

---

# **BEHAVIORAL HEALTH IMPLEMENTATION GUIDE FOR THE NATIONAL STANDARDS FOR CULTURALLY AND LINGUISTICALLY APPROPRIATE SERVICES IN HEALTH AND HEALTH CARE**

---



**OMH**

U.S. Department of  
Health and Human Services  
Office of Minority Health

# CONTENTS

<b>INTRODUCTION</b>	<b>3</b>
<b>NATIONAL STANDARDS FOR CULTURALLY AND LINGUISTICALLY APPROPRIATE SERVICES (CLAS) IN HEALTH AND HEALTH CARE</b>	<b>6</b>
<b>PRINCIPAL STANDARD</b>	<b>7</b>
<b>Standard 1:</b> Provide effective, equitable, understandable, and respectful quality care and services	7
Purpose	7
<b>THEME 1: GOVERNANCE, LEADERSHIP, AND WORKFORCE</b>	<b>8</b>
Behavioral Health Scenario	8
<b>Standard 2:</b> Advance and sustain organizational governance and leadership that promote CLAS and health equity through policy, practices, and allocated resources	8
Purpose	8
Implementation Strategies	8
<b>Standard 3:</b> Recruit, promote, and support a culturally and linguistically diverse governance, leadership, and workforce responsive to the population in the service area	9
Purpose	9
Implementation Strategies	9
<b>Standard 4:</b> Educate and train governance, leadership, and workforce in culturally and linguistically appropriate policies and practices on an ongoing basis	9
Purpose	9
Implementation Strategies	10
Implementation Examples	10
<b>THEME 2: COMMUNICATION AND LANGUAGE ASSISTANCE</b>	<b>12</b>
Behavioral Health Scenario	12
<b>Standard 5:</b> Offer language assistance to individuals who have limited English proficiency and/or other communication needs at no cost to them to facilitate timely access to all health services	12
Purpose	12
Implementation Strategies	13
<b>Standard 6:</b> Inform all individuals of the availability of language assistance services clearly and in their preferred language, verbally and in writing	13
Purpose	13
Implementation Strategies	13
<b>Standard 7:</b> Ensure the competence of individuals providing language assistance, recognizing that the use of untrained individuals and/or minors as interpreters should be avoided	14
Purpose	14
Implementation Strategies	14

<b>Standard 8:</b> Provide easy-to-understand print and multimedia materials and signage in the languages commonly used by populations in the service area	15
Purpose	15
Implementation Strategies	15
Implementation Examples	16
<b>THEME 3: ENGAGEMENT, CONTINUOUS IMPROVEMENT, AND ACCOUNTABILITY</b>	<b>17</b>
Behavioral Health Scenario	17
<b>Standard 9:</b> Infuse CLAS goals, policies, and management accountability throughout an organization’s planning and operations	17
Purpose	17
Implementation Strategies	17
<b>Standard 10:</b> Conduct ongoing assessments of an organization’s CLAS-related activities and integrate CLAS-related measures into measurement and continuous quality improvement activities	18
Purpose	18
Implementation Strategies	18
<b>Standard 11:</b> Collect and maintain accurate and reliable demographic data to monitor and evaluate the impact of CLAS on health equity and outcomes and to inform service delivery	19
Purpose	19
Implementation Strategies	19
<b>Standard 12:</b> Conduct regular assessments of community health assets and needs and use the results to plan and implement services that respond to the cultural and linguistic diversity of populations in the service area	20
Purpose	20
Implementation Strategies	20
<b>Standard 13:</b> Partner with a community to design, implement, and evaluate policies, practices, and services to ensure cultural and linguistic appropriateness	20
Purpose	20
Implementation Strategies	20
<b>Standard 14:</b> Create conflict and grievance resolution processes that are culturally and linguistically appropriate to identify, prevent, and resolve conflicts or complaints	21
Purpose	21
Implementation Strategies	21
<b>Standard 15:</b> Communicate the organization’s progress in implementing and sustaining CLAS to all stakeholders, constituents, and the general public	22
Purpose	22
Implementation Strategies	22
Implementation Examples	23
<b>REFERENCES AND RESOURCES</b>	<b>24</b>

## INTRODUCTION

In 2000, the U.S. Department of Health and Human Services (HHS) Office of Minority Health (OMH) released the National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care (National CLAS Standards). The intent of the National CLAS Standards is to improve the quality of care, help eliminate health care disparities, and advance health equity by establishing a blueprint for health and healthcare organizations to implement culturally and linguistically appropriate services. In 2010, OMH revisited the National CLAS Standards, as a way of recognizing the nation's increasing population diversity, significant growth in the fields of cultural and linguistic competency, emerging federal, state policies and legislation regarding health equity, and growing interest from health plans and providers. (For more details on the development of each standard, see <https://www.thinkculturalhealth.hhs.gov/>.)

In 2013, OMH released the enhanced National CLAS Standards, which are a comprehensive set of 15 guidelines that inform, guide, and facilitate practices related to culturally and linguistically appropriate health services. An accompanying implementation initiative resulted in the development of the [Blueprint for Advancing and Sustaining CLAS Policy and Practice](#), providing specific and systematic guidance for implementing each standard.

Now, more than two decades after the release of the original CLAS Standards, and eight years since the enhanced [National CLAS Standards](#) were published, there is still much work to be done. Racial/ethnic disparities in health and health care remain a public health challenge, despite advances in health care technology and new delivery systems, and even when factors such as health insurance coverage, income, and educational level are taken into consideration.

While the original and enhanced CLAS Standards were developed for all health care professions and systems, early adopters of the standards were often physical health care organizations, such as primary care clinics, hospitals, health plans and public health agencies. At the time, there was less participation in and engagement with the standards among behavioral health providers, or providers who address the mental health and substance use issues of individuals. Now, increasingly, behavioral health providers and education systems are recognizing the value of the National CLAS Standards in advancing behavioral health equity. This awareness raises the potential for establishing a new benchmark for culturally and linguistically appropriate services to improve the behavioral health of racial/ethnic minority and underserved populations.

To advance this effort, the Substance Abuse and Mental Health Services Administration (SAMHSA) collaborated with the OMH to develop this **Behavioral Health Implementation Guide for the National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care (Behavioral Health Guide)**. This Behavioral Health Guide underscores the ways in which the National CLAS Standards can improve access to behavioral health care, promote quality behavioral health programs and practice, and ultimately reduce persistent disparities in mental health and substance use treatment for underserved, minority populations and communities.

### How to Use the Behavioral Health Guide

The Behavioral Health Guide is a companion document to the [Blueprint for Advancing and Sustaining CLAS Policy and Practice](#). Together these documents provide concrete, feasible implementation strategies for the health and behavioral healthcare community to improve the provision of services to all individuals, regardless of race, ethnicity, language, socioeconomic status, and other cultural characteristics. The implementation examples are past grantee examples. The Behavioral Health Guide is organized by the overarching themes of the 15 standards: Principal Standard; Governance, Leadership and Workforce; Communication and Language Assistance; and Engagement, Continuous Improvement, and Accountability. Each section (except for the Principal Standard) includes:

- *Purpose* – the purpose of the associated National CLAS Standards
- *Behavioral Health Scenario* – a hypothetical behavioral health scenario relevant to the National CLAS Standards
- *Implementation Strategies* – practical, concrete National CLAS Standard implementation strategies pertaining to the behavioral health scenario
- *Implementation Examples* – “real-life” National CLAS Standard implementation examples from SAMHSA grantees or member organizations from the National Network to Eliminate Disparities in Behavioral Health (NNED)<sup>1</sup> illustrating key components of the National CLAS Standards “in action”

<sup>1</sup> The National Network to Eliminate Disparities in Behavioral Health (NNED) is a network of community-based organizations focused on the mental health and substance use issues of diverse racial and ethnic communities. The NNED National Facilitation Center is funded by SAMHSA.

