be integrated into and reflect the organization's policies, procedures, mission, as well as other internal systems.

It is important that health care organizations have knowledge of applicable local, state, and federal regulations regarding collection of data on individual patients/consumers. Organizations have the responsibility of adhering to the rights of individuals and mandates specified by such entities as the Office of Human Rights under the Department of Behavioral Health and Developmental Services.

Standard 10 is an OMH guideline that addresses: 1) the purpose of data collection, 2) specific information to collect from patients/customers, 3) legal and confidential issues, 4) standardization, 5) information management, and 6) other related considerations regarding human data collection.

#### **Discussion:**

Purpose of Data Collection:

The final report of the National Standards for Culturally and Linguistically Appropriate Services in Health Care (2001) identifies purposes for the collection of patient information on race, ethnicity, and language. Some examples 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;
- Assure that health care services provide equitably.
- for staff identification of a patient/consumer's desired spoken or written form of communication;
- to deliver care of services in a timely and appropriate manner; and
- To ensure identification and inclusion of verbal and linguistic data.

Health care organizations should view implementation of the standards, when collecting information on race, ethnicity, and language as a benefit to its overall internal and external operations. Addressing the

needs of patients/consumers and of the community demonstrates and increases an organization's ability to provide appropriate and quality services.

#### What Information to Collect on Patients/Customers and Standardization of Collection:

OMB provides standards for maintaining, collecting, and presenting federal data on race, ethnicity. These standards provide uniformity and comparability for data on race and ethnicity for the population groups specified (Katzen, 1997). Data collection on race, ethnicity, and language should follow the categories specified in the 1997 Office of Management and Budget (OMB) and as adapted in the 2000 United States Census (U.S. Department, 2001).

Self-reporting or self-identification is two formats as methods used, separately or together, for collection of data on race and ethnicity. Five categories for data on race are a part of the OMB standards: 1) American Indian or Alaska Native, 2) Asian, 3) Black or African American, 4) Native Hawaiian or Other Pacific Islander, and 5) White. Organizations should consult the resources identified in this Guidebook, regarding a definition and explanation of the above categories and standardization of data collection for further information and direction.

#### Legal and Confidentiality Issues of Data Collection on Race, Ethnicity, and Language- Management of Information:

Health care organizations should develop and implement a cautious plan of management and monitoring of patient/consumer information. Awareness by organizations of legal and confidential issues, such as patient/consumer rights, should be part of the management and monitoring plan. This Guidebook recommends that organizations should at minimum, consult the policies, procedure, and legal applications of the:

- The Department of Behavioral Health and Developmental Services;
- Code of Virginia;
- Office of Human Affairs (OMB);
- Health and Human Services (HHS); and
- United States Office of Management and Budget (OMB).

Health care organizations should always explain and provide to patient/consumers reasons for collection of data on race, ethnicity, and language in a confidential setting and an appropriate manner. A patient/consumer should not be required to or coerced into providing information nor denied services as a result of not doing so. This includes providing attention to the needs of a patient/consumer's parent or legal guardians who are involved with and or may be acting on behalf of the patient/consumer.

It is vital that staff be properly trained, knowledgeable, culturally and linguistically competent in the data collection process gained from all contacts. Additionally, knowledge of proper and timely documentation of collected data is equally important.

#### Other Considerations on Race Ethnicity and Language Information-Additional Identifiers:

Data collected should not be limited to one and or both of the two data formats. A detail and broad collection of data is encouraged by Health and Human Services (HHS) and can be of benefit to the organization in its effort to provide appropriate, quality, and diverse services.

Additional "identifiers" is information collected from patients/consumers, who are outside of the realm of the categories, by race as according to OMB standards. The additional information would also help in

the assessment and improvement of health care services. Some examples of and reasons to collect additional identifiers are:

- Cultural background;
- socioeconomic status;
- country of origin;
- collecting information regarding country of origin to identify high risk illness based on national and international CDC studies;
- to help identify preferred written and spoken forms of communication among the patients/consumers served and related services;
- collecting information on language to identify diversity in dialects and other languages such as the American Sign Language (ASL); and
- Development of linguistic services and resource base to meet the needs of hard of hearing patients/consumers.

Health care organizations should always maintain organized methods of record keeping and documentation. Organizations should strive to adhere to legal, confidential, and human rights of individuals as outlined in local, state, and Federal guidelines.

