

**REPORT OF THE NEW YORK STATE DEPARTMENT OF HEALTH  
MINORITY HEALTH COUNCIL**

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## 1. OVERVIEW

Chapter 757 of the Laws of 1992 created the Office of Minority Health within the New York State Department of Health (“the Department”) to promote and serve as the Department’s focal point for minority health matters. This statute also established the Minority Health Council, a 15-member advisory body created within the Office of Minority Health, to serve as a liaison and advocate for the Department on issues concerning matters of minority health. Public Health Law §243(5) provides that:

“[t]he minority health council shall, at the request of the commissioner, consider any matter relating to the preservation and improvement of minority health, and may advise the commissioner thereon; and it may, from time to time, submit to the commissioner, any recommendations relating to the preservation and improvement of minority health.”

This report of the New York State Minority Health Council (“the Council”) is submitted in accordance with this statutory mandate and reflects five strategic priorities and the strategic alliances identified by the Council. The development of these priority areas span four years of Council deliberations and underscores the breadth of minority health issues the Council considers. The report includes six policy recommendations for consideration by the Commissioner of the Department of Health. These recommendations are intended to produce two outcomes:

- By building on Departmental successes, acknowledging opportunities for improvement, and highlighting a ‘call for accountability’, ensure that health inequalities – amply documented among the State’s most vulnerable populations, many of whom are racial and ethnic minorities – are systematically and substantially addressed at every level of Department operations; and
- Ensure there is focus on evidence demonstrating both effort and outcomes.

Copies of the Council’s meeting minutes from 2006 and a summary of the biennial report prepared by the Department are included at the end of this report. Both the Council’s report and the biennial report serve as important tools for building awareness and improving understanding of the multitude of minority health issues in New York State.

## II. STRATEGIC PRIORITIES

Hiroshi Nakajima, Director-General of the World Health Organization, maintains, “Access to health is everybody’s right; the ethical basis of health policy remains Health for All, and inequity is both unacceptable and avoidable. Our challenge for the next decade is to tackle inequity and mobilize support for a rebirth of health for all.”<sup>1</sup>

Table 1 summarizes the five strategic priorities, cornerstones of the Council’s work since 2002, which are aimed at enhancing the Department’s capacity to meet this challenge. The table also includes a list of corresponding strategic alliances the Council is fostering to assist in this effort. These five priorities, which are measured by increased accessibility and availability of quality health care that is culturally and linguistically appropriate for the diverse populations of New York, are:

- Community-based Care
- Workforce Diversity
- Provider, Organization and Health System Cultural Competence
- Provider Reimbursement Equity, and
- Health Care Coverage for All.

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<sup>1</sup> World Health Organization. (1996). *Equity in health and health care: A WHO/SIDA initiative*. Geneva.

**Table 1: Minority Health Council’s Key Result Areas and Strategic Alliances**

<b>Strategic Priorities</b>	<b>Strategic Alliances (partial list)</b>
1. Community-based Quality Health Care	<ul style="list-style-type: none"> <li>▪Community Health Centers Association of New York State</li> <li>▪County Health Departments</li> <li>▪Centers of Excellence in Partnerships for Community Outreach, Research on Health Disparities and Training (Project EXPORT)</li> <li>▪New York State Education Department</li> <li>▪The Commonwealth Fund</li> <li>▪The Robert Wood Johnson Foundation</li> </ul>
2. Workforce Diversity	<ul style="list-style-type: none"> <li>▪Graduate Medical Education’s Subcommittee on Underrepresented Minorities in Medicine</li> <li>▪New York State Nurses Association</li> <li>▪New York State Area Health Education Center System</li> <li>▪Greater New York Hospital Association</li> <li>▪Medical Society of the State of New York</li> <li>▪New York State Office of Mental Health</li> <li>▪U.S. DHHS Office of Minority Health</li> <li>▪Project EXPORT</li> <li>▪County Health Departments</li> <li>▪Community-based Organizations</li> <li>▪Local National Medical Association Chapters</li> </ul>
3. Provider, Organization and Health System Cultural Competence	<ul style="list-style-type: none"> <li>▪New York State Office of Mental Health, Cultural Diversity Task Force</li> <li>▪U.S. DHHS Office of Minority Health</li> <li>▪Medical Society of the State of New York</li> <li>▪County Health Departments</li> <li>▪Community-based Organizations</li> </ul>
4. Provider Reimbursement Equity	<ul style="list-style-type: none"> <li>▪Project EXPORT</li> </ul>
5. Health Care Coverage for All	<ul style="list-style-type: none"> <li>▪Project EXPORT</li> <li>▪The Commonwealth Fund</li> </ul>