## The Audience for the Enhanced National CLAS Standards and the Behavioral Health Guide

The behavioral healthcare community can benefit from the framework offered by the enhanced National CLAS Standards, which is directed toward a broad spectrum of professionals, providers and organizations influencing health and healthcare delivery every day. The standards address each point of contact throughout the health and behavioral health care services continuum. The following is a partial list of potential audiences and how they might respectively apply the standards:

- **Accreditation and Credentialing Agencies:** to assess and compare behavioral health care facilities, relevant human service organizations, and providers who offer culturally humble and linguistically appropriate services and ensure quality care for diverse populations. Institutions such as The Joint Commission and the National Committee for Quality Assurance have made important strides in implementing policies and standards to help ensure these quality services.
- **Advocacy Organizations:** to promote quality health care for diverse populations and to assess and monitor care and services being delivered. The potential advocate audience is broad and includes: legal services, consumer education agencies, faith-based organizations, and other local, regional, or national nonprofit organizations that address behavioral health care issues.
- **Behavioral Health Care Providers:** to incorporate cultural humility and linguistic competency into the delivery of quality behavioral healthcare and services. This audience would include behavioral health clinicians, practitioners, and the full continuum of care from inpatient and hospital care to community-based outpatient and recovery services and supports.
- **Behavioral Health Care Staff and Administrators:** to implement culturally and linguistically appropriate services throughout an organization, at every point of contact. This audience would include employees, contractors, and volunteers serving throughout the organization.
- **Education System:** to incorporate cultural and linguistic competency into the school-based delivery of quality behavioral healthcare and services. This audience would include school-based counselors, therapists, and social workers.
- **Governance and Policy Leadership:** to draft consistent and comprehensive laws, regulations, and contract language supporting cultural and linguistic competency. This audience would include federal, state, tribal, and local governments. The audience would also include the individuals within organizations who are responsible for developing regulations, grants and contracts, as well as the leadership responsible for decision-making regarding regulations, grants and contracts.
- **Patients/Consumers and their Families:** to understand their right to receive accessible and appropriate behavioral health care services and to evaluate whether providers can offer such services. The standards also articulate their legal right to linguistically appropriate services.
- **Professional Training Institutions and Faculty:** to incorporate cultural and linguistic competency into their curricula and to raise awareness about the impact of culture and language on health and behavioral health care services. This audience would include faculty from academic institutions, state health professional licensing agencies, and faculty from legal and social service professions.
- **Public Health Workforce:** to implement cultural humility and linguistic competency into the provision of public health services. This audience would include experts from environmental health, surveillance and epidemiology, and population health that identify the socio-environmental factors that impact behavioral health in diverse communities.
- **Purchasers of Behavioral Health Services:** to promote the needs of diverse consumers of behavioral health services and related support from insurers and health plans. This audience would include government and employer purchasers of health benefits and influence their contracting language with providers.

## The Case for CLAS

There is a compelling need to reduce disparities in behavioral health care in communities across the country. These disparities directly affect the quality of life for all individuals. The lack of behavioral health equity adversely affects neighborhoods, communities, and the broader society, making the issue not only an individual concern but also a public health concern. Culturally and linguistically appropriate services are increasingly recognized as effective in improving the quality of care and services (Beach et al., 2004; Goode et al., 2006). By providing a structure to implement culturally and linguistically appropriate services, the enhanced National CLAS Standards, in conjunction with the Behavioral Health Guide, provide the potential to improve an organization's ability to address behavioral health care disparities and ultimately improve behavioral health for communities across the country.

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 **“Provide effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs.”** This essential goal of the National CLAS Standards is framed in its Principal Standard (Standard 1), and the remaining 14 Standards span three themes including 1) governance, leadership, and workforce; 2) communication and language assistance; and 3) engagement, continuous improvement, and accountability.

## Conclusion

OMH hopes that the behavioral health care community finds this guide useful in supporting the implementation of strategies to improve the provision of services and to promote behavioral health equity. Please visit the Think Cultural Health website ([thinkculturalhealth.hhs.gov](http://thinkculturalhealth.hhs.gov)) for more resources to support the implementation of the National CLAS Standards, including:

- [Improving Cultural Competency for Behavioral Health Professionals](#) – online continuing education program to help behavioral health professionals increase their cultural and linguistic competency.
- [An Implementation Checklist for the National CLAS Standards](#) – checklist of successful CLAS-related organizational activities and CLAS action worksheet to support planning of CLAS activities.
- [Evaluation of the National CLAS Standards: Tips and Resources](#) – framework and toolkit to guide efforts in evaluating the implementation of the National CLAS Standards by health care organizations.

## Contributors

Aika Aluc, Michael Awad, Alexis Bakos, Tenly Biggs, Juliet Bui, Bryan Castro, Victoria Chau, Joya Chowdhury, Gem Daus, Julio Dicient Taillepiere, Nancy Gutierrez, Larke Huang, Andrea King, Roslyn Holliday Moore, Nellie Moualeu, Carolina Regalado Murillo, David Robles, Leslie Quiroz, Andrew Sanderson, Tonia Schaffer, Rashmita Subedi, Melodye Watson, Tony Welch

## Acknowledgments

The HHS Office of Minority Health is grateful for the collaboration with and contributions from the SAMHSA Office of Behavioral Health Equity which made this guide possible.

# NATIONAL STANDARDS FOR CULTURALLY AND LINGUISTICALLY APPROPRIATE SERVICES (CLAS) IN HEALTH AND HEALTH CARE

## *Principal Standard*

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

## *Governance, Leadership and Workforce*

2. Advance and sustain organizational governance and leadership that promotes CLAS and health equity through policy, practices, and allocated resources.
3. Recruit, promote, and support a culturally and linguistically diverse governance, leadership, and workforce that are responsive to the population in the service area.
4. Educate and train governance, leadership, and workforce in culturally and linguistically appropriate policies and practices on an ongoing basis.

## *Communication and Language Assistance*

5. Offer language assistance to individuals who have limited English proficiency (LEP) and/or other communication needs, at no cost to them, to facilitate timely access to all health care and services.
6. Inform all individuals of the availability of language assistance services clearly and in their preferred language, verbally and in writing.
7. Ensure the competence of individuals providing language assistance, recognizing that the use of untrained individuals and/or minors as interpreters should be avoided.
8. Provide easy-to-understand print and multimedia materials and signage in the languages commonly used by the populations in the service area.

## *Engagement, Continuous Improvement, and Accountability*

9. Establish culturally and linguistically appropriate goals, policies, and management accountability, and infuse them throughout the organization's planning and operations.
10. Conduct ongoing assessments of the organization's CLAS-related activities and integrate CLAS-related measures into measurement and continuous quality improvement activities.
11. Collect and maintain accurate and reliable demographic data to monitor and evaluate the impact of CLAS on health equity and outcomes and to inform service delivery.
12. Conduct regular assessments of community health assets and needs and use the results to plan and implement services that respond to the cultural and linguistic diversity of populations in the service area.
13. Partner with the community to design, implement, and evaluate policies, practices, and services to ensure cultural and linguistic appropriateness.
14. Create conflict and grievance resolution processes that are culturally and linguistically appropriate to identify, prevent, and resolve conflicts or complaints.
15. Communicate the organization's progress in implementing and sustaining CLAS to all stakeholders, constituents, and the general public.

## PRINCIPAL STANDARD

### *Standard 1: Provide effective, equitable, understandable, and respectful quality care and services*

#### Purpose

1. To create a safe and welcoming environment at every point of contact that both fosters appreciation of the diversity of individuals and provides patient- and family-centered care
2. To ensure that all individuals who receive health care and services have culturally and linguistically appropriate encounters
3. To meet communication needs so that individuals can understand the health care and services they are receiving, participate effectively in their own care, and make informed decisions
4. To eliminate discrimination and disparities

Standard 1 is the **Principal Standard** because, conceptually, the ultimate aim in adopting the remaining standards is to achieve Standard 1. Standards 2 through 15 represent the practices and policies intended to be the fundamental building blocks of CLAS that are necessary to achieve the Principal Standard. For this reason, specific Behavioral Health Scenarios, Implementation Strategies, and Implementation Examples for Standard 1 are not listed here. If each of Standards 2 through 15 is implemented and maintained, health care organizations and systems will be better positioned to achieve the desired goal of “*effective, equitable, understandable, and respectful 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

### *Behavioral Health Scenario*

The following scenario relates to the first theme and its associated National CLAS Standards (2-4).

