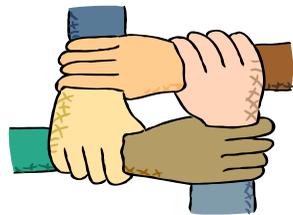


OFFICE OF MINORITY HEALTH

Affirming LEP Access and Compliance in Federal and Federally-Assisted Programs

CLAS National Standards for Culturally & Linguistically Appropriate Services (CLAS) in Health Care

Issued by the U.S. Department of Health and
Human Services' (DHHS)
Office of Minority Health (OMH)



Did You Know.....

That all federal programs and those receiving assistance from the federal government must take reasonable steps to ensure that persons who are limited English proficient have meaningful access to the programs, services, and information that those entities provide.

Who is a Limited English Proficient Person?

Limited English proficient persons are those who do not speak English as their primary language and who have a limited ability to read, speak, write, or understand English.

Why Must Organizations Comply?

Title VI of the Civil Rights Act of 1964 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." 42 U.S.C. § 2000d. U.S. Department of Health and Human Services, Office for Civil Rights, 2000.

The United States Supreme Court in *Lau vs. Nichols* (1974) stated that one type of national origin discrimination is discrimination based on a person's inability to speak, read, write, or understand English. U.S. Department of Health and Human Services, Office for Civil Rights, 2000.

Who Must Comply & Who Can be Found in Violation?

All programs and operations of entities that receive federal funds either directly or indirectly, such as subgrantees, must comply. These include but are not limited to the following:

- Hospitals
- State agencies
- Public assistance programs
- Universities
- Nursing homes
- Family health centers and clinics
- Mental health centers and programs
- Alcohol and treatment centers
- Others that receive federal financial assistance.

U.S. Department of Health and Human Services, Office for Civil Rights, 2000.

How are the CLAS Standards Related to Title VI?

The lack of comprehensive standards on culturally and linguistically appropriate services (CLAS) in health care has left organizations and providers with no clear guidance on how to provide CLAS in health care settings. Some of the CLAS standards are **mandates**, others are guidelines, and still others are recommendations. All are issued by the U.S. DHHS Office of Minority Health. They are intended to inform, guide, and facilitate **required** and recommended practices related to cultural and linguistically appropriate health services. They were designed to contribute to the elimination of health disparities by addressing the linguistic and cultural needs of individuals in an appropriate manner.
U.S. Department of Health and Human Services

These proposed standards are presented as guidelines for accreditation and credentialing agencies and others that assess and compare providers who say they provide culturally competent services, and to assure quality for diverse populations.

How are the CLAS Standards Applied?

These 14 standards are organized by themes and stringency levels:

- **Culturally Competent Care** (Standards 1-3)
- **Language Access Services** (Standards 4-7)
- **Organizational Supports for Cultural Competence** (Standards 8-14)

Mandates, Guidelines, & Recommendations?

The standards are intended to be inclusive of all cultures and not limited to any particular population group or sets of groups; however, they are especially designed to address the needs of racial, ethnic, and linguistic population groups that experience unequal access to health services.

- **Mandates (Standards 4, 5, 6, & 7)** are current Federal requirements for all recipients of Federal funds
- **Guidelines (Standards 1, 2, 3, 8, 9, 10, 11, 12, and 13)** are activities recommended by the OMH for adoption as mandates by Federal, State, and national accrediting agencies.
- **Recommendations (Standard 14)** are suggested by the OMH for voluntary adoption by health care organizations.

Mandates that Address Language Access Services

4. Health care organizations must offer and provide language assistance services, including bilingual staff and interpreter services, at no cost to each patient/consumer with limited English proficiency at all points of contact, in a timely manner during all hours of operation.
5. Health care organizations must provide to patients/consumers in their preferred language both verbal offers and written notices informing them of their right to receive language assistance services.
6. Health care organizations must assure the competence of language assistance provided to limited English proficient patients or consumers by interpreters and bilingual staff. Family and friends should not be used to provide interpretation services (except on request by the patient/ consumer).
7. Health care organizations must make available easily understood patient-related materials and post signage in the languages of the commonly encountered groups and/or groups represented in the service area.

Guidelines that Address Culturally Competent Care

1. Health care organizations should ensure that patients/consumers received from all staff members effective, understandable, and respectful care that is provided in a manner compatible with their cultural health beliefs and practices and preferred language.
2. Health care organizations should implement strategies to recruit, retain, and promote at all levels of the organization a diverse staff and leadership that are representative of the demographic characteristics of the service area.
3. Health care organizations should ensure that staff at all levels, and across all disciplines receive ongoing education and training in culturally and linguistically appropriate service delivery.

Standards that Address Organizational Supports for Cultural Competence

8. Health care organizations should develop, implement, and promote a written strategic plan that outlines clear goals, policies, and operational plans, and management accountability/oversight mechanisms to provide culturally and linguistically appropriate services.
9. Health care organizations should conduct initial and ongoing organizational self-assessments of CLAS-related activities and are encouraged to integrate cultural and linguistic competence-related measures into their internal audits, performance improvement programs, patient satisfaction assessments, and outcomes-based evaluations.
10. Health care organizations should ensure that data on the individual patients/consumer's race, ethnicity, and spoken and written language are collected in health records, integrated into the organization's management information systems, and periodically updated.
11. Health care organizations should maintain a current demographic, cultural and epidemiological profile of the community as well as a needs assessment to accurately plan for and implement services that respond to the cultural and linguistic characteristics of the service area.
12. Health care organizations should develop participatory, collaborative partnerships with communities and utilize a variety of formal and informal mechanisms to facilitate community and patient/consumer involvement in designing and implementing CLAS-related activities.
13. Health care organizations should ensure that conflict and grievance resolution processes are culturally and linguistically sensitive and capable of identifying, preventing, and resolving cross-cultural conflicts or complaints by patients/consumers.
14. Health care organizations are encouraged to regularly make available to the public information about their progress and successful innovations in implementing the CLAS standards and to provide public notice in their communities about the availability of this information.

Rationale for Cultural Competence in Health Care

With the increase of racially, ethnically, culturally, and linguistically diverse individuals and families coming to Nebraska, it is important that health care providers and organizations incorporate culturally competent approaches into their work. The National Center for Cultural Competence (2003) found the following reasons justify the need cultural competence at the patient-provider level:

- The perception of illness and disease and their causes vary by culture;
- Diverse belief systems exist related to physical health, mental health, healing and well being;
- Culture influences help-seeking behaviors and attitudes toward primary care providers;
- Individual preferences affect traditional and other approaches to primary care;
- Patients must overcome personal experiences of biases within primary care systems;
- Primary care providers from culturally and linguistically diverse groups are under-represented in current service delivery systems;
- Numerous others

Other Compelling Reasons for Cultural Competence

- Respond to current and projected demographic changes in the United States.
 - To eliminate long-standing disparities in the health status of people of diverse racial, ethnic and cultural backgrounds.
 - To eliminate disparities in the mental health of people of diverse racial, ethnic, and cultural groups.
 - To improve the quality of services and primary care outcomes.
 - To meet legislative, regulatory, and accreditation mandates.
 - To gain a competitive edge in the market place.
 - To decrease the likelihood of liability/malpractice claims.
- National Center for Cultural Competence.



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