AAPCHO

Cultural Language Access Standards in Asian American, Native Hawaiian and Pacific Islander Serving Health Centers: 2016 Survey Report

Established in 1987, the Associations of Asian Pacific Community Health Organizations (AAPCHO) is a national association of 35 community health organizations dedicated to promoting advocacy, collaboration and leadership that improves the health status and access of Asian Americans, Native Hawaiians, and Pacific Islanders (AA&NHPIs) in the United States and its territories.

We would like to acknowledge and thank staff at participating AA&NHPI-serving health centers and AAPCHO that contributed to this survey.

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To meet the needs of increasingly diverse patient populations, health centers must continually work on providing culturally and linguistically appropriate services. The National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care, developed by the Department of Health and Human Services (HHS), provide a robust framework for health care organizations to implement services that advance health equity, improve quality, and help eliminate health disparities.

The National CLAS Standards were first published in 2000, and then revised in 2013. Health centers that are funded by the Health Resources and Services Administration (HRSA) as Health Center Program grantees already address some of the National CLAS Standards simply by meeting the program requirements.

Asian American, Native Hawaiians and Pacific Islanders (AA&NHPIs) are among the fastest growing racial/ethnic groups projected to triple in size between 2005 and 2050.[1] AA&NHPI patients receiving care at health centers have increased 114% between 2006 and 2015.[2] AA&NHPIs are diverse in their culture, language and health needs, representing more than 50 ethnic groups and over 100 languages.

Coming from different backgrounds and origins, this population faces unique and significant social, emotional and physical health burdens due to deficits in many of the social determinants of health (SDH) (e.g., poverty, limited English proficiency, education, health insurance status). AA&NHPIs are more likely to live below 100% of Federal Poverty Level (FPL) than non-Hispanic Whites,

with almost three-quarters of AA&NHPIs living below 200% of FPL. About two-thirds of AA&NHPIs are foreign born compared to 10% of the U.S. population.[3] In general, AA&NHPIs are less likely to utilize health care and to participate in health programs for which they are eligible compared with other racial groups leading to significant health disparities. These include less access to care, less satisfaction with care, fewer screening and preventive services, poorer quality care, and higher disease incidence of liver cancer, tuberculosis, certain cancers and heart disease, compared with non-Hispanic whites.

AA&NHPIs receiving care in the health center setting face significant disparities in health outcomes and access to quality health care due to language and cultural barriers. The provision of culturally and linguistically appropriate services (CLAS) is a critical strategy in working towards the reduction and elimination of health disparities. Best practices in the application of CLAS in the health center setting ensure not only culturally and linguistically competent workforce development, but a standard of care that is readily adaptive and efficient in meeting the compounding language and cultural needs of AA&NHPI health center patients.

1. http://www.pewhispanic.org/2008/02/11/us-population-projections-2005-2050/. Accessed May 26, 2015.
2. HRSA, 2015 Health Center Data, http://bphc.hrsa.gov/uds/datacenter.aspx?q=tall&year=2015&state=. Accessed November 10, 2016.
3. Ye, J, Mack D, Fry-Johnson Y, Parker, K. Health Care Access and Utilization among US-born and foreign-born Asian Americans. J Immigr Minor Health. 2012; 14 (5): 731-7.

The AAPCHO CLAS Survey for AA&NHPI Serving health centers was designed as a first step in beginning to assess the specific cultural and language access policies, practices, and services provided by health centers. The survey was implemented specifically with health centers that reported serving more 5% or more AA&NHPI patients in UDS 2014. Survey questions were prioritized into the following four distinct CLAS focal areas:

1. Governance, Leadership, and Workforce
2. Language Access Services
3. Data Collection and Assessment
4. Community Engagement and Partnership

The information from the survey will allow AAPCHO to identify documented policies and organizational practices that exist among AA&NHPI serving health centers used to improve the quality of care and health outcomes for AA&NHPI serving health center patients. The lessons learned from this survey assist in identifying a baseline of practices and policies by which CLAS is achieved for AA&NHPI populations.

Defining AA&NHPI-Serving Health Centers

From the 2014 dataset of 1,278 health centers, a total of 123 were identified as AA&NHPI-serving health centers. AAPCHO defines AA&NHPI-serving health centers are those that serve at least 5% or more AA&NHPIs, totaling at least 1,000 AA&NHPIs. The minimum threshold of 5% was selected because it represents the total proportion of Asian Americans (4.8%, 3.8%) plus Native Hawaiians and Pacific Islanders (0.2%, 1.2%) according to Census 2010 US population and UDS 2014 data, respectively.

DATASET

For this report, we examined data from the Uniform Data System (UDS) maintained by the Bureau of Primary Health Care (BPHC) within HRSA, provided to us on September 2, 2015. All HRSA-supported health centers are required to report on their performance to UDS annually. UDS contains a core set of information on the operation and performance of health centers. The total number of health centers reporting to UDS in 2014 was 1,278.

DEVELOPMENT OF SURVEY

An advisory group was first formed to clarify the purpose of the AAPCHO CLAS Survey for AA&NHPI Serving Health Centers. The group consisted of a cross-section of leadership representing AA&NHPI serving health center leaders, primary care association leadership, and health advocates with expertise and experience working with and advocating on behalf of AA&NHPI, multilingual, communities of color.

The advisory group prioritized a need to begin to assess the current status of AA&NHPI serving health centers in accordance with CLAS focal areas by taking a deeper look into documented standards of care, policies, and practices. The advisory group was consulted on the survey design and target sample.

IMPLEMENTATION OF SURVEY

AAPCHO examined data from the UDS maintained by the BPHC within HRSA to identify AA&NHPI-serving health centers (see definition above). Also in practice, serving a subpopulation larger than 1000 will have an impact on the health center's resource allocation for culturally competent services. To ensure we included smaller AA&NHPI serving health centers, we also included those that served at least 25% of AA&NHPIs but that did not

reach the threshold of 1000. There were a total of 123 health centers that met the criteria that were contacted to participate in the survey.

AAPCHO contacted senior leadership including Chief Executive Officers, Chief Financial Officers, medical directors and UDS points of contact to ultimately achieve a response rate of 25% for the survey. Of the 123 health centers that were surveyed for this study, 31 (25%) provided responses. Responses to survey questions addressed four CLAS (4) categories:

1. **Governance, Leadership, and Workforce** refers to a health center's organizational structure related to policies, procedures, trainings, and goals to develop and maintain a culturally and linguistically diverse staff mixture.