A health center is located in an urban community of a large city with a growing number of immigrant residents, and provides services to a diverse and underserved population struggling with acculturation, assimilation, trauma, and limited English proficiency (LEP) among other concerns. Over the past five years, the center has grown into a well-equipped and adequately staffed institution, but it is not seeing clients at the rate one would expect with the high demand for primary and behavioral health care in the area. The center's administration finds the center's low service use unexpected and is determined to identify ways to help expand the reach of its services.

The center's administration decides to recruit a cultural and linguistic competence (CLC) expert, Mr. Da, who was born and raised in the local area, and is half American Indian and half Mexican American. Mr. Da's insight around some of the reasons for poor utilization of services provided by the center is gained from his bond with family, friends, and neighbors.

Mr. Da's first recommendation is to gather objective information to inform organizational change. He conducts a CLC assessment on staff and community demographics, preferences, and attitudes; and collects information about the physical spaces and materials offered by the center. Next, he facilitates focus groups that draw upon the insights of

diverse community members including patients, families, caregivers, and community leaders. His report highlights several key areas:

1. The center's administration and staff were not representative of the community it served and lacked diversity. The apparent lack of culturally and linguistically competent personnel among certain staff, administrative, and other mental health providers created communications barriers between the health care center and the community.
2. The physical setting feels intimidating rather than welcoming and has an institutional look with bare white walls. It offers no privacy for patients when checking in, during intake, or during clinical interviews. Nor does it offer designated area(s) for children – especially children with behavioral health disorders – to occupy themselves with age-appropriate activities while waiting.
3. When seeking assistance, community members reported feeling disrespected and felt their cultural and linguistic needs are unmet.
4. Given the demographics of the community, there were clear inequities in access to services as well as institutional barriers in access to culturally and linguistically competent mental health services and social supports.

### *Standard 2: Advance and sustain organizational governance and leadership that promote CLAS and health equity through policy, practices, and allocated resources*

#### **Purpose**

1. To ensure the provision of the appropriate resources and accountability needed to support and sustain initiatives
2. To model appreciation and respect for diversity, inclusiveness, and all beliefs and practices
3. To support a model of transparency and communication between the service setting and the populations it serves

#### **Implementation Strategies**

What actions should a health center prioritize to improve the cultural and linguistic experiences of students and their families?

1. Engage community members in the designing and furnishing of physical spaces to promote a welcoming and culturally respectful environment.
2. Develop strategies to collect authentic, sustained representative public input that includes the immigrant community.
3. Develop multiple communication channels with community members. Place a priority focus on outreach to and engagement with immigrant families by establishing relationships with community leaders in these groups.

4. Engage state- and local-level leadership to promote and support the National CLAS Standards at an institutional and community level.
5. Develop and implement a sustainability plan that includes annual evaluation of CLAS competencies and related policies and practices.
6. Establish regularly scheduled CLC trainings, and identify and leverage funding opportunities for CLC professional development.
7. Post the National CLAS Standards in public areas to inform clients of their rights and the center's intent to provide culturally and linguistically competent services.

### ***Standard 3: Recruit, promote, and support a culturally and linguistically diverse governance, leadership, and workforce responsive to the population in the service area***

#### **Purpose**

1. To create an environment in which culturally diverse individuals feel welcome and valued
2. To promote trust and engagement with the communities and populations served
3. To infuse multicultural perspectives into the planning, design, and implementation of CLAS
4. To ensure that diverse viewpoints are represented in governance decisions
5. To increase staff knowledge and experience related to culture and language

#### **Implementation Strategies**

What actions are needed for a health center to recruit and retain diverse individuals that are responsive to the population in the service area?

1. Allocate resources to assist the administration in identifying pools of qualified leadership and staff members who are proportionately representative of the community served.
2. Provide hiring opportunities for education and mental health professionals, through multiple strategies including job fairs, advertisements in listservs and newsletters of national ethnic associations or organizations placing a priority on individuals that are more representative of the community served.
3. Build community trust and engagement by hiring highly qualified education and mental health professionals who are more reflective of local residents.
4. Establish a National CLAS Standards taskforce inclusive of representatives from immigrant families and community advocacy groups to establish goals, objectives, tasks, timelines, quality indicators, and responsible parties to:
  - develop a comprehensive strategic plan for ensuring a diverse, sustainable and inclusive leadership and staff; and,
  - ensure that diverse inclusive opinions are represented in governance decisions.
5. Develop a set of key activities and strategies focused on improving CLAS-driven equity, access, and quality service.

### ***Standard 4: Educate and train governance, leadership, and workforce in culturally and linguistically appropriate policies and practices on an ongoing basis***

#### **Purpose**

1. To prepare, support and sustain a workforce that demonstrates the attitudes, knowledge, and skills necessary to work effectively with diverse populations
2. To increase the capacity of staff to provide culturally and linguistically appropriate services
3. To assess the progress of staff in developing skills in cultural, linguistic, and health literacy competency
4. To foster an individual's right to respect and nondiscrimination by developing and implementing education and training programs that address the impact of culture on health and health care

## Implementation Strategies

How can a health center educate and train its leadership and staff to establish and sustain a workforce that demonstrates the attitudes, knowledge and skills necessary to work effectively with diverse populations?

1. Allocate resources to provide CLAS training, professional development, and tools to service providers, staff, and administration.
2. Allocate resources for new and existing mental health service providers and community stakeholder groups that focus on building collective CLAS competencies and making related policy, procedural, and practice improvements.
3. Consult with professional staff to learn how to respect and integrate cultural beliefs and practices with western practices to improve access, use, and health outcomes; and implement training protocols.
4. Monitor the development in staff, administration, and mental health service provider's competency in delivering culturally and linguistically appropriate practices.
5. Establish policies and procedures to support the rights of patients, their families and community to receive respectful and nondiscriminatory services by developing and implementing education and training programs that address the impact of culture on health and health care.
6. Encourage and support all other service providers to take the same steps internally and hold themselves accountable to do these actions through strategic planning in an effort to improve access, use, and outcome for *all* community members.

## Implementation Examples

### Ohio Department of Mental Health and Addiction Services

*SAMHSA Grant Program: Strategic Prevention Framework for Prescription Drugs (SPF Rx)*

The Ohio Department of Mental Health and Addiction Services (Ohio MHAS) identified disparities in services and access to treatment for prescription drug misuse among its rural and Appalachian communities. To address the issues in its health systems infrastructure, Ohio MHAS formed a workgroup through the Strategic Prevention Framework for Prescription Drugs (SPF-Rx) grant program. The SPF-Rx workgroup collaborated with the State Epidemiological Outcomes Workgroup and local communities to recruit and promote culturally and linguistically diverse local governance that are supportive of the National CLAS Standards.

To ensure leaders of the collaborative workgroups had a platform to support the implementation of the National CLAS Standards, Ohio MHAS developed a Disparities and Cultural

Competency Advisory Committee (DACC). The DACC was comprised of Ohio MHAS program staff as well as community members who could offer a more comprehensive perspective from the local level to ensure that culturally and linguistically appropriate health services were offered to the communities throughout Ohio.

To promote health equity, the Ohio MHAS required communities to utilize a performance management tool when collecting and reporting project-specific data related to the National CLAS Standards. The data allowed Ohio MHAS to monitor and ensure that communities with health services needs were identified and received culturally appropriate services.

## Georgia Department of Behavioral Health and Developmental Disabilities

*SAMHSA Grant Program: Strategic Prevention Framework for Prescription Drugs (SPF Rx)*

The Georgia Department of Behavioral Health and Developmental Disabilities (DBHDD) was addressing prescription drug misuse in the state through the SPF Rx program. Their populations of focus for prevention of substance misuse included 12- to 17-year-old youth and individuals aged 18 and older.

