Enhancements to the National CLAS Standards

Data collected during the HHS Office of Minority Health's National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care Enhancement Initiative supported the notion that it was time for an enhancement of the original National CLAS Standards. In the beginning stages of the Enhancement Initiative, a majority of individuals who provided public comment on the original National CLAS Standards indicated that though the Standards met their needs as a whole, additional guidance or direction was needed.

More specifically, individuals and organizations who provided public comment sought clarification on the Standards' intention, terminology, and implementation strategies. There was also strong support, from public comment, the Advisory Committee, and a literature review, for expanding the concepts of health and culture. The enhanced National CLAS Standards and *The Blueprint* aim to address these issues. The format of *The Blueprint* reflects the suggestions provided during the public comment period.

The past decade has shown that the National CLAS Standards are dynamic in nature. Therefore, as best and promising practices develop in the field of cultural and linguistic competency, there will be future enhancements of the National CLAS Standards. In addition, the Web version of *The Blueprint* will be updated periodically with additional information and resources as the Standards are disseminated in the field and as new information is gathered regarding promising implementation and management strategies.

The following sections discuss the enhancements made to the National CLAS Standards.

Culture

The enhanced National CLAS Standards have adopted an expanded, broader definition of culture. Specifically, in the enhanced National CLAS Standards, culture refers to "the integrated pattern of thoughts, communications, actions, customs, beliefs, values, and institutions associated, wholly or partially, with racial, ethnic, or linguistic groups, as well as with religious, spiritual, biological, geographical, or sociological characteristics." This definition is adapted from other widely accepted definitions of culture (e.g., Gilbert et al., 2007; HHS OMH, 2005) and attempts to reflect the complex and dynamic nature of culture, as well as the numerous ways in which culture has been defined and studied across multiple disciplines. Refer to the table below for additional discussion of aspects of culture.

There is considerable recognition that every patient-provider interaction is a cross-cultural interaction and that the scope of cultural competency in health care should expand to address multiple markers of difference (Khanna, Cheyney, & Engle, 2009; IOM, 2003). The broader definition of culture adopted in the enhanced National CLAS Standards mirrors other leading initiatives in the field in terms of scope, including Healthy People 2020 from the Department of Health and Human Services (HHS ODPHP, 2010a)

and The Joint Commission (*Advancing Effective Communication, Cultural Competence, and Patient- and Family-Centered Care: A Roadmap for Hospitals*, 2010). In addition, with the recognition that culture includes multiple facets and markers of difference, there is an increased opportunity for health professionals to identify and use similarities to improve health and health care interactions.

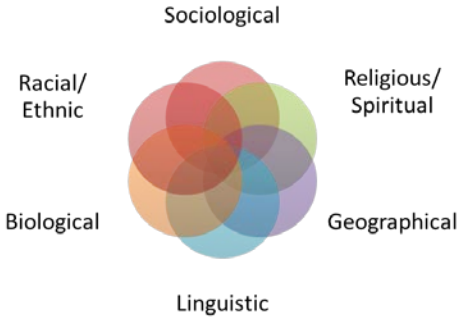
Culture: The integrated pattern of thoughts, communications, actions, customs, beliefs, values, and institutions associated, wholly or partially, with racial, ethnic, or linguistic groups, as well as with religious, spiritual, biological, geographical, or sociological characteristics. Culture is dynamic in nature, and individuals may identify with multiple cultures over the course of their lifetime.

Elements of culture include, but are not limited to, the following:

- Age
- Cognitive ability or limitations
- Country of origin
- Degree of acculturation
- Educational level attained
- Environment and surroundings
- Family and household composition
- Gender identity
- Generation
- Health practices, including use of traditional healer techniques such as Reiki and acupuncture.
- Linguistic characteristics, including language(s) spoken, written, or signed; dialects or regional variants; literacy levels; and other related communication needs.
- Military affiliation
- Occupational groups
- Perceptions of family and community