**III. POLICY RECOMMENDATIONS TO THE COMMISSIONER OF HEALTH**

The underlying goal of these policy recommendations is to improve and preserve minority health in New York State. In selecting the five areas of interest from which these recommendations emerged, Council members participated in a strategic planning process that included brainstorming to generate issues and ideas, combining of similar or related ideas, and consensus building techniques to develop the list of the top five priority issues. Rating criteria used for narrowing the list included: feasibility, policy-level focus, importance to minority health and capacity to contribute to the multi-pronged approach necessary to effectively address the complexities of minority health. In addition to the five priority areas described, the Council acknowledges health literacy and

access as important cross-cutting issues affecting minority health and health disparities. Considered holistically, the recommendations, each of which is supported by evidence, can help the Department develop innovative integrated models to address the challenges of persistent health disparities in the State.

Policy Recommendation #1: Integrate the goal of eliminating health disparities across all Department of Health assessment, assurance and policy activities. This includes requiring that all contractors provide culturally and linguistically appropriate services.

Rationale: In *Unequal Treatment* (ibid, p.1), the Institute of Medicine (IOM) advises that a comprehensive, multi-level strategy is needed to eliminate health disparities. The broad range of departmental programs recognizes the healthcare gap between racial and ethnic groups in the State. Additionally, as the State's population becomes more diverse, all sections of the public health system are interacting with populations from many different cultural and linguistic backgrounds. Because culture and language are vital factors in how health care and public health services are delivered and received, it is important that the Department's staff and contracting agencies understand and respond with sensitivity to the cultural and linguistic factors that diverse patients and consumers bring to health encounters. The *National Standards for Culturally and Linguistically Appropriate Services in Health Care* (CLAS), issued by the U.S. Department of Health and Human Services' Office of Minority Health (OMH), respond to the need to ensure that all people entering the health care system receive equitable and effective treatment in a culturally and linguistically appropriate manner.<sup>2</sup> There are fourteen (14) CLAS standards, which are organized along three themes—Culturally Competent Care (Standards 1-3), Language Access Services (Standards 4-7), and Organizational Supports for Cultural Competence (Standards 8-14). CLAS **mandates** (Standards 4, 5, 6 and 7) are current federal requirements for all recipients of federal funds. CLAS **guidelines** (Standards 1, 2, 3, 8, 9, 10, 11, 12 and 13) are activities recommended by the federal OMH for adoption as mandates by federal, state and national accrediting agencies. CLAS **recommendations** (Standard 14) are suggested by the federal OMH for voluntary adoption by health care organizations. Attachment I is a list of the CLAS Standards.

Policy Recommendation # 2: Ensure the availability of an adequately staffed, diverse, well-trained public health workforce who can work in and partner with communities and collaborate with contracting agencies, county health departments and other state and federal governmental entities. A diverse workforce improves the State's ability to plan for and respond to the needs of the State's diverse population.