DBHDD ensured that cultural competency was incorporated in all activities to address prescription drug misuse among all communities. DBHDD prioritized training and educating their workforce to successfully implement the National CLAS Standards throughout prevention efforts. DBHDD required SPF Rx project staff to participate in at least four webinars that provided information about the National CLAS Standards and education on disparities among communities. Some webinar topics have included:

- Introduction to the National Standards for CLAS in Health and Health Care
- Culturally and Linguistically Appropriate Services for African American and Hispanic Populations
- Culturally and Linguistically Appropriate Services for LGBT Populations
- Culturally and Linguistically Appropriate Services for Individuals who are HIV Positive

Upon completing the training, adherence to the National CLAS Standards were monitored. Technical assistance (TA) was available to address challenges and issues that may have arisen and additional training was offered to project and partner staff to enhance their capacity to provide culturally and linguistically appropriate services. DBHDD was committed to addressing the needs of all community members by tailoring project training and TA activities on an ongoing basis.

## THEME 2: COMMUNICATION AND LANGUAGE ASSISTANCE

### *Behavioral Health Scenario*

The following scenario relates to the second theme and its associated National CLAS Standards (5-8).

Jacques is a French-speaking 16-year-old male who recently immigrated with his family to the United States, and lives in a low-income, predominately Haitian community in Miami, FL. Jacques's school provides English-as-second-language classes and his improvement is impressive. However, his parents have limited English proficiency (LEP) and depend heavily on Jacques to provide translation and interpretation.

Due to substance related infractions, Jacques is arrested and subsequently court-mandated to attend addictions treatment to avoid placement in a juvenile detention center. The court-mandated clinic lacks French-speaking behavioral health providers, but offers language assistance at a cost. Jacques's parents participate as part of Jacques's treatment, but are unable to afford an interpreter and continue to rely on Jacques for interpretation.

Soon after beginning treatment, while waiting to see his probation officer, Jacques gets a phone call notifying him that his mother is in the emergency room. Frantic and feeling guilt over his mother's poor health, Jacques leaves without notifying his probation officer, but the next day finds there is a warrant out for his arrest. Without his parents' ability to vouch for his whereabouts due to their LEP, Jacques is at risk of entering juvenile detention. Upon Jacques's return to meet

with his probation officer, he explains the events leading to his abrupt departure. Not knowing the medical details of his mother's emergency room visit, he becomes increasingly worried and increasingly stressed, as he fears being separated from them. The probation officer, now understanding the context, refers him to a bilingual psychologist, Dr. St. Claire.

Dr. St. Claire is concerned about the lack of language services provided at the court-mandated addiction clinic and offers to accompany Jacques and his family to the clinic. She informs the clinic of its failure to recognize that Jacques has been acting as an interpreter for his parents. Dr. St. Claire emphasizes that relying on friends and family does not qualify as competent interpretation. Based on her feedback, the clinic administration inspects their print materials, multimedia materials, and signs throughout the office. They discover a widespread lack of culturally and linguistically appropriate materials given the population in their service areas. There is a lack of translated materials in languages commonly used in their communities, a limited variety of modes of communication available to clients to improve health literacy and understanding, and a lack of protocol to facilitate comprehension of, and adherence to, instructions and health plan requirements.

### ***Standard 5: Offer language assistance to individuals who have limited English proficiency and/or other communication needs at no cost to them to facilitate timely access to all health services***

#### **Purpose**

1. To ensure that individuals with LEP and/or other communication needs have equitable access to health services
2. To help individuals understand their care and service options and participate in decisions regarding their health and health care
3. To increase individuals satisfaction and adherence to care and services
4. To improve patient safety and reduce medical error related to miscommunication
5. To help organizations comply with the requirements of such laws as Title VI of the Civil Rights Act of 1964; the Americans with Disabilities Act of 1990; and other relevant federal, state, and local requirements

## Implementation Strategies

How can a hospital/clinic/practice support individuals with LEP and/or other communication needs to have equitable access to behavioral health services?

1. Conduct community needs assessments and Strengths, Weaknesses, Opportunities and Threats (SWOT) analyses to assess the language needs of their patients and family members.
2. Ensure that staff are fully aware of, and trained in, the use of language assistance services, policies and procedures.
3. Develop strategies for identifying the language(s) an individual speaks and add this information to that person's health record.
4. Conduct an internal assessment of organizational capabilities, including the capacity to provide free language interpretation.
5. Use qualified and trained interpreters to facilitate communication, including ensuring the quality of the language skills of self-reported bilingual staff who use their non-English language skills during patient encounters.
6. Recruit and hire qualified bilingual providers/practitioners.
7. Ensure communication with community members is appropriate to diverse linguistic characteristics, including, but not limited to, primary language, literacy skills, and disability status.
8. Assist with community members' access to federally required interpreter services.
9. Plan and implement language access services that are low-cost or, if possible, free of cost.
10. Post signs that inform patients that language assistance services are available.
11. Establish contracts with interpreter services for in-person, over-the-phone, and video remote interpreting.
12. Partner with organizations and community members to ensure training incorporates aspects of cultural humility needed for social flourishing, community resilience and empowerment.

## ***Standard 6: Inform all individuals of the availability of language assistance services clearly and in their preferred language, verbally and in writing***

### Purpose

1. To inform individuals with LEP, in their preferred language, that language services are readily available at no cost to them
2. To facilitate access to language services
3. To help organizations comply with the requirements of such laws as Title VI of the Civil Rights Act of 1964; the Americans with Disabilities Act of 1990; and other relevant federal, state, and local requirements

## Implementation Strategies

To comply with Title VI of the Civil Rights Act of 1964<sup>2</sup> and related laws, what steps can a hospital/clinic/practice take to inform clients and their families of the availability of language assistance services?

1. Develop verbal and written language service notification protocol and training for personnel that describes the type of communication and language assistance available, including telephonic language services, to whom they are available, and the process for identifying patients with LEP and how to connect them to appropriate language services.
2. Place written language service notifications, which are easy to understand at low literacy levels, on the registration desks, in the waiting rooms, and in financial screening rooms.
3. Standardize procedures for personnel who serve as initial point of contact to provide staff with a script to ensure that they inform clients and family members in both verbal and written form of the availability of language assistance and to inquire whether they will need to utilize any of the services available.

<sup>2</sup> Title VI of the Civil Rights Act of 1964 and Executive Order 13166 require that the federal government and those receiving assistance from the federal government must take reasonable steps to ensure that LEP persons have meaningful access to the programs, services, and information those entities provide. For more information, see <https://www.lep.gov/13166/eolep.pdf>.

4. Develop organization policies for cross-communication exchange and interpreter services such as using “I speak” cards written in native languages for patients to indicate their preferred language to personnel upon arrival.
5. Develop and utilize a patient survey tool that identifies and documents the patient’s language preference and type of language services needed (verbal or written), and include it in the patient’s medical files.
6. Ensure all written intake forms clearly state that communication and language assistance is provided by the organization, and whether it is free of charge to individuals.
7. Publicize availability of language assistance services in local foreign language media, such as television channels and newspapers.

***Standard 7: Ensure the competence of individuals providing language assistance, recognizing that the use of untrained individuals and/or minors as interpreters should be avoided***

**Purpose**

1. To provide accurate and effective communication between individuals and providers
2. To reduce misunderstanding, dissatisfaction, the omission of vital information, misdiagnoses, inappropriate treatment, and patient safety issues caused by reliance on staff or individuals lacking interpreter training
3. To empower individuals to negotiate and advocate, on their own behalf, important services through effective and accurate communication with health and health care staff
4. To help organizations comply with the requirements of such laws as Title VI of the Civil Rights Act of 1964; the Americans with Disabilities Act of 1990; and other relevant federal, state, and local requirements

**Implementation Strategies**

To comply with Title VI of the Civil Rights Act of 1964 and related laws, what language assistance strategies can a hospital/clinic/practice implement to provide interpretation and translation services and ensure the competence of individuals providing language assistance?