2. **Language Access Services** refers to the health center's current working capacity and organizational structure in providing CLAS services to their patient populations.

3. **Data Collection and Assessment** refers to a health center's processes to collect and utilize data to inform provision of CLAS services.

4. **Community Engagement and Partnership** assesses a health center's level of engagement with its patients and community members in.

Health centers were given the option to select multiple answers for each question to allow for a more comprehensive answer that is more closely reflective of the health centers' capacity. Aggregate responses for each question are found in tables 1-4.

LIMITATIONS

The survey response rate of 25% indicates a limited data set of the total number of identified AA&NHPI serving health centers. However, the respondents who did participate were representative of some of the largest AA&NHPI serving health centers overall. Overall, the multiple-choice nature of the survey also created limited options for respondents to describe the category of "other" which was selected frequently. Further follow-up will be necessary to help identify the additional practices in place to support CLAS. Further, all responses to the survey were self-reported. More information would be required to understand the specific nature of policies and procedures that work well for the health centers to implement CLAS.

SECTION 1: GOVERNANCE, LEADERSHIP, AND WORKFORCE

The following survey section was intended to identify the presence of documented policies, procedures, or practices that support culturally and linguistically diverse governance, leadership, and workforce in the health center. The following questions focused on an individual health center's efforts in education and training, retention, promotion practices with staff and board.

Findings

More than half of survey respondents (55%) indicated that they had a policy and procedure in place to support the recruitment, retention, and promotion of culturally and linguistically diverse staff while 32% indicated they had no policy or procedure in place.

A total of 32% indicated structure was in place for promoting CLAS and 23% indicated policies and procedures were in place for the retention of diverse staffing.

Overall, a total of 22.6% of respondents (n=7/31) indicated they provided a policy and procedure for training staff and board members (either initially and ongoing) on

culturally and linguistically appropriate services.

When asked if a health center has policies and procedures for training staff on CLAS, 65% of respondents indicated that they offered initial training while 55% went on to provide ongoing training to health center staff. Nearly 20% indicated that they had no policy or procedure for trainings on CLAS and requested technical assistance in this area.

Survey results indicate that a majority of health center respondents (65%) did not have a policy and procedure in place to provide training to board members on CLAS. Only 23% indicated offering initial training on CLAS and 3% went on to provide ongoing training in CLAS.

A majority of respondents (64%) indicated that their health center did have clearly defined goals for delivering CLAS. Another 19% indicated they did not have clear goals in place and requested technical assistance in this area. Similarly, 19% also responded that they had other efforts in place to ensure the delivery of CLAS. More information and follow-up is needed to further understand these resources and practices.

Does your health center have a policy and procedure (PP) for training board members on CLAS?	Percentage Response Rate (n = 31)
No PP for training board members on CLAS	64%
PP to provide initial training for board members on CLAS	23%
PP to provide ongoing training for board members on CLAS	10%
Doesnt' know	6%
Other	19%

Table 1.3

Does your health center have clearly defined goals for delivering CLAS?	Percentage Response Rate (n = 31)
No	19%
Yes	65%
Doesn't know	3%
Other	19%

Table 1.4

SECTION 2: LANGUAGE ACCESS SERVICES

The following section was intended to identify whether or not an AA&NHPI serving health center had any form of documented structure, policy, or procedure in providing language assistance to individuals with limited English proficiency as well as provide easy to understand print materials and signage in the languages commonly used by the populations in their service area.

Findings

General Language Assistance Services
100% of health center respondents indicated they offered general language assistance services and language interpretation services while 87% indicated that they provided only translation of materials. When asked to what percentage of languages spoken in their service area health centers provided language assistance services in, 87% of respondents provided language services to 50% or more of patients in their service area while 13% indicated they provided less than 50%.

Interpretation Services
All health center respondents (100%) indicated the use of staff and volunteers, and third party language services for interpretation in the health center. Further, 90% of respondents also indicated they did provide a policy and procedure for notifying patients of available free language assistance services.

When asked what type of language interpretation services are provided at their health center, respondents indicated:

What type of language interpretation services are provided at your health center to ensure that limited English proficient patients are able to access timely care?	Percentage Response Rate (n = 31)
None	0%
Staff interpreter via telephone/video conferencing	48%
In-person staff interpreter	74%
Bilingual clinical staff	97%
Bilingual non-clinical staff (medical assistant, community health worker, etc.)	97%
Volunteers (students, AmeriCorps member, etc.)	13%
Third party language service	90%
Doesn't know	0%
Other	3%

Table 2.4

Translation Services and Service Area Language Needs
When asked about the availability of translation services (translating words or text from one language to another), 84% of health centers indicated that they have staff to provide translation services and 68% of health centers used third party language services for translation.

77% of health centers responded that they provide translation for 50% or more languages spoken in their service area while 16% indicated they reached less than 50%.

65% of health centers indicated having a policy and procedure for providing translations in one or more languages. Our analysis also found that there is no direct correlation between a health center having a policy and procedure and providing translations of languages spoken in their service area.

What type of language translation services does your health center utilize to translate materials (e.g., posted signage, intake forms, brochure, website, patient portal, etc.) for limited English proficient patients to ensure that they are able to access timely care?	Percentage Response Rate (n = 31)
None	0%
Staff translator	84%
Third party language services	68%
Doesn't know	0%
Other	13%

Table 2.5

Website & Patient Portal

When asked whether there was a policy or procedure related to translation of the health center's website, 65% of participants indicated they did not while 23% indicated they had other mechanisms in place.

65% of health center respondents indicated they do not have a policy or procedure in place to provide translation to their patient portal in another language aside from English. 13% responded they had a policy in place for 1 language and 6% for more than one language. 16% indicated other, suggesting there was another practice in place- more information is needed to better understand these practices that potentially can grow to become standing policies in the future.