Rationale: The American Public Health Association, in a public health workforce issue brief<sup>3</sup>, examines the precipitous decline in public health professionals and resources and the impact on the health of Americans. The report notes that in addition to the overall worker shortage, of special concern is the lack of diversity in the public health professions. Twenty-five percent of the U.S. population is composed of underrepresented

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<sup>2</sup> U.S. DHHS Office of Minority Health. (March 2001). *National standards for culturally and linguistically appropriate services in health care. Final Report*. Available at [www.omhrc.gov/CLAS](http://www.omhrc.gov/CLAS)

<sup>3</sup> Perlino, C.M. (September 2006). *The public health workforce shortage: Left unchecked, will we be protected?* American Public Health Association Issue Brief. Available at <http://www.apha.org/workforcebrief.pdf>

groups, yet they represent only 10 percent of the health professions. The report concludes that, ultimately, a comprehensive approach to the shortage is needed; it cannot and should not be implemented piecemeal.

Policy Recommendation #3: Integrate the goal of improving health literacy across all Department of Health assessment, assurance and policy activities. This includes requiring that contractors, where applicable, provide or facilitate access to educational programs that help consumers develop the functional abilities to gather relevant health information, engage in meaningful dialogue with their healthcare providers, and explain their symptoms and health experiences clearly.

Rationale: Widespread problems with health literacy significantly limit effective dissemination and understanding of relevant health information, especially among many vulnerable populations where health literacy challenges are especially pervasive (Parker & Kreps, 2005<sup>4</sup>). A concerted effort by the public health and health care systems, the education system, the media, and health care consumers is needed to improve the nation's health literacy. If patients cannot comprehend needed health information, attempts to improve the quality of care and reduce health care costs and disparities may fail. An IOM report, *Health Literacy: A Prescription to End Confusion*, recommends that health care systems develop and support programs to reduce the negative effects of limited health literacy, and that health knowledge and skills be incorporated into the existing curricula of kindergarten through 12th grade classes, as well as into adult education and community programs. Furthermore, programs to promote health literacy, health education, and health promotion programs should be developed with involvement from the people who will use them. And all such efforts must be sensitive to cultural and language preferences<sup>5</sup>.

Policy Recommendation #4: Increase access to health care for all New Yorkers.

Rationale: According to the IOM report, *Insuring America's Health: Principles and Recommendations*<sup>6</sup>, lack of health insurance causes roughly 18,000 unnecessary deaths every year in the United States. The lack of health insurance for tens of millions of Americans has serious negative consequences and economic costs not only for the uninsured themselves but also for their families, the communities they live in, and the whole country.

Policy Recommendation #5: Expand support for the quality improvement framework initiatives, such as, the U.S. Department of Health and Human Services Health Resource Services Administration's (HRSA) Health Disparities Collaborative (HDC), as cost effective, community-based approaches for improving health care access and reducing health disparities. This includes (1) creating and enhancing systems where performance

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<sup>4</sup> Parker, R., & Kreps, G.L. (2005). Library outreach: Overcoming health literacy challenges. *J. Med Libr Assoc*, 93(4), Supplement, S81-S85.

<sup>5</sup> Nielsen-Bohlman, L., Panzer, A.M. and Kindig, D.A. (Eds.). (2004). *Health literacy: A prescription to end confusion*. Washington, DC: The National Academies Press.

<sup>6</sup> Committee on the Consequences of Uninsurance. Board on Health Care Services. Institute of Medicine. (2004). *Insuring America's health: Principles and recommendations*. Washington, DC: The National Academies Press.

is measured and consumers, purchasers, insurers, providers and the public health and health delivery workforce understand what quality health care is and how to make it happen; and, (2) partner with organizations, foundations and others exploring the effectiveness of pay for performance models in improving quality of care and health outcomes for minority and other vulnerable populations; and, analyzing the impact on minority providers and others, practicing in high need areas.