- Perceptions of health and well-being and related practices
- Perceptions/beliefs regarding diet and nutrition
- Physical ability or limitations
- Political beliefs
- Racial and ethnic groups – including but not limited to – those defined by the U.S. Census Bureau.
- Religious and spiritual characteristics, including beliefs, practices, and support systems related to how an individual finds and defines meaning in his/her life.
- Residence (i.e., urban, rural, or suburban)
- Sex
- Sexual orientation
- Socioeconomic status

Individuals do not experience their lives or their health through a single lens of identity (e.g., solely race, gender, or religious); rather, many elements inform their perceptions, beliefs, customs, and reactions (e.g., Frable, 1997). Figure 2 depicts various aspects of culture through which an individual may frequently experience his/her cultural identity. For example, an individual's religious/spiritual characteristics often overlap with and are informed by the sociological and racial/ethnic groups with which he/she identifies (e.g., an African American Christian male may experience the world simultaneously by his race, sex, and religious beliefs). Each of the circles within Figure 2 represents a very broad area of culture, as described within the definition. These areas are by no means exhaustive, as there are many other aspects of cultural identity.



(Graves, 2001, revised 2011)

Figure 2: Interrelationship of Aspects of Culture

Health

Health encompasses many aspects, including physical, mental, social, and spiritual well-being (HHS IHS, n.d.; HHS OSG et al., 2012; WHO, 1946). The World Health Organization also notes that health is "not merely the absence of disease or infirmity" (WHO, 1946). From this perspective, health status falls along a continuum and therefore can range from poor to excellent. In addition, how individuals experience health and define their well-being is greatly informed by their cultural identity. The advancement of health equity allows the attainment of the highest level of health for all people.

Health and Health Care Organizations

Adopting a more comprehensive conceptualization of health requires, by extension, a more inclusive recognition of the variety of professionals and organizations providing the related care and services. The enhanced National CLAS Standards reference both health and health care organizations and professionals to acknowledge those working not only in health care delivery facilities (e.g., hospitals, clinics, community health centers) but also in organizations that provide services such as behavioral and mental health, public health, emergency services, and community health and prevention. The National CLAS Standards are intended for use within all areas of health and human services.

This expansion also acknowledges the growing body of literature that pertains to the social determinants of health, defined by the World Health Organization as the "the conditions in which people are born, grow, live, work, and age, including the health system" and the role that social, economic, and environmental factors, such as socio-economic status and housing, play in health outcomes between different populations (WHO, 2012). The enhanced National CLAS Standards should be understood as applicable to hospitals or other health care delivery organizations as well as any public or private institution addressing individual, family, or community health, health care, or well-being.

Individuals and Groups

To further reflect the more inclusive nature of the enhanced National CLAS Standards, the enhanced Standards use the terminology *individuals and groups* in lieu of *patients and consumers*. *Individuals and groups* encompass patients, consumers, clients, recipients, families, caregivers, and communities.

Statement of Intent

In response to public comment and the National Project Advisory Committee feedback requesting further clarification on the intent of the National CLAS Standards, a statement of intent for the enhanced National CLAS Standards was crafted and has been added as an introductory statement to the Standards.

The National CLAS Standards are intended to advance health equity, improve quality, and help eliminate health care disparities by establishing a blueprint for health and health care organizations to:

The addition of the intention statement ties the culturally and linguistically competent policies and practices posed in the enhanced National CLAS Standards directly to the goals of advancing health equity, improving quality, and eliminating health care disparities.

Advance Health Equity

Health equity is defined as the attainment of the highest level of health for all people (HHS OMH, 2011). Currently, many individuals are unable to attain their highest level of health for several reasons, including social factors such as inequitable access to quality care and individual factors such as limited resources. Lack of health equity has a significant economic and societal impact. Recent research on the economic burden of health inequality and health disparities found that:

- Approximately 30.6% of direct medical care expenditures for African Americans, Asians, and Hispanics were excess costs due to health inequalities (LaVeist et al., 2009).
- Eliminating health inequalities for minorities would have reduced indirect costs associated with illness and premature death by more than $1 trillion (LaVeist et al., 2009).