Does your health center have a PP for providing translation on the health center's website in a language other than English?	Percentage Response Rate (n = 31)
None	65%
Yes, in one language	6%
Yes, in more than one language	19%
Not applicable – no website	0%
Doesn't know	0%
Other	23%

Table 2.7

Does the health center have a PP for providing translation to your patient portal in a language other than English?	Percentage Response Rate (n = 31)
None	65%
Yes, in one language	13%
Yes, in more than one language	6%
Not applicable – no website	10
Doesn't know	0%
Other	16%

Table 2.8

SECTION 3: DATA COLLECTION AND ASSESSMENT

Results from the data collection and needs assessment section of the survey inquired whether health center respondents had a policy and procedure for collecting culture and language data for patients and for what specific data they collected. Of the respondents, 100% answered yes for having policies and procedures in place for data collection. Respondents indicated the following or specific data collected: 100% collected race and ethnicity data, 94% reported collecting a patient's preferred language, 77% collected a patient's communication needs such as preference for an interpreter, and only 45% collected country of origin data.

When asked about needs assessments conducted to assess the culture and language data of their patients, 65% of health centers indicated that they conduct needs assessments, 61% of which indicated they used this in planning and implementing services.

Does your health center have a PP for collecting cultural and language data for patients? If yes, what data are collected?	Percentage Response Rate (n = 31)
No	0%
Yes, race and ethnicity	100%
Yes, country of origin	45%
Yes, patient's preferred language	94%
Yes, patient's communication preferences or needs (such as literacy level, preferred interpreter, etc.)	77%
Doesn't know	0%
Other	6%

Table 3.1

Does your health center use the community cultural and language needs assessment results in planning and implementing services?	Percentage Response Rate (n = 31)
No	16%
Yes	74%
Doesn't know	10%
Other	0%

Table 3.3

SECTION 4: COMMUNITY ENGAGEMENT AND PARTNERSHIP

Health center respondents indicated a variety of mechanisms they use in engaging patients in the design, implementation, and evaluation of their services ranging from patient satisfaction surveys (97%) to patient leadership and advisory programs.

Of the respondents, 97% utilized patient satisfaction surveys, 58% used patient focus groups or interviews, and 35% engaged patients in health center committees, while 29% utilized patient advisory groups or leadership programs.

When asked about whether a health center has a policy and procedure or practice in notifying patients or community of the progress in implementing culturally and linguistically appropriate services to patients and community, a majority (61%) indicated they did not, while 39% used social media or their website to communicate, 32% utilized town halls or community meetings, while 23% used their organization's newsletter as the primary mode of communication.

What processes are administered at your health center for engaging patients in the design, implementation, and evaluation of services?	Percentage Response Rate (n = 31)
None	6%
Patient satisfaction survey	97%
Patient focus groups or interviews	58%
Patient membership in health center committees (e.g. management, QI, etc.)	35%
Patient advisory or leadership program	29%
Doesn't know	0%
Other	10%

Table 4.1

Does your health center have a PP for communicating the health center's progress in implementing culturally and linguistically appropriate services to its patients or community?	Percentage Response Rate (n = 31)
No	61%
Yes, through newsletter	23%
Yes, through website or social media	39%
Yes, through town hall/community meetings	32%
Doesn't know	0%
Other	13%

Table 4.2

GOVERNANCE, LEADERSHIP AND WORKFORCE

Overall, survey findings indicate that there is a need for policy and procedure development to help support the processes by which CLAS are integrated into the governance, leadership recruitment, retention, and training of health center staff and board members.

For example, survey findings indicated that a majority of health center respondents (65%) had policies and procedures in place to provide initial and ongoing training on CLAS to staff, but did not have a similar policy and procedure in place to provide training to board members. This suggests that simple steps can be taken by health centers to support the adaptation of existing and ongoing CLAS education training tools to align for board members.

Further, the majority of health center respondents (64%) indicated they did not have clearly defined goals for delivering CLAS and requested technical assistance in this area. This suggests that there is a need for more explicit education and examples of how CLAS can be more intentionally aligned with current health center policies, procedures, and practices.

LANGUAGE ACCESS

As suspected the majority of AANHPI serving health center respondents indicated they provided their own language assistance services including interpretation (100%) and translation services (87%) and had a policy and procedure for both communicating availability of language services, interpretation, and translation services.

Health center respondents also indicated using a breadth of staffing resources and coordination required to provide interpretation services including the use of direct staff,

third party contractors, and trained volunteers. Similarly, respondents indicated that staff additionally assist in providing translation services in the health center (84%) while 68% indicated they also used third party contractors to assist with translation needs (signage, health education materials, administrative needs, patient communications).

WEBSITE AND PATIENT PORTAL

As health centers look to the ongoing requirements of meaningful use, the issue of patient portals and website engagement for patients in AA&NHPI and limited English serving health centers pose unique challenges. Among health center survey respondents, 65% indicated they did not have a policy, procedure, or practice currently in place to guide the translation of their health center's website content other than in English. Much can be learned from the 13% of respondents who indicated they did have structures in place to address the needs of 2 or more languages.

DATA COLLECTION AND ASSESSMENT

The collection of disaggregated data for AA&NHPI serving health centers remains a critical issue to ensure the ability to address health disparities as well as the infrastructure for population management. Among AA&NHPI serving health center respondents, a majority collected race and ethnicity data (100%), preferred language (94%), and a patient's communication preferences/needs such as preference for an interpreter (77%).

In contrast, the survey also found that 45% collected country of origin data. This issue raises concern as nearly two-thirds of AA&NHPIs are foreign born compared to 10% of the U.S. population.[4] Country of origin data helps

4. American Community Survey 2010

to further inform and assist in the likelihood of health disparities including the higher incidence of diseases such as tuberculosis, liver cancer, and hepatitis B – all more common among Asian American, Native Hawaiian, and Pacific Islander populations.

Responses from AA&NHPI serving health centers also indicated the need for tools to assist in the conduction needs assessments conducted to assess the culture and language data of their patients. While a majority (65%) of health centers indicated that they conduct needs assessments, only 61% of which indicated they used this in planning and implementing services. This data suggests the need to enhance the utility of needs assessments on culture and language and apply ways they can inform health center planning and improve operations.

COMMUNITY ENGAGEMENT AND PARTNERSHIP

AA&NHPI serving health center respondents apply a variety of strategies to engage patients in the design, implementation, and evaluation of their services. Among the most frequently used mechanisms were patient satisfaction surveys (97%), patient focus groups or interviews (58%), patients engaged in health center committees (35%), while 29% utilized patient advisory groups or leadership programs.

Despite the levels of engagement with patients and community, a majority of respondents (61%) did not have a standing policy, procedures, or practice used to communicate the progress in implementing CLAS to patients and community. This is an area in which health centers can improve to ensure patients and community remain engaged. More can be learned from the health center respondents who indicated using social media/

website (39%), town halls or community meetings (32%), or their organizational newsletter (23%).

