APIAHF
ASIAN & PACIFIC ISLANDER AMERICAN HEALTH FORUM

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Deputy Assistant Secretary Garth Graham
United States Department of Health and Human Services
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Re: *Comments on Existing National Standards for the Culturally and Linguistically Appropriate Services in Health Care*

Dear Assistant Secretary Graham:

The Asian & Pacific Islander American Health Forum (APIAHF) thanks the Office of Minority Health, Department of Health and Human Services for the opportunity to comment on the Culturally and Linguistically Appropriate Services (CLAS) enhancement initiative. The CLAS enhancement initiative will support OMH's efforts to improve the health and well-being of racial and ethnic minority populations including Asian American, Native Hawaiian, and Pacific Islander (AA and NHPI) communities by strengthening existing standards to better address cultural and linguistic barriers to care and other health care disparities.

For almost 25 years, APIAHF has dedicated itself to improving the health and well-being of Asian American, Native Hawaiian, and Pacific Islander communities. Research continues to show differences in the health and health care outcomes of people of color and other vulnerable populations and their White counterparts. AAs and NHPIs in particular suffer disproportionately high rates of cervical cancer, stomach cancer, hepatitis B, mental health issues, and many other serious health impairments. Our communities are also overwhelmingly immigrant; over 60 percent of Asian Americans and 30 percent of Pacific Islanders living in the U.S. are foreign-born, representing the full spectrum of immigration status categories including lawful permanent residents, refugees, asylees, U.S. nationals, undocumented immigrants and naturalized citizens. As such, many immigrants are excluded from essential health care services or are unable to meaningfully access these services. In addition, high rates of uninsurance, affecting over one in six Asian Americans and one in four Native Hawaiian and Pacific Islanders, and limited English proficiency compound the obstacles these communities face in achieving good health. Over one-third of Asian Americans are limited English proficient, and language barriers are widely known to reduce rates in enrollment and lower the quality and effectiveness of prevention, treatment and patient education programs.

For these reasons, we strongly support the CLAS enhancement initiative and its emphasis on addressing disparities in care. In addition, we urge OMH to consider the following additions and modifications to existing CLAS Standards:

1. Promote the CLAS Standards to ensure expanded use.
2. Expand the definition of "culture" within CLAS.
3. Align CLAS with other national quality standards.
4. Align CLAS with the Affordable Care Act.

Our comments detail these recommendations below.

1. Promote the CLAS Standards to Ensure Expanded Use
OMH should develop a comprehensive approach to promoting the CLAS standards to ensure public knowledge and use.

- Inform providers of the existence of CLAS standards: Consistent with the Department of Health and Human Services, Office of Inspector General Guidance and Standards on Language and Access Services: Medicare Providers[i] (OIG Guidance on Language Access), OMH should collaborate with the Office of Civil Rights (OCR) as part of OCR's interactions with Medicare providers to increase provider awareness and understanding of how CLAS can be used to promote patient-centered care.

- Conduct outreach: Consistent with the OIG Guidance on Language Access, OMH should conduct outreach to promote utilization of CLAS standards and be "proactive" in letting providers and organizations know of the existence of these standards in formats in addition to existing online resources.

- Develop model written materials for providers: Consistent with the OIG Guidance on Language Access, OMH should work with CMS to develop standard language and translations for frequently used written materials in Medicare (as well as other CMS programs like Medicaid and the Children's Health Insurance Program), in common languages, to increase compliance with CLAS and lessen the financial burden on providers. OMH should also collaborate with other HHS operating divisions such as HRSA, SAMHSA and CDC to develop culturally and linguistically appropriate materials, including translations in common languages, and disseminate them to providers and patients. The www.cuidadodesalud.gov website is an example of the type of multilingual information that all HHS operating divisions should be providing. We strongly encourage that these translations go beyond Spanish and include at least the most common Asian languages.