Rationale: According to the Commonwealth Fund<sup>7</sup>: Quality suffers when patients encounter long waiting times, have difficulty getting referrals to needed specialty care, or when their doctors fail to explain their treatments in terms they can understand. When patient information gets lost in transit, quality gets lost, too. When substandard care or outright errors go unnoticed, or when physicians fail to provide preventive care or manage chronic conditions, quality is compromised. One promising strategy for improvement is primary care case management, which seeks to ensure that all patients have regular providers who assume responsibility for accessibility of care, periodic preventive services, management of chronic conditions, and coordination of care across health care settings. The HDC is an innovative health initiative that exemplifies the primary care case management strategy. It seeks to: (1) generate and document improved health outcomes for underserved populations; (2) transform clinical practice through new evidence-based models of care; (3) develop infrastructure, expertise and multi-disciplinary leadership to improve health status; and (4) build strategic partnerships. The HDCs have three main components: a Learning Model, a Care Model, and an Improvement Model<sup>8</sup>. Data from the first year of the Centers for Medicare and Medicaid Services/Premier Hospital Quality Incentive Demonstration project<sup>9</sup> reflect a significant improvement in the quality of care across five clinical focus areas as measured by 33 nationally standardized and widely accepted quality indicators. The average improvement across the clinical areas was 6.6 percent. The pay-for-performance models demonstrated in the project include financial incentives and public recognition for top-performing hospitals as well as financial penalties for hospitals that do not improve above a pre-defined quality measure threshold by the third year of the project (Executive Summary). Development of similar interventions for community health settings in New York holds promise as another approach toward improved health care quality.

Policy Recommendation #6: Report and disseminate data, at a minimum biennially, on minority health in New York State, by federal Office of Management and Budget categories as described in Statistical Directive 15<sup>10</sup> (i.e., White; Black; Asian American/Pacific Islander; and American Indian/Alaska Native) and using sub-population groups (e.g., Hispanic—Puerto Ricans, people of Dominican Republic; African Americans—Caribbean Blacks; Asians—Chinese; and rural populations) wherever possible.

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<sup>7</sup> Robert Wood Johnson Foundation. *Health care quality: an overview*. Available at [www.cmwf.org](http://www.cmwf.org). See also, *Redesigning Systems to Improve the Quality of Care*. Available at [www.rwjf.org](http://www.rwjf.org)

<sup>8</sup> For further information, visit [www.healthdisparities.net](http://www.healthdisparities.net)

<sup>9</sup> Premier, Inc. (2006). *Centers for Medicare and Medicaid Services (CMS)/Premier Hospital Quality Incentive Demonstration Project: Findings from Year One*. Charlotte, NC: Author. Accessed 11/15/06 at <http://www.premierinc.com/quality-safety/tools-services/p4p/hqi/hqi-whitepaper041306.pdf>

<sup>10</sup> Federal Register (October 1997). Revisions to the Standards for Classification of Federal Data on Race and Ethnicity. Federal Register 62(210), 58782-58790. *National Archives and Records Administration*. Washington, DC: U.S. Government Printing Office. Available at <http://www.whitehouse.gov/omb/fedreg/race-ethnicity.html>

Rationale: Reliable information on race and ethnicity is useful to the various groups charged with providing quality health care to increasingly diverse populations<sup>11</sup>. According to the editors of *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care*<sup>12</sup>, standardized data collection is critically important in the effort to understand and eliminate racial and ethnic disparities in health care. As was highlighted for the annual National Healthcare Disparities Report, regular reporting has the potential to educate both policy makers and the larger public on the extent of racial and ethnic health disparities and to focus attention on areas where action is most needed. In other words, reporting helps set the agenda to address this major health care issue with which too few are familiar or know how to effectively address<sup>13</sup>.

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<sup>11</sup> Arday, S.L., Arday, D.R., Monroe, S. & Zhang, J. (2000). HCFA's racial and ethnic data: Current accuracy and recent improvements. *Health Care Financing Review*, 21 (4), 107-116.

<sup>12</sup> Smedley, B.D., Stith, A.Y. and Nelson, A.R. (Eds.). (2003). *Unequal treatment: Confronting racial and ethnic disparities in health care*. Washington, DC: The National Academies Press.

<sup>13</sup> Greenfield, S. (September 2002) Preface. In E. Swift. (Ed.), *Guidance for the National healthcare disparities report (pp. x-xi)*. Washington, DC: The National Academies Press.