FURTHER ASSESSMENT OF AA&NHPI SERVING HEALTH CENTERS AND CLAS

While an initial assessment of the status of CLAS, the findings from the survey help to inform areas in which CLAS can be elevated in its integration of current health center requirements and operations. Further examination in the following areas will continue to inform future assessments of CLAS within AA&NHPI serving health centers:

- Identification of key resources or tools that facilitate initial and ongoing training on CLAS and its relationship to performance outcomes.

- Further mapping to assist in identifying CLAS policies and procedures that may be best aligned with health center requirements and performance including:
    - Examination of which health centers with CLAS policies and procedures and also have received quality improvement awards.
    - Examination of the relationship between CLAS policies, procedures, and practices and UDS provider performance.
    - Examining CLAS policies and procedures and their relationship with the number of enabling services and enabling services providers at health centers.
    - Further analysis of the relationship between CLAS policies and procedures with the number of languages served and provider performance.

To meet the needs of increasingly diverse patient populations, health centers must continually work on providing culturally and linguistically appropriate services. The National CLAS Standards in Health Care developed by HHS provide a robust framework for health care organizations to implement services that advance health equity, improve quality, and help eliminate health disparities. While all health centers serve high need populations, health centers serving AA&NHPIs encounter unique challenges requiring infrastructure to manage the diversity of language, cultural health beliefs, and health disparities of patient populations.

Primary Care Associations (PCAs) working with AA&NHPI or other limited English serving health centers, can use this report to assist in the prioritization of health center trainings and resources for policies across the 4 CLAS areas. PCAs may also consider adopting and

implementing the following assessment with members to further examine the relationship of CLAS policies and procedures and health center performance. The survey tool can serve as a self-assessment resource for individual AA&NHPI and limited English serving health centers working to evaluate and improve their current infrastructure regarding CLAS.

The strategies and lessons learned from AA&NHPI serving health centers participating in the survey help to further identify the operationalization of CLAS and areas in which CLAS can be further integrated, into health center policies, practices, and ultimately, culture of a health center to improve not only health outcomes, but the overall patient experience.

National AA&NHPI Community Health Center Survey on Culturally and Linguistically Appropriate Services (CLAS)

The Association of Asian Pacific Community Health Organizations (AAPCHO) is conducting this survey. AAPCHO is a national network of community health centers and organizations dedicated to serving medically underserved Asian Americans, Native Hawaiians and other Pacific Islanders (AA&NHPIs). AAPCHO's mission is to promote advocacy, collaboration and leadership that improve the health status and access of AA&NHOPIs within the United States, its territories and freely associated states. AAPCHO is a Bureau of Primary Health Care's National Cooperative Agreement (NCA) holder, funded to provide training and technical assistance to any community health centers serving Asian Americans, Native Hawaiian and other Pacific Islander populations. AAPCHO offers a wider spectrum of expertise and technical assistance services in language access, cultural competency education and training, community asset mapping, and linkage building to key leaders in the AA&NHPI community.

Purpose and Explanation of Study: Asian Americans, Native Hawaiians and Pacific Islanders face significant disparities in health outcomes and access to quality health care due to language and cultural barriers. The provision of culturally and linguistically appropriate services (CLAS) is one strategy to help eliminate health disparities. The purpose of this survey is to better understand the current culture and language access policies, practices, and services being provided by community health centers that serve AA&NHPIs.

The survey will address four areas of CLAS-related policies, practices, and services. The information from the survey will allow AAPCHO to identify strength areas and gaps related to cultural and language services provided by community health centers that serve AA&NHPI to inform our technical assistance services. Furthermore, this survey will be the first part of a multi-phase effort to demonstrate the value of CLAS-related policies, practices and services offered at AA&NHPI-serving community health centers.

AAPCHO

Cultural Language Access Standards in
Asian American, Native Hawaiian, and Pacific Islander Serving Health Centers:
2015-2016 Survey Tool

SECTION 1. GOVERNANCE, LEADERSHIP, AND WORKFORCE

1. Does your health center have a policy and procedure for **recruiting, retaining, and promoting culturally and linguistically** diverse staff? (Select all that apply)

    a. No, we do <u>not have </u>a policy and procedure for recruiting, retaining, and promoting culturally and linguistically diverse staff.
    b. Yes, we have a policy and procedure for <u>recruiting</u> culturally and linguistically diverse staff
    c. Yes, we have a policy and procedure for <u>retaining</u> culturally and linguistically diverse staff
    d. Yes, we have a policy and procedure for <u>promoting</u> culturally and linguistically diverse staff
    e. I don't know
    f. Other (please specify) _____
    g. I am interested in receiving technical assistance and training in this area.

2. Does your health center have a policy and procedure for training **staff** on culturally and linguistically appropriate services? (Select all that apply)

    a. No, we <u>do not</u> have a policy and procedure for training **staff** on culturally and linguistically appropriate services.
    b. Yes, there is a policy and procedure to provide <u>initial</u> training for new staff
    c. Yes, there is a policy and procedure to provide <u>ongoing</u> training for staff
    d. I don't know
    e. Other (please specify) _____
    f. I am interested in receiving technical assistance and training in this area.

3. Does your health center have a policy and procedure for training **board members** on culturally and linguistically appropriate services? (Select all that apply)

    a. No, we <u>do not</u> have a policy and procedure for training **board members** on culturally and linguistically appropriate services.
    b. Yes, there is a policy and procedure to provide <u>initial</u> training for new board members.
    c. Yes, there is a policy and procedure to provide <u>ongoing</u> training for board members.
    d. I don't know
    e. Other (please specify) _____
    f. I am interested in receiving technical assistance and training in this area.

4. Does your health center have clearly defined goals for delivering culturally and linguistically appropriate services? (Select all that apply)

   a. No, we <u>do not</u> have clearly defined goals for delivering culturally and linguistically appropriate services.
   b. Yes, we have clearly defined goals for delivering culturally and linguistically appropriate services.
   c. I don't know
   d. Other [please specify other examples of how your health center is expressing value/goals toward delivering culturally and linguistically appropriate services to staff (e.g., vision statement, personnel manual, etc.).] _____
   e. I am interested in receiving technical assistance and training in this area.