- Require all HHS operating divisions to adopt the CLAS standards: All HHS operating divisions (especially CMS, HRSA, SAMHSA and CDC) should adopt the CLAS standards as requirements in their respective grants and contracts. The Office of Consumer Information and Insurance Oversight (OCIIO), as part of the grant process for the Consumer Assistance Program under the Affordable Care Act has already set the example by requiring its grantees to demonstrate their ability to provide assistance that is culturally and linguistically appropriate to the needs of the population served, including their ability to communicate effectively and provide interpreter services for consumers with limited English proficiency.[ii]

2. Expand the Definition of "Culture" within CLAS
The CLAS standards view health as a cultural construct in which cultural issues are central to the delivery of treatment and prevention interventions. Given the importance of culture in health care delivery, OMH should expand the definition of culture beyond the beliefs of racial, ethnic, religious and social groups. An expanded definition would align with OMH's charge of improving the health status

of racial and ethnic minorities, eliminating health disparities, and achieving health equity in the United States.

- Expand "culture" to include: gender, sexual orientation and gender identity/expression, disability, education, health literacy, geography, immigration status and religion/spirituality. This expanded definition would align with Healthy People 2020's goal of achieving health equity and its more inclusive definition of disparity populations:

  > "Healthy People 2010 defines a health disparity as a particular type of health difference that is closely linked with social, economic, and/or environmental disadvantage. Health disparities adversely affect groups of people who have systematically experienced greater obstacles to health based on their racial or ethnic group; religion; socioeconomic status; gender; age; mental health; cognitive, sensory, or physical disability; sexual orientation or gender identity; geographic location; or other characteristics historically linked to discrimination or exclusion."[iii]

- Rename CLAS: OMH should consider renaming CLAS to the "Standards for Patient-Centered and Equitable Health Care" to more accurately reflect the Institute of Medicine's quality framework, the more recent emphasis on patient-centeredness and equity under the Affordable Care Act, and on health equity under Healthy People 2020:

  > *Healthy People 2020* defines health equity as the "attainment of the highest level of health for all people. Achieving health equity requires valuing everyone equally with focused and ongoing societal efforts to address avoidable inequalities, historical and contemporary injustices, and the elimination of health and health care disparities."[iv]

3. Align CLAS with Other National Quality Standards

Since the CLAS standards were initially developed in 2000, numerous national quality frameworks (including the U.S. Office of Minority Health Draft National Partnership for Action to End Health Disparities, National Quality Forum, National Committee for Quality Assurance, Joint Commission Accreditation Standards for Hospitals, and the Institute of Medicine, Report on Race, Ethnicity and Language Data Standardization) have adopted and expanded on the CLAS framework. These quality frameworks should be used to inform and enhance current CLAS standards. Please see Appendix A for a crosswalk of the CLAS Standards with the above mentioned national quality frameworks and standards.

APIAHF recommends the following additions and modifications to Culturally Competent Care:

- Standard 1:
  - Health care organizations should explicitly prohibit discrimination on the basis of age, race, ethnicity, religion, culture, language, physical or mental disability, socioeconomic status, sex, sexual orientation, and gender identity or expression.

    - Health care organizations should involve a patient in making decisions about his or her care, treatment or services.
    - Health care organizations should include family members in health care decisions, when requested by the patient.
    - Health care organizations should consider a patient's cultural, religious and spiritual beliefs in delivering care.
- Standard 2:
    - Health care organizations should build relationships and collaborate with professional health education institutions, universities, colleges and high schools to support racially, ethnically, and culturally diverse students to enter into the health professions.
- Standard 3:
    - Health care organizations should incorporate cultural and linguistic competency into training and professional development requirements, including continuing education on the nondiscrimination requirements under Title VI of the Civil Rights Act of 1964, for all health care providers and health care administration staff.
    - Health care organizations should actively seek strategies to improve the knowledge and skills that are needed to address cultural competency in the organization.
    - Health care organizations should develop cultural competency training and education that is informed by the demographics of the population being served.

