COMMUNITY CATALYST

30 WINTER STREET
SUITE 1010
BOSTON, MA 02108
TEL 617.338.6035
FAX 617.451.5838
WWW.COMMUNITYCATALYST.ORG

December 30, 2010

CLAS Standards
c/o HHS Office of Minority Health
1101 Wootton Parkway, Suite 600
Rockville, MD 20852

Re: Comments on revising the existing National Standards for Culturally and Linguistically Appropriate Services in Health Care (CLAS)

Thank you for the opportunity to comment on the CLAS standards and how they might be enhanced. Community Catalyst is a national advocacy organization that has been giving consumers a voice in health care reform for more than a decade. Community Catalyst provides leadership and support to state and local consumer organizations, policymakers and foundations that are working to guarantee access to high quality, affordable health care for everyone.

We strongly support the initiative to enhance the CLAS standards. We believe the standards can help improve access to quality health care, and reduce health disparities, by removing barriers created when patients and caregivers come from different cultures and speak different languages. Evidence shows that culturally competent care and the provision of quality language assistance services lead to expanded use of preventive care, reduced hospitalization, fewer medical errors, more accurate diagnoses and an increase in patient satisfaction.

To fully achieve that purpose, we recommend that the Office of Minority Health (OMH) and the Department of Health and Human Services (HHS) expand the impact and reach of the standards by taking steps to enforce the standards, incorporate them into other initiatives, and educate health care organizations and the public about them.

Of prime importance is enforcing the current federal requirements (under Title VI of the Civil Rights Act of 1964) that providers who receive federal funds meet standards #4 through #7. A study published in the December issue of *Medical Care* found that many hospitals do not provide language assistance in a timely manner. In addition, advocates in states across the country regularly hear complaints — or horror stories — about patients who failed to get appropriate care because of the lack of interpreters or because of cultural miscues.

One enforcement mechanism would be to authorize OMH to work in conjunction with the HHS Office of Civil Rights to take on a watchdog role. Another might require health care organizations to report their progress in meeting the standards to the OMH. Finally, the standards could also be incorporated into HHS regulations to give them more weight. Requiring all branches of HHS, such as the Centers for Medicare and Medicaid Services, (CMS), Health Resources and Services Administration (HRSA), Substance Abuse and Mental Health Services Administration (SAMHSA) and Centers for Disease Control and Prevention (CDC), to incorporate all the standards — not just 4 through 7 — into their policies and regulations, and make compliance with the CLAS standards mandatory for all their grantees and contractors would be a big step forward.

Other steps that could enhance the impact of the standards include:

1. Joining with other branches of HHS to promote the CLAS standards among health providers and health insurers nationwide. Promotional material should identify the CLAS standards as the minimum required, and encourage providers and insurers to do more whenever possible
2. Launching a national educational effort aimed at consumers that publicizes the availability of free interpreter services and that engages national, state and community-based consumer organizations
3. Incorporating the CLAS standards into the National Quality Strategy that is being developed as part of the Affordable Care Act
4. Requiring state Exchanges established under the Affordable Care Act adopt the CLAS standards and apply these standards as a measure of quality for health plans that will be sold through Exchanges
5. Defining "health care organizations" in the standards to include health care providers

In addition, we recommend revising the specific content of the standards as follows. (New language is <u>underlined,</u> and comments are in **bold type**.)

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.

We strongly support this standard as the basis for quality care.

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. <u>Where possible, health care organizations should collaborate with educational organizations to build a pipeline of racially, ethnically and culturally diverse health care workforce.</u>

We believe that health care organizations can play a bigger role in helping to address the current lack of diversity among health care workers, particularly clinicians.

Standard 3: Health care organizations should ensure that staff at all levels and across all disciplines receive ongoing education and training in federal and state anti-discrimination laws; the importance of cultural and linguistic competency; the health beliefs, practices and values of people served; and how to meet the CLAS standards.

Because of the links between the CLAS standards and Title VI of the Civil Rights Act of 1964 training must include the law as well as CLAS delivery.

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 and in a timely manner during all hours of operation.

We support this standard as written.

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 free of charge. In addition to posting signs and providing information to each patient, establishing multilingual helplines may be an effective means of helping individuals connect with services.

Standard 6: Health care organizations must ensure 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 after he or she is informed of the availability of free interpreter services). Minors should never be used except in cases of emergencies.

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. This must include essential brochures, forms and notices used by patients.

Standard 8: Health care organizations should develop, implement and promote a written strategic plan that outlines clear goals, policies, operational plans, necessary resources and management accountability/oversight mechanisms, including designated staff responsible for implementation to provide CLAS. Health care organizations should seek consumer input in developing the strategic plan.

Appropriate resources and staff are essential to providing quality services.

Standard 9: Health care organizations should regularly evaluate the availability and accessibility of, and consumer satisfaction with culturally and linguistically appropriate services. Assessments of consumer satisfaction must be conducted in the languages spoken by the population served.

We recommend rewording this standard as indicated to make the point simpler and clearer. Evaluation of these services is a critical part of ensuring that the services are meeting the needs of consumers. It may be helpful to include consumers in the design of these evaluations.

Standard 10: Health care organizations should periodically collect data on the individual patient's/consumer's race, ethnicity, preferred spoken and written language, and English language proficiency, and should maintain this data in patient health records and integrate it into the organization's management information systems. Data on race, ethnicity, and language should be broken down into the most detailed sub-categories possible.

Collection of this data is essential to help identify needs for specific CLAS services, as well as to identify health disparities and develop targeted strategies to address them.

Standard 11: Health care organizations should maintain a current demographic, cultural, and epidemiological profile of the community as well as a community needs assessment to accurately plan for and implement services that respond to the cultural and linguistic characteristics of the service area. Consumers and consumer advocates who are representative of the range of people in the community should be actively involved in the needs assessment.

Requiring community involvement will improve the accuracy of the assessment as well as make this standard conform to new requirements for non-profit hospitals included in the Affordable Care Act.

Standard 12: Health care organizations should develop participatory, collaborative partnerships with communities and patients in designing and implementing CLAS-related activities and in devising community interventions to address the social determinants of health that underlie health disparities.

The new ACA requirements for non-profit hospitals to conduct community needs assessments and devise plans to address those needs may serve as a model for this standard.

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, discriminatory treatment, or complaints by patients/consumers. Health care organizations should examine and track grievances for patterns that flag needed changes in procedures.

Standard 14: Health care organizations should annually make available to the public information about their progress and successful innovations in implementing the CLAS standards, including information on programs, staffing and resources, and should publicize the availability of this information.

Strengthening this standard may ensure more accountability from health care organizations and make it easier for them to learn from each other.

We appreciate the opportunity to comment on how to enhance the CLAS standards. We stand ready to provide any additional information that is needed. Please contact Deputy Policy Director Alice Dembner at 617-275-2880 or adembner@communitycatalyst.org with any questions.

Sincerely,

Robert Restuccia
Executive Director
Community Catalyst