SECTION 2. LANGUAGE ACCESS SERVICES

5. What type of **language assistance services** are provided at your health center to ensure that limited English proficient patients are able to access timely care? (Select all that apply)

   a. None, we <u>do not</u> provide language assistance services. (Skip logic)
   b. We provide <u>translated materials</u> (e.g., posted signage, intake forms, brochure, website, patient portal, etc.)
   c. We provide <u>language interpretation</u>.
   d. I don't know.
   e. Other (please specify) _____
   f. I am interested in receiving technical assistance and training in this area.

6. Of the languages most commonly spoken by patients in your health center's service area, what percentage does your health center provide with **language assistance services** for? (Select all that apply)

   a. None
   b. We provide language assistance services for <u>less than 50% of languages spoken</u> in our service area.
   c. We provide language assistance services for <u>50% or more languages spoken</u> in our service area.
   d. I don't know
   e. Other (please specify) _____
   f. I am interested in receiving technical assistance and training in this area.

7. Does your health center have a policy and procedure for providing notice of available free **language assistance services** to patients? (Select all that apply)

    a. No, we <u>do not</u> have a policy and procedure for providing notice to patients regarding our language assistance services available to them.
    b. Yes, we have a policy and procedure for providing notice to patients regarding our language assistance services available to them.
    c. I don't know.
    d. Other (please specify) _____
    e. I am interested in receiving technical assistance and training in this area.

8. What type of language **interpretation** services are provided at your health center to ensure that limited English proficient patients are able to access timely care? (Select all that apply)

    a. None, we <u>do not</u> provide language interpretation services.
    b. We have <u>staff interpreter</u> that provide interpretation via telephone/video conferencing.
    c. We have <u>staff interpreter</u> that provide in-person interpretation.
    d. We have <u>bilingual clinical staff</u> that provide language interpretation.
    e. We have <u>bilingual non-clinical staff</u> that provide language interpretation (e.g. Medical Assistant, Community Health Worker)
    f. We have <u>volunteers</u> that provide language interpretation (e.g., students, AmeriCorps member, etc.).
    g. We provide language interpretation through <u>third party language services</u> (e.g., language line services/companies, etc.).
    h. I don't know
    i. Other (please specify) _____
    j. I am interested in receiving technical assistance and training in this area.

9. What type of language **translation** services does your health center utilize to translate materials (e.g, posted signage, intake forms, brochure, website, patient portal, etc.) for limited English proficient patients to ensure that they are able to access timely care? (Select all that apply)

    a. None, we <u>do not</u> provide translated materials. (Skip logic)
    b. We have <u>staff translator(s)</u> to translate our materials.
    c. We use <u>third party language services</u> to translate our materials
    d. I don't know
    e. Other (please specify) _____
    f. I am interested in receiving technical assistance and training in this area.

10. Of the languages most commonly spoken by patients in your health center's service area, what percentage does your health center provide **translation** for (e.g, posted signage, intake forms, brochure, website, patient portal, etc.)? (Select all that apply)

   a. None
   b. We provide translation for <u>less than 50% of languages spoken</u> in the service area.
   c. We provide translation for <u>50% or more of languages spoken</u> in service area.
   d. I don't know
   e. Other (please specify) _____
   f. I am interested in receiving technical assistance and training in this area

11. Does your health center have a policy and procedure for providing translation on **the health center's website** in a language other than English? (Select all that apply)

   a. No, we <u>do not</u> have a policy and procedure for providing translation on the health center's website in a language other than English
   b. Yes, we have a policy and procedure for providing translation on the health center's website in in <u>one language</u> other than English
   c. Yes, we have a policy and procedure for providing translation on the health center's website in in <u>more than one language</u> other than English
   d. Not applicable - We do not have a website
   e. I don't know
   f. Other (please specify) _____
   g. I am interested in receiving technical assistance and training in this area.

12. Does the health center have a policy and procedure for providing translation to your **patient portal** in a language other than English? (Select all that apply)

   a. No, we <u>do not</u> have a policy and procedure for providing translation to our patient portal in a language other than English
   b. Yes, we have a policy and procedure for providing translation to our patient portal in <u>one language</u> other than English
   c. Yes, we have a policy and procedure for providing translation to our patient portal <u>in more than one language</u> other than English
   d. Not applicable - We do not have a patient portal
   e. I don't know
   f. Other (please specify) _____
   g. I am interested in receiving technical assistance and training in this area.

13. Does your health center have a policy and procedure for providing **translated print materials** (e.g., posted signage, intake forms, brochure, etc.) in the languages commonly used by the populations in the service area? (Select all that apply)

    a. No, we do not have a policy and procedure for providing translated print materials in the languages commonly used by the populations in the service area
    b. Yes, we have a policy and procedure for providing translated print materials in the languages commonly used by the populations in the service area
    c. I don't know
    d. Other (please specify) _____
    e. I am interested in receiving technical assistance and training in this area.

SECTION 3. DATA COLLECTION AND ASSESSSMENT

14. Does your health center have a policy and procedure for **collecting cultural and language** data for patients? If yes, what data are collected? (Select all that apply)

    a. No, we do not collect cultural and language data
    b. We collect race and ethnicity
    c. We country of origin
    d. We collect the patient's preferred language
    e. We collect the patient's communication preferences or needs (such as literacy level, preferred interpreter, etc.)
    f. I don't know
    g. Other (please specify) _____.
    h. I am interested in receiving technical assistance and training in this area.

15. Does your health center have a policy and procedure for **assessing community cultural and language** needs? If so, how often is the assessment conducted per year? (Select all that apply)

    a. No, we do not have a policy and procedure for assessing community cultural and language needs.
    b. Yes, the needs assessment is conducted once per year.
    c. Yes, the needs assessment is conducted more than once per year.
    d. Yes, but not sure how often the needs assessment is conducted.
    e. Other (please specify) _____.
    f. I am interested in receiving technical assistance and training in this area.

16. Does your health center use the **community cultural and language** needs assessment results in planning and implementing services? (Select all that apply)

    a. No, we do not use the assessment results in planning and implementing services
    b. Yes, assessment results are used in planning and implementing services
    c. I don't know
    d. Other (please specify) _____.
    e. I am interested in receiving technical assistance and training in this area.