1. Establish policies that recognize interpreting in a mental health situation is a specialized skill, even for experienced healthcare interpreters. Interpretation requires knowledge of culture, including an understanding of the idioms used to express emotions. [The National Council on Interpreting in Health Care](#) offers resources on mental health care in translation.
2. Develop a process for ensuring the availability of qualified individuals who can provide language assistance services based on the language, hearing and visual needs of the district. These individuals should meet the standards established by interpreting professional organizations such as the American Translators Association, National Council on Interpreting in Health Care or in the Registry of Interpreters for the Deaf for American Sign Language.
3. Partner with certifying agencies for healthcare interpreters, or language companies for training individuals in providing language assistance. Interpreter services can also be found in registries maintained by national/international organizations such as:
  - [American Translators Association](#)
  - [National Board of Certified Medical Interpreters](#)
  - [Certification Commission for Healthcare Interpreters](#)
  - [Registry of Interpreters for the Deaf](#)
4. Develop and administer a survey to assess personnel’s rating of the interpreter services offered and if they can recognize when a patient is using an untrained interpreter (e.g., minor, family member).
5. Employ a “multifaceted model” of language assistance. Provide language assistance in a variety of models, including bilingual staff, dedicated language assistance (e.g., a contract interpreter), telephone or digital technology.
6. Partner with the foreign language, public health education, and communication departments of local colleges and universities to identify and utilize faculty members and/or advanced/graduate students who can be/are trained to serve as interpreters and translators. Independent study credits for health education and health promotion can be offered to reduce the costs to the clinic.

7. Develop a strategy to ensure the staff who wish to communicate in a language other than English are trained and tested.
8. Hire qualified mental health translators to translate all materials into the languages used in the area.
9. Engage community members to do the translation, including dialects used among the community to create and sustain community partnerships to address behavioral health issues.
10. Track how often interpretation is done by untrained interpreters (e.g., staff members, patient's family or friends, etc.) as part of quality improvement monitoring.

### ***Standard 8: Provide easy-to-understand print and multimedia materials and signage in the languages commonly used by populations in the service area***

#### **Purpose**

1. To ensure that readers of other languages and individuals of various health literacy levels are able to access care and services
2. To provide access to health-related information and facilitate comprehension of and adherence to instructions and health plan requirements
3. To enable all individuals to make informed decisions regarding their health, health care, and service options
4. To offer an effective way to communicate with large numbers of people and supplement information provided orally by staff members
5. To help organizations comply with requirements such as Title VI of the Civil Rights Act of 1964; the Americans with Disabilities Act of 1990; and other relevant federal, state, and local requirement

#### **Implementation Strategies**

To comply with Title VI of the Civil Rights Act of 1964 and related laws, what strategies can a hospital/clinic/practice implement to provide easy-to-understand materials and signage?

1. Conduct ongoing needs assessments of the cultural and linguistic appropriateness of the communication and language assistance.
2. Develop and administer patient and staff surveys to assess the literacy levels of educational materials and the variety/quality of translated languages used in educational materials. Assessment tools like CDC's [Clear Communication Index](#) and AHRQ's [Patient Education Materials Assessment Tool](#) can also be used for English-only materials.
3. Develop protocols to evaluate the print and multimedia materials and signage used that are responsive to the populations served by using easy-to-understand language.
4. Develop protocols to establish a standard for the availability of copies of important documents in languages other than English. Protocols should also include provisions for sight translation where an interpreter explains an English form on the spot to a patient. The National Council on Interpreting in Health Care offers [guidelines for sight and written translation for healthcare interpreters](#).
5. Conduct ongoing assessments of staff and personnel of the understanding and availability of patient's educational materials and the cultural and linguistic appropriateness of signs and maps.
6. Promote translated print and multimedia materials and language assistance signage to all patients and families, and supplement written information with oral translation by trained staff members when needed.

## Implementation Examples

### BestSelf Behavioral Health

*SAMHSA Grant Program: Primary and Behavioral Health Care Integration (PBHCI)*

BestSelf Behavioral Health (BBH) is a community behavioral health organization that serves adults and children, located in Buffalo, New York. BBH championed the National CLAS Standards through implementing a variety of activities and interventions. They practiced person-centered care, which incorporated an understanding of diverse cultural and language needs. BBH's populations of focus included underserved communities, specifically Latino/Hispanic, African Americans, and a growing number of immigrants.

BBH encouraged clients to feel comfortable by learning about their behavioral health in their preferred language. Clients were made aware of the availability of verbal and written communication in their preferred language upon contacting BBH. Forms were translated into different languages to ensure that clients were able to understand the information that was being shared.

If clients met with a behavioral health specialist and required an interpreter, BBH provided an interpreter onsite. If no one was available to provide the necessary services onsite, then an offsite interpreter was brought in to meet with the client. If no one was available to meet in-person, a language line—where a conversation is conducted by phone with a trained interpreter—was used. The main languages used in the organization were English and Spanish. Arabic and other languages were requested due to an increase in refugee populations. To respond to the rapid change, there had been an emphasis on employing bicultural and bilingual individuals who were proficient in their languages.

BBH also provided cultural competency training for new employees at orientation. A cultural competency committee ensured that culturally and linguistically appropriate services were meeting the needs of the clients.

### Ohio Department of Mental Health and Addiction Services and Bhutanese Nepali Community of Columbus\*

*National Network to Eliminate Disparities in Behavioral Health (NNED) Member*

In an effort to enhance behavioral health care utilization in the Bhutanese Nepali community, several key service organizations in Ohio, including the Ohio Department of Mental Health and Addiction Services (Ohio MHAS) and the Bhutanese Nepali Community of Columbus, collaborated to translate the Five Signs of Emotional Suffering. The Five Signs of Emotional Suffering served as a toolkit for the Bhutanese Nepali community to identify emotional suffering in a timely matter and connect their loved ones to appropriate services. The Five Signs of Emotional Suffering framework was translated to Nepali, using culturally appropriate definitions, emoticons, and explanations of emotional suffering.

The collaborative efforts ensured the translation would effectively engage the Bhutanese Nepali community by avoiding complicated terminology and choosing culturally and linguistically appropriate terms. Once the translation phase was completed, the document was thoroughly vetted and discussed in focus groups that were representative of the Bhutanese Nepali population at risk for mental health issues, including bilingual Bhutanese Nepali- and English-speaking seniors and young adults.

The focus population of Bhutanese Nepali seniors and young adults were identified as highly vulnerable to negative health outcomes in an epidemiological study in Ohio. In 2015, researchers found symptoms of emotional suffering most common in middle-aged men and seniors in Bhutanese Nepali communities, and determined it was critical to engage them in a timely manner to connect them with appropriate services.

*\*Since this effort the name of the organization has changed from the Bhutanese Nepali Community of Columbus to the Bhutanese Community of Central Ohio.*

## THEME 3: ENGAGEMENT, CONTINUOUS IMPROVEMENT, AND ACCOUNTABILITY

### *Behavioral Health Scenario*

The following scenario relates to the third theme and its associated National CLAS Standards (9-15).

An established Midwest community health center received a federal grant to serve a community experiencing behavioral health challenges. Over the past three years, the center began noticing concerning trends including an increase in the number of youth suicide attempts and completions, along with a steep but steady decrease in its services use.

To address these concerning trends, the center decided to create a subcommittee to plan and execute a community service assessment comprising a needs and assets assessment, a resource inventory, and a gap analysis with particular attention given to the context in which the suicide attempts had taken place. Some of the challenges the center faced were 1) how to access and serve community members in a culturally and linguistically competent manner; 2) who to include as members of the subcommittee; 3) how to accurately collect the demographic information of individuals served across its various services; 4) how to measure the services improvements as they start to make changes; and 5) how to do all this in a continuous and sustainable manner.

