

by [Resources for Cross Cultural Health Care](#)  
[Center for the Advancement of Health](#) for [HHS Office of Minority Health](#)

[Full Report available on OMH Website](#)

## Background

Cultural diversity is a core part of the economic engine that drives this country, and its impact at this time has significant implications for health care delivery and policymaking throughout the United States. Doctors' offices, clinics, and hospitals see this diversity every day, and the need for culturally and linguistically competent health care services for diverse populations is attracting increased attention from health providers and those who judge their quality and efficiency.

Cultural and linguistic competence suggests an ability by health care providers and health care organizations to understand and respond effectively to the cultural and linguistic needs brought by patients to the health care encounter. For example, an elderly Bosnian woman being admitted with terminal cancer may present the following challenges for health care staff and organizations: she and her family do not read, speak or understand English; her Muslim faith requires modesty during physical examinations; and her family may have cultural reasons for not discussing end-of-life concerns or her impending death. A culturally and linguistically appropriate response would include interpreter staff; translated written materials; sensitive discussions about treatment consent and advance directive forms; clinical and support staff who know to ask about and negotiate cultural issues; appropriate food choices; and other measures. The provision of these kinds of services has the potential to improve patient outcomes and the efficiency and cost-effectiveness of health care delivery.>

Unfortunately, many health care providers feel they don't have clear guidance on how to prepare for or respond to these situations. As language about culturally and linguistically competent services proliferates in health policy discourse and practice, a common understanding of what this means is essential to assuring quality. Today, if a provider asserts they are culturally competent (which many increasingly do), it may be impossible for the consumer to know how that relates to services—if in fact it refers to specific services at all. Standards offer a guidepost for many different purposes and audiences. They set forth what

should be done by service providers and how it should be done, and provide a basis for evaluation, comparison, and quality assurance by policymakers, consumers, and researchers.

To begin moving towards a national consensus on this issue, the U.S. Department of Health and Human Services Office of Minority Health (OMH) in 1997 asked ***Resources for Cross Cultural Health Care*** and the

***Center for the Advancement of Health***

to review and compare existing cultural and linguistic competence standards and measures in a national context, propose draft national standard language where appropriate, assess the information or research needed to relate these guidelines to outcomes, and develop an agenda for future work in this area.

**The Cultural and Linguistic Competence Standards and Research Agenda Project**, with a two-part report submitted to OMH in May 1999, is the result of this request.

The first part of this report recommends national standards for culturally and linguistically appropriate services (CLAS) in health care. Based on an analytical review of key laws, regulations, contracts, and standards currently in use by federal and state agencies and other national organizations, these recommended standards were developed with input from a national advisory committee of policymakers, health care providers, and researchers. Each standard is accompanied by commentary that addresses the proposed guideline's relationship to existing laws and standards, and offers recommendations for implementation and oversight to providers, policymakers, and advocates.

While drafts of these standards have been circulated for initial comment, at this stage they are still recommendations and not mandates. OMH has recognized the need for further review and revision, and, eventually, widespread dissemination of the standards to all the key stakeholder groups cited in the report.

### **Seeking Stakeholder Input and Revising the Draft CLAS Standards**

The Office of Minority Health has determined that the appropriate next step for the draft CLAS Standards is to undergo a national process of public comment that will result in a broader awareness of HHS interest in CLAS, significant input from stakeholder groups on the draft standards, and revision of the standards and accompanying commentary supported by the expertise of a national advisory committee.

Publication of the CLAS standards in the Federal Register, and publicizing the availability of the complete report with commentary on the internet and through local, regional, and national organizations will allow us to reach as wide an audience of stakeholders as possible. This period of dissemination and awareness-raising will set the stage for three regional meetings to gather and solicit detailed input from interested individuals and organizations that will complement and enhance the formal public comments received by HHS through written and electronic means. As proposed by OMH, the public comment period and regional meetings will be designed to:

- present the draft standards on culturally and linguistically appropriate services to key national health care stakeholders and other interested parties;
- identify, analyze and incorporate public comments from key national stakeholders and others (i.e., health plan directors, health care providers, policy makers, accreditation officials, advocates, and consumers), for improving and refining the final standards on culturally and linguistically appropriate services; and
- develop, based on public comments received in writing, electronically, and from the three regional meetings, recommended national standards on culturally and linguistically appropriate health care services.

### **Significance of this Project for Policymakers, Providers, and Consumers**

The most significant potential impact of national standards for CLAS is that we can begin to replace the patchwork of different definitions, suggestions and requirements with one universally understood set of expectations. Given that the federal government has begun to mention cultural and linguistic competence in an expanding number of important program rules and regulations, this uniformity of expectations would ideally be started at the federal level. A formal process of publishing and receiving comments on the CLAS standards is the logical first step to achieving this.