SECTION 4. COMMUNITY ENGAGEMENT AND PARTNERSHIP

17. What processes are administered at your health center for engaging patients in the design, implementation, and evaluation of services? (Select all that apply)

    a. None
    b. Patient satisfaction survey
    c. Patient focus groups or interviews
    d. Patient membership in health center committees (e.g. management, QI)
    e. Patient advisory or leadership program
    f. I don't know
    g. Other (please specify) _____
    h. I am interested in receiving technical assistance and training in this area.

18. Does your health center have a policy and procedure for communicating the health center's progress in implementing culturally and linguistically appropriate services to its patients or community? (Select all that apply)

    a. No, we <u>do not</u> have a policy and procedure for communicating the health center's progress in implementing culturally and linguistically appropriate services to its patients or community
    b. Yes, through newsletter
    c. Yes, through website or social media
    d. Yes, through town hall/community meetings
    e. I don't know
    f. Other (please specify) _____
    g. I am interested in receiving technical assistance and training in this area.

National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health and Health Care

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:

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 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.

OMH
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Office of Minority Health

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The Case for the Enhanced National CLAS Standards

Of all the forms of inequality, injustice in health care is the most shocking and inhumane.
— Dr. Martin Luther King, Jr.

Health equity is the attainment of the highest level of health for all people (U.S. Department of Health and Human Services [HHS] Office of Minority Health, 2011). Currently, individuals across the United States from various cultural backgrounds are unable to attain their highest level of health for several reasons, including the social determinants of health, or those conditions in which individuals are born, grow, live, work, and age (World Health Organization, 2012), such as socioeconomic status, education level, and the availability of health services (HHS Office of Disease Prevention and Health Promotion, 2010). Though health inequities are directly related to the existence of historical and current discrimination and social injustice, one of the most modifiable factors is the lack of culturally and linguistically appropriate services, broadly defined as care and services that are respectful of and responsive to the cultural and linguistic needs of all individuals.

Health inequities result in disparities that directly affect the quality of life for all individuals. Health disparities adversely affect neighborhoods, communities, and the broader society, thus making the issue not only an individual concern but also a public health concern. In the United States, it has been estimated that the combined cost of health disparities and subsequent deaths due to inadequate and/or inequitable care is $1.24 trillion (LaVeist, Gaskin, & Richard, 2009). Culturally and linguistically appropriate services are increasingly recognized as effective in improving the quality of care and services (Beach et al., 2004; Goode, Dunne, & Bronheim, 2006). By providing a structure to implement culturally and linguistically appropriate services, the enhanced National CLAS Standards will improve an organization's ability to address health care disparities.

The enhanced National CLAS Standards align with the HHS Action Plan to Reduce Racial and Ethnic Health Disparities (HHS, 2011) and the National Stakeholder Strategy for Achieving Health Equity (HHS National Partnership for Action to End Health Disparities, 2011), which aim to promote health equity through providing clear plans and strategies to guide collaborative efforts that address racial and ethnic health disparities across the country. Similar to these initiatives, the enhanced National CLAS Standards are intended to advance health equity, improve quality, and help eliminate health care disparities by providing a blueprint for individuals and health and health care organizations to implement culturally and linguistically appropriate services. Adoption of these Standards will help advance better health and health care in the United States.

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Appendix B

Meeting the National CLAS Standards:
A Crosswalk For Health Centers

To meet the needs of increasingly diverse patient populations, health centers must continually work on providing culturally and linguistically appropriate services. The National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care (National CLAS Standards), developed by the Department of Health and Human Services (HHS), provide a robust framework for health care organizations to implement services that advance health equity, improve quality, and help eliminate health disparities. The National CLAS Standards were first published in 2000, and then revised in 2013.

Health centers that are funded by the Health Resources and Services Administration (HRSA) as Health Center Program grantees already address some of the National CLAS Standards simply by meeting the program requirements. Many health centers are additionally working towards National Committee for Quality Assurance (NCQA) Patient-Centered Medical Home (PCMH) certification. The NCQA standards also require health care practices to address the cultural and linguistic needs of their patients.

The purpose of this table is to help health centers better understand how and where the Health Center Program and NCQA PCMH Standards align with National CLAS Standards. This crosswalk can help health centers identify where they may already be meeting, or working towards meeting, some of the National CLAS Standards, and where they should prioritize future efforts in providing more culturally and linguistically appropriate services.

The 15 National CLAS Standards are listed in the first column. In the next two columns are the Health Center Program Statute and Regulations, and PCMH Standards and Guidelines that correspond to or support that National CLAS Standard.

Note: This table does not include information from HRSA's Policy Information Notices (PINs) and Program Assistance Letters (PALs), which are issued on an ongoing basis, and may contain additional requirements and recommendations for health center program grantees.

National CLAS STANDARDS	HEALTH CENTER PROGRAM STATUE & REGULATIONS	NCQA PCMH STANDARDS & GUIDELINES
Principle Standard		
National CLAS Standard 1: Provide Effective, Equitable, Understandable, and Respectful Quality Care and Services *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.*	**A health center must provide services that are available and accessible promptly, as appropriate, and in a manner which will assure continuity of service to the residents of the center's catchment area. The center must be operated in a manner calculated to preserve human dignity and to maximize acceptability and effective utilization of services.** *42 CFR Part 51c.303(a)(m)* **In the case of a center which serves a population including a substantial proportion of individuals of limited English-speaking ability, the center has developed a plan and made arrangements responsive to the needs of such population for providing services to the extent practicable in the language and cultural context most appropriate to such individuals.** *Section 330(k)(3)(K) of the PHS Act* **Requirements of title VI of the Civil Rights Act of 1964 and section 504 of the Rehabilitation Act of 1973 apply, which prohibit discrimination on the grounds of race, color, national origin, age, sex, creed, marital status, or handicap.** *42 CFR Part 51c.109*	Goals for PCMH and Beyond: · **Primary care clinicians will deliver safe, effective and efficient care that is well coordinated across the medical neighborhood and optimizes the patient experience.** · **Primary care will be the foundation of a high-value health care system that provides whole-person care at the first contact. Everyone in primary care practices—from physicians and advanced practice nurses to medical assistants and frontline staff—should practice to the highest level of their training and license in teams, to support better access, self-care and care coordination.** · **PCMHs will show the entire health care system what patient-centered care looks like: care that is "respectful of and responsive to individual patient preferences, needs, and values, and ensures that patient values guide all clinical decisions." Individuals and families get help to be actively engaged in their own healthy behaviors and health care, and in decisions about their care.** · **PCMHs will revitalize the "joy of practice" in primary care, making it more appealing and satisfying.** *PCMH Standards and Guidelines Front Matter*
Governance, Leadership and Workforce		
National CLAS Standard 2: Advance and Sustain Governance and Leadership that Promotes CLAS And Health Equity *Advance and sustain organizational governance and leadership that promotes CLAS and health equity through policy, practice, and allocated resources.*	**The health center governing board is composed of individuals, a majority of whom are being served by the center and who, as a group, represent the individuals being served by the center. The board meets at least once a month, selects the services to be provided by the center, schedules the hours during which such services will be provided, approves the center's annual budget, approves the selection of a director for the center, and, except in the case of a governing board of a public center, establishes general policies for the center.** *Section 330(k)(3)(H) of the PHS Act*	N/A