## **National Standards for Culturally and Linguistically Appropriate Services in Health Care (CLAS)<sup>14</sup>**

CLAS Standards, issued by the U.S. Department of Health and Human Services' Office of Minority Health, respond to the need to ensure that all people entering the health care system receive equitable and effective treatment in a culturally and linguistically appropriate manner. They are proposed as a means to correct inequities that currently exist in the provision of health services and make these services more responsive to the individual needs of all patients/consumers. They are intended to be inclusive of all cultures and not limited to any particular population group or sets of groups; however, they are specially designed to address needs of racial, ethnic, and linguistic populations that experience unequal access to health services.

Ultimately, the aim of the standards is to contribute to the elimination of racial and ethnic health disparities and to improve the health of all Americans.

The CLAS standards identify elements of culturally and linguistically competent care, which health care organizations can use to discover and address inequities in the delivery of health care services.

The CLAS standards are organized along three themes—Culturally Competent Care (Standards 1-3), Language Access Services (Standards 4-7), and Organizational Supports for Cultural Competence (Standards 8-14).

CLAS *mandates* are current federal requirements for all recipients of federal funds (Standards 4, 5, 6, and 7).

CLAS *guidelines* are activities recommended by OMH for adoption as mandates by federal, State and national accrediting agencies (Standards 1, 2, 3, 8, 9, 10, 11, 12, and 13).

CLAS *recommendations* are suggested by OMH for voluntary adoption by health care organizations (Standard 14).

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<sup>14</sup> U.S. DHHS Office of Minority Health. (March 2001). *National standards for culturally and linguistically appropriate services in health care*. Final Report. Washington DC.

**Standard 1. 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.**

This standard constitutes the fundamental requirement on which all activities specified in other CLAS standards are based. Its intent is to ensure that all patients/consumers receiving health services experience culturally and linguistically competent encounters with an organization's staff. The standard is relevant not only to staff, who ultimately are responsible for the kinds of interactions they have with patients/consumers, but also to their organizations, which must provide the managers, and systems that support the realities of culturally competent encounters. Ways to operationalize this standard include implementing all other CLAS standards.

**Standard 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.**

Although hiring bilingual individuals from different cultures does not in itself ensure that the staff is culturally competent and sensitive, this practice is a critical component to the delivery of relevant and effective services for all patients/consumers. 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 governing boards, clinicians, and administrative personnel. Staff diversity at all levels of an organization can play an important role in considering the needs of patients/consumers from various cultural and linguistic backgrounds in the decisions and structures of the organization. The goal of staff diversity should be incorporated into organizations' mission statements, strategic plans, and goals. Organizations should encourage the retention of diverse staff by fostering a culture of responsiveness toward ideas and challenges that a culturally diverse staff offers.

**Standard 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.**

Hiring a diverse staff does not automatically guarantee the provision of culturally competent care. Staff education and training are also crucial to ensuring CLAS delivery because all staff will interact with patients/consumers representing different countries of origin, acculturation levels, and social and economic standing. Staff refers not only to personnel employed by the health care organization but also its subcontracted and affiliated personnel. Health care organizations should either verify that staff at all levels and in all disciplines participate in ongoing CME- or CEU-accredited education or other training in CLAS delivery, or arrange for such education and training to be made available to staff. This training should be based on sound educations (i.e., adult learning) principles, include pre-and post-training assessments, and be conducted by appropriately qualified individuals. Training objectives should be tailored for relevance to the particular functions of the trainees and the needs of the specific populations served, and over time should include the following topics:

- Effects of differences in the cultures of staff and patients/consumers on clinical and other workforce encounters, including effects of the culture of American medicine and clinical training;
- Elements of effective communication among staff and patients/consumers of different cultures and different languages, including how to work with interpreters and telephone language services;
- Strategies and techniques for the resolution of racial, ethnic, or cultural conflicts between staff and patients/consumers;
- Health care organizations' written language access policies and procedures, including how to access interpreters and translated written materials;