Improve Quality

Culturally and linguistically appropriate services and related education initiatives affect several aspects of an organization's continuous quality improvement initiatives. For example, research suggests that after implementation of CLAS initiatives, there are substantial increases in provider knowledge and skill acquisition and improvements in provider attitudes toward culturally and linguistically diverse patient populations (Beach et al., 2004). Studies also indicate that patient satisfaction increases when culturally and linguistically appropriate services are delivered (Beach et al., 2004). At the organizational level, hospitals and clinics that support effective communication by addressing CLAS have been shown to have higher patient-reported quality of care and more trust in the organization (Wynia, Johnson, McCoy, Passmore Griffin, & Osborn, 2010). Preliminary research has shown a positive impact of CLAS on patient outcomes (Lie, Lee-Rey, Gomez, Bereknyel, & Braddock, 2010), and a growing body of evidence illustrates the effectiveness of culturally and linguistically appropriate services in improving the quality of care and services received by individuals (Beach et al., 2004; Goode et al., 2006).

Help Eliminate Health Care Disparities

Eliminating health care disparities is one of the ultimate goals of advancing health equity. Disparities exist and persist across many culturally diverse groups, with individuals who identify as racial or ethnic minorities being less likely to receive preventive health services, even when insured (DeLaet, Shea, & Carrasquillo, 2002).

The following are a few selected findings featured in the HHS Agency for Healthcare Quality and Research [AHRQ] 2011 National Healthcare Quality Report and National Healthcare Disparities Report that highlight the disparities experienced by many in the United States (AHRQ, 2012a, 2012b):

- Access to quality health care remains suboptimal, particularly for minority and low-income groups.
- Despite improvements in quality, access and disparities have not improved.
- Certain services, geographic areas and populations were found to be in serious need of improvements in quality and progress in disparities reduction.

As the enhanced National CLAS Standards are disseminated, the inclusion of the statement of intent within the actual Standards ensures that every person who uses the Standards will understand their importance. Although this brief introductory statement cannot convey all the potential purpose(s) of the Standards, it does convey their primary goals.

Clarity and Action

Each of the National CLAS Standards was revised for greater clarity and focus. In addition, the wording of each of the 15 Standards now begins with an action word to emphasize how the desired goal may be achieved.

Standards of Equal Importance

The original National CLAS Standards designated each Standard as a recommendation, mandate, or guideline. The recommendation (original Standard 14) was a suggestion for voluntary adoption by health care organizations. The mandates (original Standards 4, 5, 6, and 7) were Federal requirements for all recipients of Federal funds. The guidelines (original Standards 1, 2, 3, 8, 9, 10, 11, 12, and 13) were activities recommended for adoption as mandates by Federal, State, and national accrediting agencies.

However, the enhanced National CLAS Standards promote collective adoption of all Standards as the most effective approach to improve the health and well-being of all individuals. The Standards are intended to be used together, as mutually reinforcing actions, and each of the 15 Standards should be understood as an equally important guideline to advance health equity, improve quality, and help eliminate health care disparities.

Although the enhanced National CLAS Standards do not represent statutory requirements, failure by a recipient of Federal financial assistance to provide services consistent with Standards 5 through 8 could result in a violation of Title VI of the Civil Rights Act of 1964 implementing regulation (See 42 USC 2000d et. Seq. and 45 CFR Part 80). Therefore, although Standards 5 through 8 do not represent legal requirements in all cases, implementation of these goals will help ensure that health care organizations

and individual providers serve persons of diverse backgrounds in a culturally and linguistically appropriate manner and in accordance with the law. Advances in technology help health and human service organizations provide efficient and cost-effective language assistance services (Sperling, 2011). Health care organizations and individual providers are encouraged to seek technical assistance from the HHS Office for Civil Rights or review the *HHS Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons* document (HHS Office for Civil Rights [OCR], 2003) to assess whether or to what extent language access services must be provided in order to comply with the Title VI requirement to take reasonable steps to provide meaningful access to their programs for persons with limited English proficiency.