For assistance, the center reached out to local cultural leaders and native healers as consultants. Additional organizations, associations, and other entities representing diverse cultural groups were invited to discuss the cluster of suicide attempts and completions. Community members' experiences and perspectives were gathered through

qualitative (i.e., focus groups) and quantitative data (i.e., surveys and records). For some groups, this was the first time their opinions and guidance were requested and valued for community problem solving.

The assessment identified that 1) the community was growing increasingly diverse and was comprised of Whites, African Americans, American Indians, and Latinx residents; 2) the center had not diversified its services to meet the needs of the changing demographics; 3) the suicide attempts of Latina adolescents and the completed suicide rates of male American Indian youth were disproportionately high; and 4) community members lacked trust that their needs would be adequately met based on past negative experiences including limited availability of translated materials and interpretation services and feeling judged due to financial barriers. Due to the absence of a conflict and grievance resolution process, community members were left without a voice and felt discouraged to seek additional services.

Although community members believed that their participation in this needs assessment was an important one, they were unsure if their perspectives would be taken into consideration, if they would be able to see any differences in accessing services with the center, and if they would ever hear from the center again.

### *Standard 9: Infuse CLAS goals, policies, and management accountability throughout an organization's planning and operations*

#### **Purpose**

1. To make CLAS central to the organization's service, administrative, and supportive functions
2. To integrate CLAS throughout the organization (including the mission) and highlight its importance through specific goals
3. To link CLAS to other organizational activities, including policy, procedures, and decision making related to outcomes accountability

#### **Implementation Strategies**

To comply with Title VI of the Civil Rights Act of 1964 and related laws, what are some comprehensive strategies to infuse CLAS goals, policies, and management accountability throughout a community health center's planning and operations?

1. Develop a patient assessment form that considers the patient's holistic health needs related, but not limited to cultural and religious beliefs, socio-emotional needs and considerations, desire and motivation to learn, physical or cognitive limitations, or barriers to communication.
2. Develop a protocol to use the assessment form to inform the comprehensive Cultural and Linguistic Competence (CLC) plan.
3. Identify a CLC Lead Coordinator.
4. Convene and support a CLC Committee to develop CLC policies and procedures, as part of the governance structure, that includes representatives from the communities to be served (e.g., youth, family, and providers), and key partners.
5. Develop a CLC/CLAS strategy through a series of actions regarding the infusion and implementation of CLC as an iterative, developmental process reflecting the importance of a team approach and shared responsibilities. Its purpose is to facilitate the development and integration of CLAS and CLC. See [A Treatment Improvement Protocol Improving Cultural Competence](#) (TIP 59) for additional details.
6. Coordinate the implementation of the community team's CLC organizational self-assessment. Provide information and consultation about the community's CLC strengths, challenges, and opportunities; and include information about the community's linguistic diversity.
7. Convene a comprehensive continuous quality improvement process team where the evaluator and other team members address and assess local disparities and disproportionalities identified in the community needs assessment—where the population of focus resides.
8. Ensure CLC Committee participates in the:
  - hiring process by developing interview questions and participating in interviews, to ensure proportionate representation that reflects the population to be served both culturally and linguistically.
  - writing/editing of contracts/subcontracts/memoranda of understanding to ensure that CLC is addressed, especially in expectations and performance indicators/measures.
  - process for designing performance appraisals and the performance appraisal for staff by incorporating CLC-related performance indicators/measures, which can later be used to achieve standard 10.
  - activities for developing a culturally and linguistically competent workplace, including processes, policies, procedures, practices, and evaluation.
9. Engage the administrative team in the CLC self-assessment process as a professional development tool to assess strengths, areas of improvement and needs. Address any needs through coaching, training, information and resource sharing, and TA.
10. Develop a plan to follow up on the results of the CLC self- and organizational assessment and community needs assessment.
11. Develop CLC professional development goals and performance measures for staff.

### ***Standard 10: Conduct ongoing assessments of an organization's CLAS-related activities and integrate CLAS-related measures into measurement and continuous quality improvement activities***

#### **Purpose**

1. To assess performance and monitor progress in implementing the National CLAS Standards
2. To obtain information about the organization and the people it serves to tailor and improve services
3. To assess the value of CLAS-related activities relative to the fulfillment of governance, leadership, and workforce responsibilities

#### **Implementation Strategies**

What quality improvement strategies can a community health center promote to assess and improve CLAS-related services in support for their diverse population?

1. Conduct an organizational needs assessment using existing cultural and linguistic competency (CLC) assessment tools to inventory structural policies, procedures, and practices. These tools can provide guidance to determine whether the core structures and processes, such as management, governance, delivery systems, and customer relation functions necessary for providing CLAS are in place.

2. Use results from CLC assessments to identify assets (e.g., existing relationships with community-based ethnic organizations and leaders), risks (e.g., no translated signage or CLC training), and opportunities to improve the organization's structural framework and capacity to address CLC in care (e.g., revise mission statement)
3. Develop CLAS policies/management procedures following the CLC assessment. Ensure protocols are in place for subsequent ongoing CLC assessment to help organizations monitor their progress in refining their strategic plans.
4. Conduct assessment of client/patient feedback through a survey of services (e.g. interpreter, provider CLC, physical space, attention to care etc.). The client/patient feedback can provide a measure of patient experiences integral to improving and ensuring the care provided is high quality and tailored for individuals a center serves.

### ***Standard 11: Collect and maintain accurate and reliable demographic data to monitor and evaluate the impact of CLAS on health equity and outcomes and to inform service delivery***

#### **Purpose**

1. To accurately identify population groups within a service area
2. To monitor individual needs, access, utilization, quality of care, and outcome patterns
3. To ensure equitable allocation of organizational resources
4. To improve service planning to enhance access and coordination of care
5. To assess and improve to what extent health care services are provided equitably

#### **Implementation Strategies**

What steps can the subcommittee take to accomplish the task of developing a comprehensive data collection system?

1. Develop protocols to streamline data collection processes across agencies to ensure that data are not fragmented or poorly integrated, modify and streamline data collection instruments, and create standardized demographic data collection instruments, taking into account the [HHS Data Collection Standards](#).
2. Identify how individual data collection methods and instruments can be modified to align more closely with the National CLAS standards (see pages 109 and 110 in the [Blueprint for Advancing and Sustaining CLAS Policy and Practice](#)).
3. Work with the community members to identify the racial, ethnic, gender, language, sexual orientation, gender identity and disability status categories most relevant to the community.
4. Identify and train data collection personnel in CLC.
5. Identify and develop data-sharing mechanisms that adhere to confidentiality requirements, including the utilization of health information technology, quality assurance and accountability measures.
6. Develop a process that can facilitate client self-identification versus staff observation and visual determinations.
7. Develop Memoranda of Agreements related to data collection and sharing.
8. Develop a plan to use demographic data in concert with service and quality care data for evaluation and continuous quality improvement activities.
9. Use a validated and reliable CLC behavioral health organization self-assessment tool to inform continuous quality improvement. Refer to the [Evaluation of the National CLAS Standards toolkit \(https://minorityhealth.hhs.gov/assets/PDF/Evaluation\\_of\\_the\\_Natn\\_CLAS\\_Standards\\_Toolkit\\_PR3599\\_final.508Compliant.pdf\)](https://minorityhealth.hhs.gov/assets/PDF/Evaluation_of_the_Natn_CLAS_Standards_Toolkit_PR3599_final.508Compliant.pdf) for a guide to evaluating the implementation of the National CLAS Standards.

## ***Standard 12: Conduct regular assessments of community health assets and needs and use the results to plan and implement services that respond to the cultural and linguistic diversity of populations in the service area***

### **Purpose**

1. To determine the service assets and needs of the populations in service areas (needs assessment)
2. To identify all services available and unavailable to populations in the service areas (resource inventory and gap analysis)
3. To determine which services to provide and how to implement them, based on the results of the community assessment
4. To ensure that health and health care organizations obtain demographic, cultural, linguistic, and epidemiological baseline data (quantitative and qualitative), and update the data regularly to better understand the populations in their service areas

### **Implementation Strategies**

What steps can a community health center take to address the cultural and linguistic needs of a diverse population in a behavioral health service area?