Clearly, specific policy requirements have an impact on service delivery by health care organizations. A recent evaluation of California's Medicaid managed care contract requirements on linguistic and cultural competence shows that providers have responded by making many changes to improve the cultural competence of their services.

A close look at state Medicaid managed care contracts reveals that several states have adopted some of California's cultural competence contract language (although similar evaluations of the impact on service delivery in those states have not been conducted). In a separate project being undertaken by RCCHC with the George Washington University Center for Health Policy and Research, the CLAS standards produced for OMH will be used in drafting model purchasing specifications on cultural competence for inclusion in state contracts Medicaid managed care contracts for the Health Resource and Service Administration (HRSA) Center for Managed Care.

Standards that have been validated by national review and comment can also be used to strengthen accreditation standards and review processes sponsored by NCQA and JCAHO. JCAHO standards already show a *general* understanding of the impact of a patient's language, culture, and beliefs on health care. Nevertheless, few health care organizations can be said to be operating in a manner responsive to these goals. Providers and accreditation organizations will benefit when expectations are explicit and detailed, information on operationalizing cultural competence is made available, and mechanisms for review and oversight are specific.

It was not so long ago that the topic of cultural and linguistic competence in health care did not garner much attention from providers or policymakers. The last two years have seen a remarkable surge in awareness and responsiveness to the needs of diverse populations. At the Federal level alone, no less than five major policy initiatives (the adoption of the Consumer Bill of Rights by HHS programs, the Medicare+Choice regulations, the Health Care and Financing Administration's Quality Improvement System for Managed Care guidelines, the Office for Civil Rights Guidance on Limited English Proficiency, and the proposed Medicaid regulations) have directly addressed cultural competence in a range of rules that cover nearly every health care provider in the country. The issue has been brought to the forefront—this project can set the stage for the adoption of uniform and comprehensive standards that will clarify provider and patient expectations and, over time, lead to a consistent and measurable level of services.

For more information, please contact

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You may also view a summary of the project at  
<http://www.DiversityRx.org/HTML/rcproj.htm>

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### **Recommended Standards for**

#### **Culturally and Linguistically Appropriate Health Care Services**

Based on an analytical review of key laws, regulations, contracts, and standards currently in use by federal and state agencies and other national organizations, these guidelines were developed with input from a national advisory committee of policymakers, providers, and researchers. In this report, each standard is accompanied by commentary that addresses its relationship to existing laws and standards, and offers recommendations for implementation and oversight to providers, policymakers, and advocates.

#### **Preamble:**

Culture and language have considerable impact on how patients access and respond to health care services. To ensure equal access to quality health care by diverse populations, health care organizations and providers should:

1. Promote and support the attitudes, behaviors, knowledge, and skills necessary for staff to

work respectfully and effectively with patients and each other in a culturally diverse work environment.

2. Have a comprehensive management strategy to address culturally and linguistically appropriate services, including strategic goals, plans, policies, procedures, and designated staff responsible for implementation.

3. Utilize formal mechanisms for community and consumer involvement in the design and execution of service delivery, including planning, policy making, operations, evaluation, training and, as appropriate, treatment planning.

4. Develop and implement a strategy to recruit, retain and promote qualified, diverse and culturally competent administrative, clinical, and support staff that are trained and qualified to address the needs of the racial and ethnic communities being served.

5. Require and arrange for ongoing education and training for administrative, clinical, and support staff in culturally and linguistically competent service delivery.

6. Provide all clients with limited English proficiency (LEP) access to bilingual staff or interpretation services.

7. Provide oral and written notices, including translated signage at key points of contact, to clients in their primary language informing them of their right to receive no-cost interpreter services.

8. Translate and make available signage and commonly-used written patient educational material and other materials for members of the predominant language groups in service areas.

9. Ensure that interpreters and bilingual staff can demonstrate bilingual proficiency and receive training that includes the skills and ethics of interpreting, and knowledge in both languages of

the terms and concepts relevant to clinical or non-clinical encounters. Family or friends are not considered adequate substitutes because they usually lack these abilities.

10. Ensure that the clients' primary spoken language and self-identified race/ethnicity are included in the health care organization's management information system as well as any patient records used by provider staff.

11. Use a variety of methods to collect and utilize accurate demographic, cultural, epidemiological and clinical outcome data for racial and ethnic groups in the service area, and become informed about the ethnic/cultural needs, resources, and assets of the surrounding community.

12. Undertake ongoing organizational self-assessments of cultural and linguistic competence, and integrate measures of access, satisfaction, quality, and outcomes for CLAS into other organizational internal audits and performance improvement programs.

13. Develop structures and procedures to address cross cultural ethical and legal conflicts in health care delivery and complaints or grievances by patients and staff about unfair, culturally insensitive or discriminatory treatment, or difficulty in accessing services, or denial of services.

14. Prepare an annual progress report documenting the organizations' progress with implementing CLAS standards, including information on programs, staffing, and resources.