**Case 4–1 NATIONAL STANDARDS ON CULTURALLY AND LINGUISTICALLY APPROPRIATE SERVICES (CLAS)**

In 1997, the Office of Minority Health (OMH) in the U.S. Department of Health and Human Services began work on national standards for culturally and linguistically competent health care. The stated goal was to help reduce health disparities. OMH published draft standards in December 1999 and solicited public comment through a variety of channels over a 4-month period. On December 22, 2000, it published the final standards. Although the standards are primarily directed at health care organizations, OMH encourages their use by individual providers as well as by policy makers, accreditation and credentialing agencies, purchasers, patients, advocates, educators, and the health care community in general (OMH, [2001](http://online.vitalsource.com/books/9780763787646/content/id/bm01bib203)).

**CULTURALLY COMPETENT CARE (GUIDELINES FOR ACTIVITIES RECOMMENDED BY OFFICE OF MINORITY HEALTH FOR ADOPTION AS MANDATES BY FEDERAL, STATE, AND NATIONAL ACCREDITING AGENCIES)**

**Standard 1**

Health care organizations (HCOs) should ensure that patients/consumers receive effective, understandable, and respectful care from all staff members that is provided in a manner compatible with their cultural health beliefs and practices and preferred language.

**Standard 2**

HCOs 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.

**Standard 3**

HCOs should ensure that staff members at all levels and across all disciplines receive ongoing education and training in culturally and linguistically appropriate service delivery.

**LANGUAGE ACCESS SERVICES (MANDATED REQUIREMENTS FOR ALL RECIPIENTS OF FEDERAL FUNDS)**

**Standard 4**

HCOs 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.

**Standard 5**

HCOs must provide to patients/consumers in their preferred language both verbal offers and written notices informing them of their right to received language assistance services.

**Standard 6**

HCOs 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).

**Standard 7**

HCOs must make available easily understood patientrelated materials and post signage in the languages of the commonly encountered groups and/or groups represented in the service area.

**ORGANIZATIONAL SUPPORTS FOR CULTURAL COMPETENCE**

Standards 8–13 are guidelines for activities recommended by the Office of Minority Health for adoption as mandated by federal, state, and national accrediting agencies. Standard 14 is suggested for voluntary adoption by HCOs.

**Standard 8**

HCOs 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.

**Standard 9**

HCOs 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.

**Standard 10**

HCOs should ensure that data on 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.

**Standard 11**

HCOs 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.

**Standard 12**

HCOs should develop participatory, collaborative partnerships with communities and use a variety of formal and informal mechanisms to facilitate community and patient/consumer involvement in designing and implementing CLAS-related activities.

**Standard 13**

HCOs 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.

**Standard 14**

HCOs 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 (OMH, [2001](http://online.vitalsource.com/books/9780763787646/content/id/bm01bib203)).

What would you change about these regulations if you were in charge at the U.S. Department of Health and Human Services?