1. Establish a coalition that includes representatives of the community to develop and conduct a comprehensive community service assessment to assess the behavioral health needs, prevention/early identification/intervention resources, and gaps.
2. Analyze quantitative data from the assessment and the qualitative data from the consultations with cultural leaders to inform culturally appropriate services that meet the unique needs of its diverse youth population.
3. Partner with the different systems to negotiate data-sharing agreements to provide as many data points as possible to inform the process.
4. Collaborate with a local university to analyze assessment data, disaggregated by race, ethnicity, gender, language, sexual orientation, gender identity, and disability status.
5. Identify disparities or disproportionalities from the disaggregated data through a community participatory effort.
6. Invite cultural leaders and healers from the communities-at-large to inform the coalition about the historical and current cultural underpinnings that contribute to this behavior, and to inform the community's efforts to develop culturally and linguistically appropriate interventions, in order to be inclusive, representative and critical of the intersectionality present in the diverse community.

## ***Standard 13: Partner with a community to design, implement, and evaluate policies, practices, and services to ensure cultural and linguistic appropriateness***

### **Purpose**

1. To provide responsive and appropriate service delivery to a community
2. To ensure that services are informed and guided by community interests, expertise, and needs
3. To increase the use of services by engaging individuals and groups in the community in the design and improvement of services to meet their needs and desires
4. To create an organizational culture that leads to more responsive, efficient, and effective services and accountability to the community
5. To empower members of the community to become active participants in the health and health care process

### **Implementation Strategies**

What steps can a community health center take to include the voice of all sectors of a diverse community in determining cultural and linguistic appropriateness?

1. Engage all sectors of the community from the beginning and throughout the process in identifying the issues, planning the process, designing the approach and interventions, implementing the recommendations, and evaluating the policies and practices to ensure a culturally and linguistically good fit.

2. Listen to the community, especially those who have never been included in discussions or decisions about solutions to community challenges—particularly those involving behavioral health issues.
3. Value the general community’s experience and expertise in resolving complex issues because all sectors of the community—not only those in possession of authority, power, or academic knowledge—are equally valuable for developing solutions.
4. Evaluate existing behavioral health policies that affect funding, research, practice, or evaluation to determine whether they are producing the intended outcome; if they are not, work to change them so they do.
5. Assess areas that lack policies and, with partners, develop new policies and work to enact them if the existing ones are ineffective.
6. Identify “cultural brokers” that are known and trusted members of the community, to serve as a bridge between the community where they are trusted and the agencies, organizations, and systems that provide services. For example, in Spanish-speaking communities, *promotores de salud* or community health workers are indispensable members of a behavioral health team because they are also trusted members of the community who share the language, culture, customs, and values of the people they work with and can share valuable and potentially life-saving behavioral health information.

### ***Standard 14: Create conflict and grievance resolution processes that are culturally and linguistically appropriate to identify, prevent, and resolve conflicts or complaints***

#### **Purpose**

1. To facilitate open and transparent two-way communication and feedback mechanisms between individuals and organizations
2. To anticipate, identify, and respond to cross-cultural needs
3. To meet federal and/or state-level regulations that address topics such as grievance procedures, the use of ombudspersons, and discrimination policies and procedures

#### **Implementation Strategies**

What steps can a community health center take to communicate progress in implementing and sustaining CLAS?

1. Establish an advisory board with representatives from partner organizations, and key community based offices with representatives from underserved populations, including local African American, Latinx, and sexual and gender minority organizations.
2. Convene advisory board to discuss issues affecting the diverse communities and address identified disparities in services experienced by the African Americans, Latinx, and sexual and gender minority youth and adults.
3. Prepare data fact-sheets containing current community data, disaggregated by underserved demographic groups and distribute to all advisory board members for review, prior to each meeting. During meetings, encourage all members to brainstorm and produce recommendations to improve practice in areas of need and craft messages for the community’s social marketing strategies, tailored to the focus population.
4. Develop and distribute short memos, on a quarterly basis, that summarize agency-level efforts to provide CLAS in the community. Design memos in appropriate languages that are easy to understand and are aligned with Standard 8 strategies. Include demographic data on subpopulations, summaries of related staff competency trainings, results from the community assessment (Standard 10), and a synthesis of issues and complaints from consumers (Standard 14). And, distribute memos throughout agency and community-based organization listservs, to be shared at management meetings. Additionally, post memos on agency websites for public access.
5. Host a biannual community forum that is open to the general public to review progress and needs, and arrange to have the forum broadcast online, on local public access television or a similar venue to reach community members that are unable to attend. Each forum could provide written materials for service providers as well as youth and families that come from diverse backgrounds to address issues related to public health and primary care.

## **Standard 15: Communicate the organization's progress in implementing and sustaining CLAS to all stakeholders, constituents, and the general public**

### **Purpose**

1. To convey information to intended audiences about efforts and accomplishments in meeting the National CLAS Standards
2. To learn from other organizations about new ideas and successful approaches to implementing the National CLAS Standards
3. To build and sustain communication on CLAS priorities and foster trust between the community and the service setting
4. To meet community benefit and other reporting requirements, including accountability for meeting health care objectives for addressing the needs of diverse individuals or groups

### **Implementation Strategies**

What steps can a community health center take to communicate progress in implementing and sustaining CLAS?

1. What steps can a community health center take to communicate progress in implementing and sustaining CLAS?
2. Establish an advisory board with representatives from partner organizations, and key community based offices with representatives from underserved populations, including local African American, Latinx, and sexual and gender minority organizations.
3. Convene advisory board to discuss issues affecting the diverse communities and address identified disparities in services experienced by the African Americans, Latinx, and sexual and gender minority youth and adults.
4. Prepare data fact-sheets containing current community data, disaggregated by underserved demographic groups and distribute to all advisory board members for review, prior to each meeting. During meetings, encourage all members to brainstorm and produce recommendations to improve practice in areas of need and craft messages for the community's social marketing strategies, tailored to the focus population.
5. Develop and distribute short memos, on a quarterly basis, that summarize agency-level efforts to provide culturally and linguistically appropriate services in the community. Design memos in appropriate languages that are easy to understand and are aligned with Standard 8 strategies. Include demographic data on subpopulations, summaries of related staff competency trainings, results from the community assessment (Standard 10), and a synthesis of issues and complaints from consumers (Standard 14). And, distribute memos throughout agency and community-based organization listservs, to be shared at management meetings. Additionally, post memos on agency websites for public access.
6. Host a biannual community forum that is open to the general public to review progress and needs, and arrange to have the forum broadcast online, on local public access television or a similar venue to reach community members that are unable to attend. Each forum could provide written materials for service providers as well as youth and families that come from diverse backgrounds to address issues related to public health and primary care.

## Implementation Examples

### Preferred Family Healthcare, Dayspring Community Services

*National Network to Eliminate Disparities in Behavioral Health (NNED) Member*

Dayspring Community Services (DCS) is a division of Preferred Family Healthcare that operates behavioral health clinics across Oklahoma and offers a variety of behavioral health services. DCS ensures the services delivered meet the cultural and linguistic needs of their clients by utilizing the “Credible Behavioral Software” system to collect accurate and reliable demographic data. DCS carefully analyzes the demographics of their clients to inform their recruitment of competent providers who reflect the community they serve and the selection of peer support or family specialists that can relate to clients through shared personal experience.

Demographic data revealed the majority of these clients are of Mexican descent and prefer to discuss health-related matters in Spanish, and the DCS workforce mirrored the language and cultural background of this population. In a detailed analysis of population trends in school districts, the community in Jenks, Oklahoma was identified to have an increasing Burmese population requiring services. To address the needs of the increasing immigrant population, DCS collaborated with Title III administrators from various school districts in Oklahoma to hire staff from the community that were fluent in Burmese and Zomi, a dialect in Burma (also referred to as Zou), to better engage and serve the Burmese population more efficiently and with cultural understanding.