Standard 10 Reference(s)

References:

Katzen, S. (n.d). Standards for maintaining, collection, and presenting federal data on race and ethnicity in Revisions to the standards for the classification of federal data on race and ethnicity. Retrieved 2/20/09 from [www.whitehouse.gov/omb/fedreg\\_1997standards](http://www.whitehouse.gov/omb/fedreg_1997standards)

U.S. Department of Health and Human Services, OMH, (2001). National standards for culturally and linguistically appropriate services in health care [:] Final report. Retrieved February 4, 2009 from [www.vdh.state.va.us/ohpp](http://www.vdh.state.va.us/ohpp) .

### **Suggested Resources:**

HRET Disparities Toolkit

<http://www.hretdisparities.org/>

California Pan-Ethnic Health Network

Using Race, Ethnicity, and Language Data to Eliminate Disparities

<http://www.cpehn.org/pdfs/CPEHN%20data%20brief%20June2005.pdf>

### **CLAS Standard 11:**

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

### **Introduction and Definition:**

Health care organizations have the responsibility to maintain current and updated data as a means to understand and implement services that are culturally and linguistically representative of individuals and the service community. Initial or “baseline” data is useful for comparison of data collected yearly, a comparison to voter registration or U.S. census figures or for other appropriate reasons. Varied qualitative and quantitative methods are available so that health care organizations can obtain as much information about their communities as possible.

Organizations should avoid using collected data for discriminatory purposes. Standard 10 addresses confidential and legal concerns surrounding the use and collection of data. Standard 14, Information for the Public, discusses organizational accountability.

### **Discussion:**

Importance of Data Collection on Communities and Tools:

Essentially, Standard 11 centers on maintaining a current profile, needs assessment, and current baseline data (U.S. Department, 2001). Organizations should determine the reasons why they should collect data on their communities. Defining valid reasons to collect data and maintenance of information are important steps in the overall process. Clear direction regarding importance and purpose of collected information is essential to service development and delivery as well as other systems.

This standard focuses on two sets of tools that organizations can use to understand their communities. The first set includes demographic, cultural, and epidemiological profiles of the community and the second is the needs assessment (U.S. Department, 2001). Data collected regarding the growth and changes within the service community is one resource to develop a needs assessment of the community. Additionally, such data is useful in terms of strategic planning, policy, service delivery and evaluation.

Relevant Data and Potential Uses:

Qualitative and quantitative methods can help to collect data on communities. It is the responsibility of a health care organization to determine the types of data they want to collect and the reasons for doing so. An organizational strategic plan should address the purpose of and types of data to collect.

In terms of implementing CLC-related activities, an organization may choose to:

- geographic, demographic and socioeconomic data;
- conduct ethic/cultural needs assessments;
- analyze cultural needs of patients/customers in the community ;
- trends in utilization of services; and
- Preferred spoken languages and limited English proficiency (LEP) among patients/customers within the community (U.S. Department, 2001).

A health care organization should have knowledge of baseline data as required by local, state, and Federal Medicare, Medicaid, and other guidelines. Utilization of input from patients/consumers, the community and other stakeholders can help an organization determine what information it needs to collect. Community mapping is a technique, which can help an organization, understand community needs and concerns through the identification of available varied resources (U.S. Department, 2001).

Identification of resources may include the necessity to collaborate with organizations (Standard 12) in the collection of data. Partnerships with other agencies and organizations may serve as an asset particularly when an organization has limited internal financial, staffing, and other capacities to collect or maintain community profile/ need assessments (U.S. Department, 2001).

Standard 11 Reference(s)

U.S. Department of Health and Human Services, OMH, (2001). National standards for culturally and linguistically appropriate services in health care [:] Final report. Retrieved February 4, 2009 from [www.vdh.state.va.us/ohpp](http://www.vdh.state.va.us/ohpp) .

### **Suggested Resources**

The link below provides an interactive map that displays census data that show where different immigrant groups have settled in the United States over the last century.

<http://www.nytimes.com/interactive/2009/03/10/us/20090310-immigration-explorer.html>

VDH Division of Health Statistics

<http://www.vdh.virginia.gov/healthstats/>

Weldon Cooper Center

<http://www.coopercenter.org/research-analysis>

Virginia Health Information

<http://www.vhi.org/>

## **CLAS Standard 12:**

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***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.***

### **Introduction and Definition:**

The development of a culturally and linguistically competent health care organization is the result of its effective collaboration with the community and other organizations.

Outreach efforts help an organization to assess, inform, and target services which are congruent with patients/consumers and the service community. Such efforts lead to more effective programs and services, delivery of services, and utilization of services by current and potential patients/consumers.