Principal Standard and Three Enhanced Themes

The enhanced Standards have been reorganized to address feedback gleaned from the Enhancement Initiative and to improve their overall intention, clarity, and practicality.

The enhanced National CLAS Standards elevate the previous Standard 1 to the status of a Principal Standard, add a governance and leadership Standard as Standard 2, and reframe the three themes.[1]

Figure 3: Enhanced National CLAS Standards' Themes

The names of the three themes have been updated both to clarify intent and to broaden the scope of their interpretation and application.

Principal Standard

Standard 1 has been made the Principal Standard with the understanding that it frames the essential goal of all of the Standards, and if the other 14 Standards are adopted, implemented, and maintained, then the Principal Standard will be achieved.

[1] A crosswalk of the National CLAS Standards 2000 and 2012 may be found in Appendix C.

1. Provide effective, equitable, understandable, respectful, and quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs.

Theme 1: Governance, Leadership, and Workforce

Changing the name of Theme 1 from *Culturally Competent Care* to *Governance, Leadership, and Workforce* provides greater clarity on the specific locus of action for each of these Standards and emphasizes the importance of the implementation of CLAS as a systemic responsibility, requiring the investment, support, and training of all individuals within an organization.

The Standards in this theme include:

2. Advance and sustain governance and leadership that promotes CLAS and health equity
3. Recruit, promote, and support a diverse governance, leadership, and workforce
4. Educate and train governance, leadership, and workforce in CLAS

Theme 2: Communication and Language Assistance

Changing the name of Theme 2 from *Language Access Services* to *Communication and Language Assistance* broadens the understanding and application of appropriate services to include all communication needs and services, including sign language, braille, oral interpretation, and written translation.

The Standards in this theme include:

5. Offer communication and language assistance
6. Inform individuals of the availability of language assistance
7. Ensure the competence of individuals providing language assistance
8. Provide easy-to-understand materials and signage

Theme 3: Engagement, Continuous Improvement, and Accountability

Changing the name of Theme 3 from *Organizational Supports* to *Engagement, Continuous Improvement, and Accountability* underscores the importance of establishing individual responsibility in ensuring that CLAS is supported, while retaining the understanding that effective delivery of CLAS demands actions across an organization. This revision focuses on the supports necessary for adoption, implementation, and maintenance of culturally and linguistically appropriate policies and services regardless of one's role within an organization or practice. All individuals are accountable for upholding the values and intent of the National CLAS Standards.

The Standards in this theme include:

9. Infuse CLAS goals, policies, and management accountability throughout the organization's planning and operations
10. Conduct organizational assessments
11. Collect and maintain demographic data
12. Conduct assessments of community health assets and needs
13. Partner with the community
14. Create conflict and grievance resolution processes
15. Communicate the organization's progress in implementing and sustaining CLAS

New Standard: Organizational Governance and Leadership

Another theme that emerged from the feedback provided during the Enhancement Initiative was the importance of CLAS being infused throughout an organization. This requires both a bottom-up *and* a top-down approach to advancing and sustaining CLAS. Organizational governance and leadership are key to ensuring the successful adoption, implementation, and maintenance of CLAS. In recognition of this, the enhanced National CLAS Standards include a new Standard focused on the role of governance and leadership as it relates to CLAS. This new Standard was placed as the second Standard and within Theme 1, "Governance, Leadership, and Workforce."

The new second Standard states:

> Advance and sustain organizational governance and leadership that promotes CLAS and health equity through policy, practices, and allocated resources.

The inclusion of a Standard for organizational governance and leadership emphasizes the importance of a comprehensive effort to infuse culturally and linguistically appropriate services throughout an organization. The responsibility to embrace CLAS should fall throughout the entire organization. This comprehensive effort cannot succeed unless the governance and leadership of an organization has embraced these values and are willing to implement and sustain them. In addition, the scope of Standards 3 and 4 (Standards 2 and 3 in the original Standards) were expanded to include "governance and leadership" to continue to emphasize their integral role in the successful adoption of CLAS.