In summary, the “Credible Behavioral Software” system allowed providers to collect data on the client’s ethnicity, disability, level of education, geographic location, and language preference, and analyze their overall client population to identify sub-populations of need. DCS identified and responded to a rural area where CLAS were lacking, and through continuous surveillance, they can identify future geographic locations of need in their community.

### S:US Services for the Underserved

*National Network to Eliminate Disparities in Behavioral Health (NNED) Member*

Services for the Underserved (S:US) is a non-profit organization in New York City that serves people living with disabilities, in poverty, and facing homelessness. In an effort to deliver quality services, the organization established a conflict and grievance-resolution process. As part of the process, consumers were frequently asked to provide feedback about interactions with staff. The feedback was collected through face-to-face conversations, consumer advisory board meetings, comment boxes, and annual anonymous surveys. This process enabled the organization to effectively resolve complaints and conflicts and ensure their consumers felt respected and their concerns were being considered.

In the city, Latinx are the majority population. To meet the linguistic needs of their community, S:US developed translated surveys and comment forms in Spanish. Client handbooks and employee booklets were also made available in Spanish to ensure staff members could effectively connect consumers to services the organization provided, to resources around the community, and to information about the process for conflict and grievance resolution. When a language other than Spanish was requested, interpreters provided their services in person or via a phone line.

In most cases, complaints were addressed by the clinical director who is bilingual in Spanish and English. S:US had also established a Quality Assurance (QA) department for consumers who wished to file a complaint via email or phone. The QA Department was staffed with Spanish bilingual staff who initiated the investigations and addressed complaints by providing recommendations to resolve the conflict.

The federal recognition of S:US as a Certified Community Behavioral Health Clinic allowed the organization to hire more peer specialists and targeted case managers. Peer specialists who work in the clinic and directly with the community attended advisory board meetings to communicate the concerns and grievances of the consumers to the team. This increase in peer specialists and targeted case managers enabled S:US to better address the consumers’ conflicts and complaints to provide culturally appropriate care to all.

## REFERENCES AND RESOURCES

- Beach, M. C., Cooper, L. A., Robinson, K. A., Price, E. G., Gary, T. L., Jenckes, M. W., Powe, N.R. (2004). Strategies for improving minority healthcare quality. (AHRQ Publication No. 04-E008-02). Retrieved from: <https://www.ncbi.nlm.nih.gov/books/NBK11918/>
- Dixon, A. (2002). Culturally competent practices with children and youth who have serious emotional disturbance. In D. T. Marsh & M. A. Fristad (Eds.), *Handbook of serious emotional disturbances in children and adolescents* (pp. 77–92). New York, NY: Wiley. Retrieved from [http://books.google.com/books?hl=en&lr=&id=tBjGKDQ\\_nvsC&oi=fnd&pg=PA77&dq=language+barriers+in+partial+hospitalization+schools&ots=2r8Dh\\_h7t0&sig=KzcTVLC3LRlzb8sBiRa1AbWk3xs#v=onepage&q&f=false](http://books.google.com/books?hl=en&lr=&id=tBjGKDQ_nvsC&oi=fnd&pg=PA77&dq=language+barriers+in+partial+hospitalization+schools&ots=2r8Dh_h7t0&sig=KzcTVLC3LRlzb8sBiRa1AbWk3xs#v=onepage&q&f=false)
- Goode, T. D., Dunne, M. C., & Bronheim, S. M. (2006). The evidence base for cultural and linguistic competency in health care. (Commonwealth Fund Publication No. 962). Retrieved from The Commonwealth Fund website: <https://www.commonwealthfund.org/publications/fund-reports/2006/oct/evidence-base-cultural-and-linguistic-competency-health-care>
- Kalyanpur, M., Harry, B., & Skrtic, T. (2000). Equity and advocacy expectations of culturally diverse families' participation in special education. *International Journal of Disability, Development and Education*, 47(2), 119–136. Retrieved from [https://www.researchgate.net/publication/249003018\\_Equity\\_and\\_Avocacy\\_Expectations\\_of\\_Culturally\\_Diverse\\_Families\\_Participation\\_in\\_Special\\_Education](https://www.researchgate.net/publication/249003018_Equity_and_Avocacy_Expectations_of_Culturally_Diverse_Families_Participation_in_Special_Education)
- Landsberger, S. A., & Diaz, D. (2010). Inpatient psychiatric treatment of deaf adults: Demographic and diagnostic comparisons with hearing inpatients—Brief report, *Psychiatryonline*. Retrieved from <https://ps.psychiatryonline.org/doi/full/10.1176/ps.2010.61.2.196>
- Martinez, K., Francis, K., Poirier, J., Ornelas, R., Cayce, N., SooHoo, J., Johnson, A. (2010). A system of care team guide to implementing cultural and linguistic competence. Technical Assistance Partnership for Child and Family Mental Health. Retrieved from <https://ps.psychiatryonline.org/doi/full/10.1176/ps.2010.61.2.196>
- Martinez, K., Francis, K., Poirier, J. M., Brown, L. D., Jr., & Wang, M. (2013). A blueprint for using data to reduce disparities/disproportionalities in human services and behavioral health care. Washington, DC: Technical Assistance Partnership for Child and Family Mental Health. Retrieved from <https://www.air.org/resource/blueprint-using-data-reduce-disparities-disproportionalities-human-services-and-behavioral>
- National Center for Cultural Competence, Georgetown University Center for Child and Human Development, Georgetown University Medical Center. (2004). Bridging the cultural divide in health care settings: The essential role of the cultural broker programs. Retrieved from [https://nccc.georgetown.edu/culturalbroker/Cultural\\_Broker\\_EN.pdf](https://nccc.georgetown.edu/culturalbroker/Cultural_Broker_EN.pdf)
- Office of Minority Health, U.S. Department of Health & Human Services. (2013). A Blueprint for Advancing and Sustaining CLAS Policy and Practice. Retrieved from <https://www.thinkculturalhealth.hhs.gov/clas/blueprint>
- Office of Minority Health, U.S. Department of Health and Human Services. (2019). Improving Cultural Competency for Behavioral Health Professionals. Available at: <https://thinkculturalhealth.hhs.gov/education/behavioral-health>.
- Office of Minority Health, U.S. Department of Health and Human Services. (2018). Evaluation of the National CLAS Standards: Tips and Resources. Retrieved from: [https://minorityhealth.hhs.gov/assets/PDF/Evaluation\\_of\\_the\\_Natn\\_CLAS\\_Standards\\_Toolkit\\_PR3599\\_final.508Compliant.pdf](https://minorityhealth.hhs.gov/assets/PDF/Evaluation_of_the_Natn_CLAS_Standards_Toolkit_PR3599_final.508Compliant.pdf).
- Office of Minority Health, U.S. Department of Health and Human Services. (2019). An Implementation Checklist for the National CLAS Standards. Retrieved from <https://thinkculturalhealth.hhs.gov/assets/pdfs/AnImplementationChecklistfortheNationalCLASStandards.pdf>.
- Office of Minority Health, U.S. Department of Health & Human Services. (2011). National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health Care. Retrieved from <https://www.thinkculturalhealth.hhs.gov/clas/standards>
- Office of Minority Health, U.S. Department of Health & Human Services. (2004). Think Cultural Health. Retrieved from <https://www.thinkculturalhealth.hhs.gov>
- Stroul, B. A., & Blau, G. M., (Eds.). (2008). *The system of care handbook: Transforming mental health services for children, youth and families*. Baltimore, MD: Brooks Publishing.
- Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services. (2016). Increasing Cultural Competence to Reduce Behavioral Health Disparities. Retrieved from [https://www.sprc.org/sites/default/files/resource-program/CAPT\\_Increasing-cultural-competence-reduce-behavioral-hd2016.pdf](https://www.sprc.org/sites/default/files/resource-program/CAPT_Increasing-cultural-competence-reduce-behavioral-hd2016.pdf).