The collaborative process involves formal and informal activities. Organizations should be aware of and involved with persons on all levels within and outside of the service community. Developing a positive rapport with patients/consumers, family members, local leaders as well as local and State political officials are essential to the organization. An effective organizational strategic CLC plan requires appropriate distribution of tasks among staff and other stakeholders to attain and complete organizational goals, and objectives.

### **Discussion:**

#### **Overcoming Barriers and Challenges to Partnerships**

A health care organization's identification of barriers and challenges to establishing partnerships with patients/consumers and the community is essential to its mission and the collaboration process. This identification includes continuous knowledge about the cultural beliefs and mores of diverse communities.

Knowledge of behaviors such as, the lack of utilization of services and effective responses can help to understand problems. As part of its CLC-related activities organizational strategic planning should include educational and training opportunities for its staff, to promote awareness of cultural differences, their impact on and application to service delivery.

Standard 9, Organizational Self-Assessment, discusses mechanisms such as, patient/customer satisfaction surveys, to employ as opportunities to receive feedback from individuals served regarding services received. Implemented methods of external feedback can help organizations to view themselves the same as the individuals and communities they serve. The latter is an opportunity for

organizations to identify the barriers and challenges as discussed above. Organizations should be prepared to receive and respond to both negative and positive feedback.

#### Methods for Involving the Patients/Consumers and the Community:

Collaboration is an on-going process that involves internal discussions regarding creative ways to involve patients/consumers and the community in the development and improvement of culturally competent health care services. This process includes, but is not limited to:

- Partnering with individuals, groups and similar organizations within the organizational service community to promote and provide educational and other activities of importance;
- working with individuals within the service community to collect data regarding their needs, interests, available resources, groups and other pertinent information;
- allowing patients/consumers and other individuals to provide input towards and or participate in the development of organizational CLC-related activities;
- inviting community leaders to participate in on-going planning and advisory groups that design and implement the strategic plan for cultural competence (U.S. Department, 2001); and
- Participating as an active member of human service, church and other types of groups and organizations in the service community.

An organization's active involvement with the community demonstrates their commitment to sustaining the overall community.

#### Utilizing Community Referrals and Liaisons as Partnerships:

Provision of services entails partnerships with other organizations through community referrals and liaisons. These partnerships should be viewed as positive ventures versus competition for patients/customers and funding. Working with diverse populations requires having knowledge of various resources, which can help to meet the varied needs of individuals. A small organization that provides limited services to patients/customers of a particular ethnic group may need to work with another organization to help meet patients/consumers additional needs such as linguistic services.

Partnerships with other agencies, churches, organizations and other groups should be part of strategic planning and training. Appointing liaisons within your organization to work with other agencies and organizations promotes healthy partnerships. Documentation of and timely communication regarding referrals is significant in avoiding lapse of services for individuals.

#### Standard 12 Reference(s)

U.S. Department of Health and Human Services, OMH, (2001). National standards for culturally and linguistically appropriate services in health care [:] Final report. Retrieved February 4, 2009 from [www.vdh.state.va.us/ohpp](http://www.vdh.state.va.us/ohpp)

#### **Suggested Resources:**

Principles of Community Engagement

<http://www.cdc.gov/phppo/pce/>

Bridging the Cultural Divide

National Center for Cultural Competence

[http://www11.georgetown.edu/research/gucchd/NCCC/documents/Cultural\\_Broker\\_Guide\\_English.pdf](http://www11.georgetown.edu/research/gucchd/NCCC/documents/Cultural_Broker_Guide_English.pdf)

#### **CLAS Standard 13:**

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***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.***

### **Introduction and Definition:**

Standard 13 focuses on the existence of cross-cultural and linguistic differences between patients/consumers and the individuals who provide them services. This presence indicates the need for an awareness and knowledge of differences and how to appropriately respond to them. Personnel, who have little or no knowledge of individuals' cultural or linguistic needs, may respond in a discriminatory or inappropriate manner.

Organizations serve diverse populations who have racial, cultural, religious, and linguistic differences, which can determine why and how patients/consumers react to Western methods. Educational techniques are essential to informing and training staff members to recognize and use preventive methods to avoid potential conflicts (U.S. Department, 2001).

### **Discussion:**

#### Developing an Internal Knowledge Base & External Resources

Organizations should include, as part of their overall strategic plan to implement CLAS-related activities, methods to provide cultural competency training to personnel. This training should include diversity awareness and how to be culturally responsive to patients/customers, families, guardians, and significant others. It is important for organizations to document training sessions and when staff members individually complete them.

Diverse educational opportunities for staff members should address topics, which are particularly relevant to the population served. An organization that treats hospice patients may benefit from classes and workshops on diversity and end-of-life care.