<u>APIAHF recommends the following additions and modifications to Language Access Services</u>:

- Standard 4:
    - Health care organizations should maintain sufficient resources for communicating with patients in their primary written and spoken languages through qualified/competent interpreter resources, or multilingual staff, staff interpreters, contracted interpreters from outside agencies, remote interpreting services, credentialed volunteers, and others, to ensure timely and high-quality communication.
    - Health care organizations should ensure patient information is tailored to a person's age and ability to understand.
- Standard 5:
    - Health care organizations should offer and provide language access resources in the patient's primary written and spoken language at no cost, at all points of contact, and in a timely manner during all hours of operation, and provide both verbal offers and written notices informing patients of their right to receive language assistance services free of charge.
- Standard 6:
    - Health care organizations should define staff qualifications for language assistance personnel through language proficiency assessment, education training, and experience.
    - Health care organizations should use the availability of trained and certified interpreters as a quality improvement indicator.
- Standard 7:

- Health care organizations should translate all vital documents into languages commonly encountered in the service area. Non-vital written materials should also be translated when printed translation is needed for effective communication.
- Health care organizations should conduct a "learning needs assessment" for each patient, including the patient's cultural and religious beliefs, barriers to communication and physical or cognitive limitations.
- Health care organizations should explore, evaluate and consider the use of multimedia approaches and health information technology to enable the provision of health care services that are patient- and family-centered and culturally tailored to the patient.

<u>APIAHF recommends the following additions and modifications to Organizational Supports</u>:

- Standard 8:
  - Health care organizations should ensure that the necessary fiscal and human resources, tools, skills, and knowledge to support and improve culturally competent policies and practices in the organization are available.
- Standard 9:
  - Any surveys created or conducted by the health care organization must, at a minimum, collect race, ethnicity, and primary written and spoken language. Analysis and survey results must also be stratified by race, ethnicity, and primary written and spoken language.
  - Health care organizations should monitor the availability, accessibility, and consumer satisfaction with the quality of interpretation services.
- Standard 10:
  - Health care organizations should, at a minimum, collect data on race, ethnicity, and spoken and written language in a systematic and uniform manner.
  - Health care organizations should collect data on granular ethnicity based on the population served. Categories should be selected from a "national list on the basis of health care quality issues, evidence or likelihood of disparities, or size of subgroups within the population. The selection of categories should also be informed by analysis of relevant data (e.g., Census data) on the service… population."[v]
  - Self-reported patient surveys and forms should include an open-ended choice of "Other, please specify: __" for ethnicity or language categories not listed in the survey or form.[vi]
  - Health care organizations should collect data on an individual's self-assessment of his/her level of English proficiency and on the preferred spoken language needed for effective communication with health care providers. For health care purposes, a rating of spoken English language proficiency of "less than very well" is considered limited English proficient.
  - Health care organizations should also collect data on the language spoken by a patient at home and the language in which the patient prefers to receive written documents.

- Standard 11:
    - Health care organizations should use indirect methods of data collection for service planning and conducting targeted interventions, where direct methods to collect race and ethnicity are not available. Indirect data should be distinguished from self-reported data and never be placed in the patient's medical record or used in individual clinical decision-making.
- Standard 12:
    - Health care organizations should collaborate with the community to implement programs with clinical and outreach components to address culturally diverse populations, health disparities, and equity in the community.
- Standard 14:
    - Health care organizations should use a quality improvement framework to address disparities in care and improve cultural competency.

4. Align the CLAS Standards with the Affordable Care Act

The CLAS standards should align and bolster the reform objectives of the Affordable Care Act (ACA) which include quality improvement goals through patient-centered care delivery models and reductions in health disparities. The ACA includes a number of provisions that support patient-centeredness including a requirement that the Secretary of HHS develop and update annually a national quality improvement strategy that includes priorities to improve the delivery of health care services, patient health outcomes and population health. Other national accreditation organizations have also developed standards for patient-centeredness including the National Committee for Quality Assurance and URAC. The Centers for Medicare and Medicaid Services (CMS) requirements for "meaningful use" of electronic health records (EHRs) can also provide a guide for this alignment. Please refer to Appendix B for a crosswalk of the CLAS Standards with CMS meaningful use requirements and patient-centered medical/health home standards.