- The applicable provisions of: Title VI of the Civil Rights Act of 1964, 42 U.S.C §200d, 45 C.F.R. §80.1 et seq. (including Office of Civil Rights Guidance on Title VI of the Civil Rights Act of 1964, with respect to services for (LEP) individuals (65 Fed. Reg. 52762-52774, August 30, 2006);
- Health care organizations' compliance/grievance procedures;
- Effects of cultural differences on health promotion and disease prevention, diagnosis and treatment, and supportive, rehabilitative, and end-of-life care;
- Impact of poverty and socioeconomic status, race, and racism, ethnicity, and socio-cultural factors on access to care, service utilization, quality of care, and health outcomes.
- Differences in the clinical management of preventable and chronic diseases and conditions indicated by differences in the race or ethnicity of patients/consumers; and
- Effects of cultural differences among patients/consumers and staff upon health outcomes; patient satisfaction, and clinical management of preventable and chronic diseases and conditions.

*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. Title VI requires all entities receiving federal financial assistance, including health care organizations, take steps to ensure that LEP persons have meaningful access to the health services that they provide.*

**Standard 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.**

The key to providing meaningful access for LEP persons is to ensure effective communication between the entity and the LEP person. Language services include, as a first preference, the availability of bilingual staff who can communicate directly with patients/consumers in their preferred language. When such staff members are not available, face-to-face interpretation provided by trained staff, or contract or volunteer interpreters, is the next preference. Telephone interpreter services should be used as a supplemental system when an interpreter is needed instantly, or when services are needed in an unusual or infrequently encountered language.

**Standard 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.**

LEP individuals should be informed—in a language they 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 non-clinical encounter.

Some successful methods of informing patients/consumers about language assistance services include: a) using language identification or “I speak...” cards; b) posting and maintaining signs in regularly encountered languages at all points of entry; c) creating uniform procedures for timely and effective telephone communication between staff and LEP persons; and d) including statements about the services

available and the right to free language assistance services in appropriate non-English languages in brochures, booklets, outreach materials, and other materials that are routinely distributed to the public.

**Standard 6. 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).**

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. 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. 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.

**Standard 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.**

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 Office of Civil Rights 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)].

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. Organizations should develop policies and procedures to ensure development of quality non-English signage and patient-related materials that are appropriate for their target audiences.

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.

**Standard 8. 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.**

Successful implementation of CLAS standards depends on an organization's ability to target attention and resources on the needs of culturally diverse populations. The purpose of strategic planning is to help the organization define and structure activities, policy development, and goal setting relevant to culturally and linguistically appropriate services. It also allows the agency to identify, monitor, and evaluate system features that may warrant implementing new policies or programs consistent with the overall mission.

Consistent with Standard 12, the strategic plan should be developed with the participation of consumers, community, and staff who can convey the needs and concerns of all communities and all parts of the organization affected by the strategy. And, consistent with Standards 9, 10, and 11, the results of data gathering and self-assessment processes should inform the development and refinement of goals, plans, and policies.

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

Initial self-assessment, including an inventory of organizational policies, practices, and procedures, is a prerequisite to developing and implementing the strategic plan called for in Standard 8. Ongoing self-assessment is necessary to determine the degree to which the organization has made progress in implementing CLAS standards. The purpose of ongoing organizational self-assessment is to obtain baseline and updated information that can be used to define service needs, identify opportunities for improvement, develop action plans, and design programs and activities. The self-assessment should focus on the capacities, strengths, and weaknesses of the organization in meeting the CLAS standards

Linking CLAS-related measures with routine quality and outcome efforts may help build the evidence base regarding the impact of CLAS interventions on access, patient satisfaction, quality, and clinical outcomes.

**Standard 10. 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.**

The purposes of collecting information on race, ethnicity, and language 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; and
- Assure that health care services are provided equitably.