Standard 13 connects to requirements established by local, state, and Federal agencies that require CLAS-related actions regarding informing patients/consumers about their right to complain. For example, patients/consumers with limited English proficiency (LEP) may need assistance with comprehending materials (Title VI). Organizations may want to maintain a base of persons who are knowledgeable about CLAS, and other experts such as legal resources to help develop, review, and implement appropriate policies, training, and complaint procedures.

Related issues regarding the application of CLAS-related activities within established organizational complaint and grievance procedures is noted in Standards such as 8, 9, 10, 11, and 12.

#### Patient/Consumer Education and Empowerment

Patient/consumer knowledge of their rights and the complaint procedure is an on-going process, which occurs within a healthy environment that encourages, informs, and allows them to participate in all aspects of their recovery when appropriate. Organizations have the responsibility to ensure that they do not discriminate or coerce patients/consumers into participating in acts that are harmful and violate their rights.

An organization should educate patients/consumers regarding the complaint/grievance process in a manner that is understandable, confidential, easily accessible, culturally and linguistically appropriate to them. Visual, audio, tactile and text materials, such as forms and notices, must be presented in a clear, concise, and understandable way.

#### Reference

U.S. Department of Health and Human Services, OMH, (2001). National standards for culturally and linguistically appropriate services in health care [:] Final report. Retrieved February 4, 2009 from [www.vdh.state.va.us/ohpp](http://www.vdh.state.va.us/ohpp) .

### **Suggested Resources:**

Developing a culturally competence grievance process  
[www.mass.gov/Eeohhs2/docs/dph/health\\_equity/clas\\_chapter5.doc](http://www.mass.gov/Eeohhs2/docs/dph/health_equity/clas_chapter5.doc)

### **CLAS Standard 14:**

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***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 notice in their communities about the availability of this information.***

### **Introduction and Definition:**

Standard 14 is an OMH CLAS recommendation, which health organizations can implement. This Standard was not a part of the original CLAS standards report (1997). The National Advisory committee did not approve inclusion of Standard 14 until they convened in July 1998. After public comment and further discussions by the National Project Advisory Committee (NPAC), the primary purpose of Standard 14 grew to focus on the encouraging and giving organizations freedom of sharing on-going significant information with the public.

Communication is the means to share information both internally and externally on different levels. Health care organizations should utilize targeted and effective communication to disseminate understandable information regarding CLAS-related activities. It is important that health care organizations define the characteristics and realms of its “public” to ensure appropriate sharing of information.

Distribution of CLAS information to the public serves as one among many purposes or benefits of communication. Information shared internally provides health care organizations opportunity to focus on implemented CLAS standards, self-assessment, and staff training to name a few. The external sharing of CLAS activities with other health care or similar organizations allows an exchange of new ideas, accomplishments, organizational changes, and collected data.

Ultimately health care organizations have the responsibility to utilize the most efficient and applicable means of communicating its CLAS-related efforts. It is even more important for these organizations to establish methods to identify and communicate with their audience.

### **Discussion:**

Organizational Accountability, Benefits and the Need for Reporting to the Public:

Health care organizations should practice caution regarding shared information. Organizations run the risk of 1) sharing invalidated, unrealistic and misrepresented information and 2) using invalidated tools. Health care organizations should implement internal avenues of developing “best practices” such as through staff development training sessions to avoid the mistakes of sharing erroneous information with the public. The use of best practices demonstrates to the public organizational accountability and commitment to implementation of CLAS standards.

Some benefits of reporting information, based on its CLAS-related efforts, to the public include but is not limited to:

- helping organizations to embrace and make on-going quality improvements to include CLAS standards internally;
- demonstrates an organization's ability to respond to consumer/patient and community needs;
- an opportunity for organizations to learn how to reach diverse consumers/patients and communities;
- provides a clear picture of organizational operation and activities to investors on all levels; and
- The challenge of helping to make changes in the community.

Targeted publications and newsletters, conference presentations, newspaper articles, audio and video media are some means by which an organization can communicate information regarding its CLAS standard related progresses and activities to the public. How an organization chooses to share with the public information about its activities and progress toward CLAS accountability remains a key ingredient.

#### Standard 14 Reference(s)

For further information, refer to the following in this Guidebook:

- Standard 8 Organizational Framework for Cultural Competence
- Standard 12 Community Partnerships for CLAS

#### Suggested Resources:

Mittenthal, R.A. Ten keys to successful strategic planning for nonprofit and foundation leaders. Retrieved March 2, 2009 from [www.tccgrp.com/pdfs/per\\_brief\\_tenkeys.pdf](http://www.tccgrp.com/pdfs/per_brief_tenkeys.pdf).