In addition, the ACA reinforces many of the civil rights protections that are needed to achieve health equity. For instance, the ACA requires any health care activity or program receiving federal financial assistance, credits, subsidies or contract of insurance to comply with the nondiscrimination provisions of Section 1557 of the Act, which forbids discrimination on the grounds of race, color, national origin, gender, age, or disability. Health care plans, programs and organizations covered under Section 1557 must provide equitable services and benefits that are accessible to all groups, including individuals with limited English proficiency.

<u>APIAHF recommends the following additions and modifications to Culturally Competent Care:</u>

- Standard 1:
    - Health care organizations should conduct a comprehensive health assessment of all new patients to determine their risks and needs, as a method of ensuring patient-centered care.

<u>APIAHF recommends the following additions and modifications to Language</u>

Access Services:

- Standard 4:
    - Health care organizations should use language need data collection to show compliance with the standards for patient access to health care and effective patient communication.
- Standard 7:
    - Health care organizations should use EHRs to determine patient educational needs and provide patient-specific education resources, in languages commonly encountered in the service area.

APIAHF recommends the following additions and modifications to Organizational Supports:

- Standard 9:
    - Health care organizations should use EHRs to report clinical quality measures and assess internal compliance with CLAS standards.
    - Health care organizations should survey and request feedback from patients and their family members, and use this data to assess compliance with CLAS standards.
- Standard 10:
    - Health care organizations should include patient demographics, including race, ethnicity, and spoken and written language, in all patient lists and registries which are generated electronically for quality improvement.
- Standard 12:
    - Health care organizations should provide patients and their authorized family members with electronic copies or electronic access to their medical records, in the preferred languages of the patient, at appropriate literacy levels and in formats accessible by individuals with disabilities.
    - Health care organizations should provide patients with electronic access to referral and tracking of referrals to community resources.
    - Health care organizations should seek community participation from ethnic, cultural, and language minorities and other vulnerable populations at all stages of the planning and implementation process.

In conclusion, APIAHF appreciates the opportunity to comment on the CLAS enhancement initiative. APIAHF believes the CLAS standards will continue to have the potential to reduce health care disparities and promote more patient-centered and equitable care. Please contact Priscilla Huang, Associate Policy Director, at phuang@apiahf.org with any questions or for additional information.

Respectfully,

Kathy Lim Ko
President & CEO

[i] U.S. Department of Health and Human Services, Office of Inspector General, *Guidance and Standards on Language Access Services: Medicare Providers* (July 2010). Available at http://oig.hhs.gov/oei/reports/oei-05-10-00050.pdf. Accessed 12/12/10.

[ii] U.S. Department of Health and Human Services, Office of Consumer Information and Insurance Oversight, *Affordable Care Act (ACA) – Consumer Assistance Program Grants Invitation to Apply for FY 2010* (CFDA 93.519). Available at: https://www.grantsolutions.gov/gs/preaward/previewPublicAnnouncement.do?id=11720https://www.grantsolutions.gov/gs/preaward/previewPublicAnnouncement.do?id=11720. Accessed 12/22/10.

[iii] U.S. Department of Health and Human Services, the Secretary's Advisory Committee on National Health Promotion and Disease Prevention Objectives for 2020, *Phase 1 report: Recommendations for the framework and format of Healthy People 2020*, Section IV, Advisory Committee findings and recommendations. Available at http://www.healthypeople.gov/hp2020/advisory/PhaseI/sec4.htm#_Toc211942917. Accessed 12/12/10.

[iv] U.S. Department of Health and Human Services, *Healthy People 2020*, Foundation Health Measures – Disparities. Available at: http://www.healthypeople.gov/2020/about/disparitiesAbout.aspx. Accessed 12/22/10.

[v] Institute of Medicine. 2009. *Report on Race, Ethnicity and Language Data: Standardization for Health Care Quality Improvement*. Washington, D.C. The National Academies Press. Available at http://www.iom.edu/Reports/2009/RaceEthnicityData.aspx. Accessed 12/12/10.

[vi] *Id.*