

pretation of sugar- and calorie-related nutrient-content claims through transparent food marketing are needed steps to empower parents to make informed choices. If the FDA revised the current labeling requirements for foods and beverages bearing sugar- and calorie-related nutrient-content claims in this way, the replacement of added sugars with other sweet ingredients would be clearly highlighted. And a statement about product sweetness and the quantity of nonnutritive sweeten-

ers that have been added would help parents understand what they are feeding their children.

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Culturally and Linguistically Appropriate Services — Advancing Health with CLAS

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The United States continues to grow more diverse. Currently, about 20% of the U.S. population speaks a language other than English at home, and 9% has limited English proficiency. By 2050, the United States will be a “majority minority” nation, with more than half the population coming from racial or ethnic minority backgrounds. Diversity is even greater when dimensions such as geography, socioeconomic status, disability status, sexual orientation, and gender identity are considered. Attention to these trends is critical for ensuring that health disparities narrow, rather than widen, in the future.

The U.S. Department of Health and Human Services (HHS) has long promoted cultural and linguistic competence as one way to address health disparities. Boosting such competence among health care providers and organizations could not only help them

improve health equity but also increase client satisfaction, improve quality and safety, gain a market advantage, and meet legislative and regulatory standards. Although many providers are personally committed to improving cultural and linguistic competence, their organizations may remain uncertain about how best to become welcoming to all.

To address this need, in 2013, the HHS Office of Minority Health (OMH) released the enhanced National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health and Health Care (see box). These standards provide a framework for organizations seeking to offer services responsive to individual cultural health beliefs and practices, preferred languages, health-literacy levels, and communication needs.¹ Building on standards released in 2000, the enhanced standards employ broader definitions of culture

(beyond traditional considerations of race and ethnicity) and health (including mental health as well as physical health, for example). They apply to organizations focused on prevention and public health as well as health care organizations. To guide and encourage adoption, the OMH released a blueprint highlighting promising practices and exemplary programs.¹

Although adherence is voluntary, many organizations have committed to some or all of the 15 standards, which fall under three themes.¹ The first, “Governance, Leadership, and Workforce,” emphasizes that the responsibility for CLAS implementation rests at the highest levels of organizational leadership. Prominent groups have endorsed this concept. For example, the National Quality Forum identifies leadership as one of the seven primary domains for measuring and reporting cultural

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

The 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:

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 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, orally and in writing.
7. Ensure the competence of individuals providing language assistance, recognizing that the use of untrained individuals 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 processes for conflict and grievance resolution 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.

competence.¹ National public health organizations such as the American Public Health Association and the Society for Public Health Education promote CLAS and health equity policies through their mission, vision, or values statements. The Health Research

and Educational Trust, an affiliate of the American Hospital Association, asks organizations whether their boards set cultural-competence goals in their strategic plans¹ and whether diversity awareness and training are required for senior leadership, management, staff, and volunteers — since without culturally appropriate services, any client encounter could result in misunderstanding. Some studies have linked greater cultural competence in health settings to greater client trust and better patient-reported quality of care.¹⁻⁴

Standards under the second theme, “Communication and Language Assistance,” include the recommendation that language assistance should be provided as needed, in a manner appropriate to the organization's size, scope, and mission. For example, the multifaceted language assistance at California's Alameda Alliance for Health includes interpreters, bilingual staff, remote interpreting systems, and Braille materials.¹ The alliance informs members of the availability of assistance in their preferred language through welcome packets, newsletters, “I speak . . .” cards with which clients indicate their language needs, and verbal contact with the member services department. Notably, health care organizations and providers that receive federal financial assistance without providing free language-assistance services could be in violation of Title VI of the Civil Rights Act of 1964 and its implementing regulations. (The HHS Office for Civil Rights encourages requests for information and technical assistance concerning the law.⁵)

The third theme, “Engage-

ment, Continuous Improvement, and Accountability,” underscores the importance of quality improvement, community engagement, and evaluation. Organizations can assess whether their CLAS activities meet their community’s needs and communicate implementation progress to interested parties. For example, in its resource manual for stakeholders, “Making CLAS Happen,” the Massachusetts Department of Public Health recommends using “cultural brokers,” such as community health workers or *promotores de salud*, as bridges to people of various cultural backgrounds.

Building on standards released in 2000, the enhanced CLAS standards employ broader definitions of culture (beyond traditional considerations of race and ethnicity) and health (including mental health as well as physical health, for example).

Embracing systemic change, a growing number of national programs, states, and institutions have committed to adopting the CLAS standards comprehensively. For example, the Joint Commission has established accreditation standards targeting improved communication, cultural competence, patient-centered care, and provision of language-assistance services. Its “Comprehensive Accreditation Manual for Hospitals” addresses the importance of collecting data on patients’ race and ethnic background, meeting patients’ communication needs, establishing qualifications for interpreters and translators, and ensuring nondiscrimination in care delivery.

National health care groups have also leveraged the CLAS standards to move toward health equity (www.equityofcare.org). In 2011, the American College of Healthcare Executives, the American Hospital Association, the Association of American Medical Colleges, the Catholic Health Association of the United States, and the National Association of Public Hospitals and Health Systems (now known as America’s Essential Hospitals) issued a call to eliminate health care disparities by improving the collection of race, ethnicity, and language-preference data; increasing cultural-competence training; and

who can serve members and patients in their preferred language. Its Clinician Cultural and Linguistic Assessment Initiative supports language concordance programs that enable provider–patient matching based on linguistic preferences. And a Lesbian, Gay, Bisexual, Transgender Health Equity Initiative and a Member Demographic Data Collection Initiative for race, ethnicity, language preference, sexual orientation, and gender identity have earned recognition by the National Committee for Quality Assurance and the Institute of Medicine.

Future efforts should promote evaluation of the CLAS standards to build a robust evidence base about their impact. Some studies have proposed tools for assessing cultural competence within health organizations.^{2,3} Adopters of the standards can contribute to evolving knowledge about their dissemination and effect on quality of care, health literacy, and health disparities, among other critical areas. It would also be useful to study the standards’ application in addressing specific health issues, such as cardiovascular disease, HIV/AIDS, mental health, and multiple coexisting conditions, as well as in health-promotion and disease-prevention initiatives. Furthermore, research should clarify the standards’ potential effects on new models of care, including patient-centered health homes and accountable care organizations, as well as community health improvement activities. Understanding how meeting the standards ultimately changes health and economic outcomes would help organizations in weighing practice and business decisions.

Many observers today are ask-

increasing diversity in governance and leadership. Moreover, at least six states have laws requiring or strongly recommending cultural-competence training for providers that includes the CLAS standards.¹

Kaiser Permanente, a non-profit health plan with 9.3 million members, has adopted the CLAS standards and committed to myriad initiatives to support them. The company’s National Diversity and Inclusion function provides oversight, technical expertise, and consultation to promote the standards throughout its facilities in eight states and the District of Columbia. Its Qualified Bilingual Staff Model and Program trains bilingual staff

ing how our health system can best meet our country's future needs. Achieving health equity for all remains a critical goal. Advancing health with CLAS can help us attain the high-quality system of care and prevention that all people, regardless of background, need and deserve.

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