Strategic planning in smaller nonprofit organizations. Retrieved March 2, 2009 from [www.wmich.edu/nonprofit/Guide/guide7.htm](http://www.wmich.edu/nonprofit/Guide/guide7.htm)

U.S. Department of Health and Human Services, OMH, (2001). National standards for culturally and linguistically appropriate services in health care [:] Final report. Retrieved February 4, 2009 from [www.vdh.state.va.us/ohpp](http://www.vdh.state.va.us/ohpp)

Office of Management and Budget, (n.d.) [www.whitehouse.gov/omb](http://www.whitehouse.gov/omb)

## Technical Assistance and Training Resources:

Organizations requesting technical assistance or training on how to develop their cultural competency plan please contact the Office of Cultural and Linguistic Competency (OCLC).

- **DBHDS Office of Cultural and Linguistic Competence-** *The Office of Cultural & Linguistic Competence, established in August 2008, leads efforts to provide improved services to multicultural consumers and works toward eliminating the disparities within the state's mental health, intellectual disability and substance-use disorder system.*
  - <http://www.dbhds.virginia.gov/OHRDM-CLC.htm>
- **National Center for Cultural Competence-** *The mission of the National Center for Cultural Competence is to increase the capacity of health care and mental health care programs to design, implement, and evaluate culturally and linguistically competent service delivery systems to address growing diversity, persistent disparities, and to promote health and mental health equity.*
  - <http://www11.georgetown.edu/research/qucchd/nccc/>
- **National Multicultural Institute- Founded** *in 1983, the National Multicultural Institute (NMCI) is proud to be one of the first organizations to have recognized the nation's need for new services, knowledge, and skills in the growing field of multiculturalism and diversity.*
  - [www.nmci.org](http://www.nmci.org)
- **Commonwealth Fund- A framework for Cultural Competence: Measurement and Accountability**
  - <http://www.commonwealthfund.org/Content/Publications/Commentaries/2006/Oct/A-Framework-for-Cultural-Competency--Measurement-and-Accountability.aspx>
- **Joint Commission-** *Proposed Requirements to Advance Effective Communication, Cultural Competence, and Patient-Centered Care for the Hospital Accreditation Program.*
  - [http://www.jointcommission.org/PatientSafety/HLC/HLC\\_Develop\\_Culturally\\_Competent\\_Pt\\_Centered\\_Std.htm](http://www.jointcommission.org/PatientSafety/HLC/HLC_Develop_Culturally_Competent_Pt_Centered_Std.htm)
- **CARF- Making the Most of Cultural Competence Planning in your Organization**
  - <http://www.carf.org/consumer.aspx/consumer.aspx?content=content/Publications/Online/eConnection/MarApr06/Planning.htm>
- **CLAS A-Z: A Practical Guide for Implementing the National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health Care**
  - [http://minorityhealth.hhs.gov/assets/pdf/checked/CLAS\\_a2z.pdf](http://minorityhealth.hhs.gov/assets/pdf/checked/CLAS_a2z.pdf)

## Outline of a Cultural Competency Plan

The development of a cultural competency plan will depend on the size and needs of the organization. Developing a plan helps guide the organization in strengthening its cultural competence as employers and providers. Building cultural competency is a journey and therefore it is not something you complete. It is part of the mission of the organization and part of how the organization does it work. It is not something separate that occurs in isolation. It is a continuous action on the part of the organization. It is recommended that the organization review their plans on a yearly basis.

### Possible Steps:

1. Assign a person that will lead the process. This can be done by the development of a committee or a lead person for the organization.

2. Begin with an assessment. Choose an assessment tool that fits the needs of the organization. An inclusive assessment will look at several parts of the organization such as the person served and service system, human resources, the environment of the organization and the needs of the community.
3. Assess the organizations compliance to the CLAS standards.
4. Based on the results of the assessments the organization should prioritize and focus their efforts by developing a cultural and linguistic plan with measurable outcomes.
5. Because of the nature of our changing environment the plan should not extend for years out. Many organizations develop a yearly plan.
6. Report out on the plan yearly based on the efforts and achieved outcomes of the agency.
7. Review and revise for the next year.
8. Seek assistance if needed. Technical assistance is available from the Office of Cultural and Linguistic Competency.

## **Appendixes**

Sample Plans are attached to the end of this document.

## **Contributions:**

The following Provider Plan Development Subcommittee members contributed to the development of this guidance tool: Deborah Elliott, Lora Rose, Brinda Fowlkes, and Yvonne Russell. 2009-2010.