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National CLAS Standard 3: Recruit, Promote, and Support a Diverse Governance, Leadership, and Workforce *Recruit, promote, and support a culturally and linguistically diverse governance, leadership, and workforce that are responsive to the population in the service area.*	**In the case of a center which serves a population including a substantial proportion of individuals of limited English-speaking ability, the center has identified an individual on its staff who is fluent in both that language and in English and whose responsibilities shall include providing guidance to such individuals and to appropriate staff members with respect to cultural sensitivities and bridging linguistic and cultural differences.** *Section 330(k)(3)(K) of the PHS Act* **The health center governing board is composed of individuals, a majority of whom are being served by the center and who, as a group, represent the individuals being served by the center.** *Section 330(k)(3)(H) of the PHS Act*	N/A
National CLAS Standard 4: Educate and Train Governance, Leadership, and Workforce In CLAS *Educate and train governance, leadership, and workforce in culturally and linguistically appropriate policies and practices on an ongoing basis.*	N/A	**Care team members are trained on effective communication with all segments of the patient population, but particularly the vulnerable populations. Training may include information on health literacy or other approaches to addressing communication needs.** *Standard 2, Team-Based Care* • *2D (Practice team)* ○ *2D7 (Training in managing patient populations)*
Communication and Language Assistance		

National CLAS Standard 5: Offer Communication and Language Assistance
 	
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 care and services.
	"Required primary health services" includes services that enable individuals to use the services of the health center including, if a substantial number of the individuals in the population served by a center are of limited English-speaking ability, the services of appropriate personnel fluent in the language spoken by a predominant number of such individuals.
	
	Section 330(A)(2)(b)(1)(A)(iv) of the PHS Act
		The practice assesses and documents individual and population language needs, and provides third-party interpretation services or multilingual staff to meet those language needs. Communication needs (other than language) and health literacy are also assessed and taken into consideration in comprehensive health assessments and medication management. Health education programs and resources are available in languages other than English, or are available by referral.
		
		Standard 2, Team-Based Care
		• *2C (Culturally and linguistically appropriate services)*
		  ○ *2C3 (Provide interpretation or bilingual services)*
		Standard 3, Population Health Management
		• *3A (Electronic system to record patient information)*
		  ○ *3A5 (Preferred language)*
		• *3C (Comprehensive health assessment)*
		  ○ *3C10 (Assessment of health literacy)*
		Standard 4, Care Management and Support
		• *4C (Medication management)*
		  ○ *4C4 (Assess understanding of medications)*
		• *4E (Support self-care and shared decision making)*
		  ○ *4E2 (Educational programs and resources for patients)*

National CLAS Standard 6: **Inform Individuals of the Availability of Language Assistance** *Inform all individuals of the availability of language assistance services clearly and in their preferred language, verbally and in writing.*	N/A	N/A
National CLAS Standard 7: Ensure the Competence of Individuals Providing Language Assistance *Ensure the competence of individuals providing language assistance, recognizing that the use of untrained individuals and/or minors as interpreters should be avoided.*	**"Required primary health services" includes services that enable individuals to use the services of the health center including, if a substantial number of the individuals in the population served by a center are of limited English-speaking ability, the services of appropriate personnel fluent in the language spoken by a predominant number of such individuals.** *Section 330(A)(2)(b)(1)(A)(iv) of the PHS Act*	**The practice provides third-party interpretation services or multilingual staff to meet the language needs of its population. Asking a friend or family member to interpret for a patient does not meet the intent of the standard, as patients may be less forthcoming with family members present, and family members may not be familiar with medical terminology.** *Standard 2, Team-Based Care* • *2C (Culturally and linguistically appropriate services)* o *2C3 (Provide interpretation or bilingual services)*

National CLAS Standard 8: Provide Easy-to-Understand Materials and Signage
 	
Provide easy-to-understand print and multimedia materials and signage in languages commonly used by the populations in the service area.
	N/A	**The practice identifies languages spoken by at least 5 percent of its patient population and makes materials available in those languages. Written language preferences are noted in patient health information. Patients with limited English proficiency are provided forms in their native language. Health literacy is assessed and taken into consideration. Health education resources in languages other than English are available. The practice is encouraged to provide information on the role and responsibilities of the medical home in multiple formats to accommodate patient language needs.**
		
		Standard 2, Team-Based Care
		• *2B (Informing patient/family of medical home responsibilities)*
		• *2C (Culturally and linguistically appropriate services)*
		   o *2C4 (Printed materials in languages of population)*
		Standard 3, Population Health Management
		• *3A (Electronic system to record patient information)*
		   o *3A5 (Preferred language)*
		• *3C (Comprehensive health assessment)*
		   o *3C10 (Assessment of health literacy)*
		Standard 4, Care Management and Support
		• *4B (Care planning and self-care support)*
		   o *4B5 (Plan provided in writing to patient/family/caregiver)*
		• *4C (Medication management)*
		• *4E (Support self-care and shared decision making)*
		   o *4E2 (Educational programs and resources for patients)*

Engagement, Continuous Improvement and Accountability		

National CLAS Standard 9: Infuse CLAS Goals, Policies, and Management Accountability Throughout the Organization's Planning and Operations
 	
Establish culturally and linguistically appropriate goals, policies, and management accountability, and infuse them throughout the organization's planning and operations.
	In the case of a center which serves a population including a substantial proportion of individuals of limited English-speaking ability, the center has developed a plan and made arrangements responsive to the needs of such population for providing services to the extent practicable in the language and cultural context most appropriate to such individuals.
	