Collection of data on self-identified race/ethnicity should adhere to the standard procedures and racial and ethnic categories specified in the Office of Management and Budget's most current policy directive and adapted in the U.S. Census 2000. To improve the accuracy and reliability of race and ethnic identifier data, health care organizations should adapt intake and registration procedures to facilitate patient/consumer self-identification and avoid use of observational/visual assessment methods whenever possible. Health care organizations can enhance their information on subpopulation differences by collecting additional identifiers such as self-identified country of origin, which provides information relevant to patient/consumer care that is unobtainable from other identifiers.

Health care organizations should collect data from patients/consumers at the first point of contact using personnel who are trained to be culturally competent in the data collection process. No patient/consumer should be required to provide race, ethnicity, or language information, not be denied care or services if he or she chooses not to provide such information. All patient/consumer data should be maintained according

to the highest standards of ethics, confidentiality, and privacy, and should not be used for discriminatory purposes.

**Standard 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.**

The purpose of this standard is to ensure that health care organizations obtain a variety of baseline data and update the data regularly to better understand their communities, and to accurately plan for and implement services that respond to the cultural and linguistic characteristics of the service area.

A more useful and in-depth approach would use data sources such as census figure and/or adjustments, voter registration data, school enrollment profiles, county and State health status reports, and data from community agencies and organizations. Both quantitative and qualitative methods should be used to determine cultural factors related to patient/consumer needs, attitudes, behaviors, health practices, and concerns about using health care services as well as the surrounding community's resources, assets, and needs related to CLAS.

In accordance with Standard 12, health care organizations should involve the community in the design and implementation of the community profile and needs assessment.

**Standard 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.**

The culturally competent organization views responsive service delivery to a community as a collaborative process that is informed and influenced by community interests, expertise, and needs. Services that are designed and improved with attention to community needs and desires are more likely to be used by patients/consumers, thus leading to more acceptable, responsive, efficient, and effective care. This standard addresses two levels of consumer/patient and community involvement that are not token in nature, but involve working with the community in a mutual exchange of expertise that will help shape the direction and practices of the health care organization.

In addition to providing input on the planning and implementation of CLAS activities, patients/consumers and community representatives should be solicited for input on broad organizational policies, evaluation mechanisms, marketing and communication strategies, staff training programs, and so forth. There are many formal and informal mechanisms available for this, including participation in governing boards, community advisory committees, ad hoc advisory groups, and community meetings as well as information conversations, interviews, and focus groups.

Health care organizations should also collaborate and consult with community-based organizations, providers, and leaders for the purposes of partnering on outreach, building provider networks, providing service referrals, and enhancing public relations with the community being served.

**Standard 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.**

This standard requires health care organizations to anticipate and be responsive to the inevitable cross-cultural differences that arise between patient/consumers and the organization and its staff.

Patients/consumers who bring racial, cultural, religious, or linguistic difference to the health care setting are particularly vulnerable to experiencing situations where those differences are not accommodated or respected by the health care institution or its staff. These situations may range from differences related to informed consent and advanced directives, to difficulty in accessing services or denial of services, to outright discriminatory treatment. Health care organizations should ensure that all staff members are trained to recognize and prevent these potential conflicts and that patients/consumers are informed about and have access to complaint and grievance procedures that cover all aspects of their interaction with the organization.

Health care organizations should include oversight and monitoring of these culturally or linguistically related complaints/grievances as part of the overall quality assurance program for the institution.

**Standard 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.**

Sharing information with the public about a health care organization's efforts to implement the CLAS standards is a way for the organization to communicate to communities and patients/consumers about its efforts and accomplishments in meeting CLAS standards. It can help institutionalize the CLAS standards by prompting the organization to regularly focus on the extent to which it has implemented each standard. It can also be a mechanism for organizations to learn from each other about new ideas and successful approaches to implementing CLAS.

Health care organizations can use a variety of methods to communicate or report information about progress in implementing the CLAS standards, including publication of stand-alone documents focused specifically on cultural and linguistic competence or inclusion of CLAS components within existing organizational reports and documents. Other channels for sharing this information include the organization's member publications; newsletters targeting the communities being served; presentations at conferences; newspaper articles; television, radio, and other broadcast media; and postings on Web sites.

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