	Section 330(k)(3)(K) of the PHS Act
		The practice has policies to assess the cultural and linguistic needs of patients/families, and to provide language access services. Accountability is promoted through the use of various performance measures that can inform service improvement. Performance results are made public.
		
		Standard 2, Team-Based Care
		  • *2C (Culturally and linguistically appropriate services)*
		Standard 6, Measure Clinical Quality Performance
		  • *6E (Demonstrate continuous quality improvement)*
		  • *6F (Report performance)*

National CLAS Standard 10: Conduct Organizational Assessments
 	
Conduct ongoing assessments of the organization's CLAS-related activities and integrate CLAS-related measures into measurement and continuous quality improvement activities.
	N/A	**The practice measures patient/family experiences, and specifically obtains feedback from vulnerable population groups. Clinical quality performance data is stratified for vulnerable populations to assess disparities in care. The practice uses an ongoing quality improvement process to work on and achieve improvements on patient experience measures and care/service disparities.**
		
		Standard 6, Measure Clinical Quality Performance
		  • *6A (Measure clinical quality performance)*
		  • *6C (Measure patient/family experience)*
		  • *6D (Implement Continuous Quality Improvement)*
		  • *6E (Demonstrate Continuous Quality Improvement)*

National CLAS Standard 11: Collect and Maintain Demographic Data
 	
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.
	N/A	**The practice collects patient information on race, ethnicity, language preferences, and other aspects of diversity, and uses this information to assess and improve service delivery.**
		
		Standard 2, Team-Based Care
		  • *2C (Culturally and linguistically appropriate services)*
		     o *2C1 (Assess diversity of population)*
		     o *2C2 (Assess language needs of population)*
		Standard 3, Population Health Management
		  • *3A (Electronic system to record patient information)*
		     o *3A3 (Race)*
		     o *3A4 (Ethnicity)*
		     o *3A5 (Preferred language)*

National CLAS Standard 12: Conduct Assessments of Community Health Assets and Needs
 	
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.
	The health center demonstrates and documents the needs of its target population, updating its service area, when appropriate.
	
	Section 330(k)(2) and Section 330(k)(3)(J) of the PHS Act
		The practice assesses the diversity and language needs of its population by collecting data directly from patients or from the larger community served by the practice. The practice maintains a current community resource list specific to the needs of the practice's population (such as nutrition, falls prevention, and child care).
		
		Standard 2, Team-Based Care
		  • *2C (Culturally and linguistically appropriate services)*
		     o *2C1 (Assess diversity of population)*
		     o *2C2 (Assess language needs of population)*
		Standard 4, Care Management and Support
		  • *4E (Support self-care and shared decision making)*
		     o *4E6 (Current resource list on five topics or community service areas important to patient population)*

National CLAS Standard 13: **Partner with the Community**
 	
Partner with the community to design, implement, and evaluate policies, practices, and services to ensure cultural and linguistic appropriateness.
	The health center governing board is composed of individuals, a majority of whom are being served by the center and who, as a group, represent the individuals being served by the center. The board selects the services to be provided by the center, schedules the hours during which such services will be provided, approves the center's annual budget, approves the selection of a director for the center, and establishes general policies for the center.
	
	Section 330(k)(3)(H) of the PHS Act
		The practice involves patients/families/caregivers in quality improvement activities, and requests feedback from patients/families/caregivers on whether community referrals are sufficient and appropriate.
		
		Standard 2, Team-Based Care
		  • *2D (Practice team)*
		    ○ *2D10 (Involve patients/families/caregivers in QI improvement activities or advisory council)*
		Standard 4, Care Management and Support
		  • *4E (Support self-care and shared decision making)*
		    ○ *4E7 (Assess usefulness of identified resources)*

National CLAS Standard 14: Create conflict and grievance resolution processes *Create conflict and grievance resolution processes that are culturally and linguistically appropriate to identify, prevent, and resolve conflicts or complaints.*	**The governing board is responsible for development of a process for hearing and resolving patient grievances.** *42 CFR Part 51c.304(d)(3)(iv)*	**N/A**

National CLAS Standard 15: Communicate the Organization's Progress in Implementing and Sustaining CLAS
 	
Communicate the organization's progress in implementing and sustaining CLAS to all stakeholders, constituents, and the general public.
	N/A	**The practice produces performance data reports on the patient/family experience, including data specifically on vulnerable populations, and shares the results with patients and the general public.**
		
		Standard 6, Measure Clinical Quality Performance
		  • *6F (Report Performance)*
		    ○ *6F3 (Share clinician and practice performance results publicly)*
		    ○ *6F4 (Share clinician and practice performance results with patients)*

Conclusion

By having met Health Center Program Requirements, health centers are already demonstrating some level of providing culturally and linguistically appropriate services. Those that are additionally working towards, or have already fulfilled, PCMH Standards, are even closer to meeting the National CLAS Standards.

The comparison above shows that the Health Center Program Requirements and the PCMH Standards supports the National CLAS Standards. However, one notable area where both Health Center Program Requirements and PCMH Standards lack guidance is in clearly informing individuals of the availability of language assistance (National CLAS Standard 6). Health centers and PCMHs should work towards ensuring that all individuals are informed of the availability of language assistance services clearly and in their preferred language, verbally and in writing in order to be aligned with the National CLAS Standards.

It is important to note that while Health Center Program Requirements and PCMH Standards are set criteria for compliance and recognition, the National CLAS Standards are meant to serve more as guidelines and an adaptable framework. Health centers that may similarly meet CLAS standards, may implement their services differently to cater to the patients and communities they serve, as mandated by Health Center Program and PCMH requirements. For example, National CLAS Standard 3 states that health centers should "recruit, promote, and support a diverse governance, leadership, and workforce". A health center that has met Health Center Program Requirements may vary in application of this standard as Health Center Program Requirements state that, "In the case of a center which serves a population including a substantial proportion of individuals of limited English-speaking ability, the center has identified an individual on its staff who is fluent in both that language and in English".

For some health centers, with a small number of patients who speak one language other than English, having one bilingual staff person may be enough to fulfill the National CLAS Standard 3. But for a health center serving large populations from multiple language groups, meeting this Health Center Program Requirement may only be the first step to building a diverse workforce. This is just one example of the flexibility that the National CLAS Standards provides for health centers.

As health centers look towards developing more culturally and linguistically appropriate services, they should use the National CLAS Standards as a framework for best practices and to complement the work they are already doing to achieve and maintain PCMH recognition.