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

A Condensed Blueprint for Advancing and Sustaining CLAS Policy and Practice

New Jersey Department of Health
OFFICE OF MINORITY AND MULTICULTURAL HEALTH

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Commissioner

ACKNOWLEDGMENTS

The National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care (the *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 care organizations to implement culturally and linguistically appropriate services. The New Jersey Department of Health Office of Minority and Multicultural Health has compiled this condensed version of the *Blueprint for Advancing and Sustaining CLAS Policy and Practice* for our community partners, e.g. community and faith-based organizations, public health agencies, hospitals and others to have available as a quick reference to the comprehensive version which can be downloaded in its' entirety at https://www.thinkculturalhealth.hhs.gov/index.asp. We extend our appreciation to the U.S. Department of Health and Human Services' Office of the Assistant Secretary of Health (OASH) for granting the New Jersey Department of Health Office of Minority and Multicultural Health permission to create this condensed version of the *Blueprint for Advancing and Sustaining CLAS Policy and Practice*. Specifically, we would like to thank the following individuals:

1. Christine Huong Montgomery- Department of Health and Human Services Office of the Assistant Secretary of Health
2. Mayra Alvarez- Department of Health and Human Services Office of the Assistant Secretary of Health
3. Stacey L. Williams- Department of Health and Human Services Office of the Assistant Secretary of Health

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Commissioners' Message

The Department of Health is pleased to release this condensed version of the Culturally and Linguistically Appropriate Services (CLAS) Blueprint for Advancing and Sustaining CLAS Policy and Practice. We are aware of the challenges associated with providing healthcare services to the multicultural and ethnically diverse communities across the State of New Jersey. We recognize that more than 100 foreign languages are spoken as the primary language in the homes of many of our residents. We also know that language and the cultural beliefs are important variables that can impact the delivery of health services. That is why we believe releasing this condensed version of *The Blueprint* to our community partners will become a best practice for engaging and assisting residents from any culture, race or ethnicity as they access our healthcare system. *The Blueprint* describes the process for developing and following a standard way to address cultural differences and effective implementation strategies designed for any setting. It is the intent of the New Jersey Department of Health to raise the awareness of New Jersey's community and faith-based organizations, public health agencies, hospitals, federally qualified health centers, (FQHC) and others regarding the important role the CLAS standards play in the delivery of health care.

As many of you are aware, Healthy New Jersey 2020(HNJ2020) is the states' 10-year public health agenda, aimed at improving the overall health of New Jersey's residents. It is composed of key topic areas which are consistent with New Jersey's priority health areas outlining objectives and measurable outcomes for the total population including racial/ethnic, age, and gender subgroups. The importance of cultural competency standards is embedded in the goals and objectives of the Healthy New Jersey 2020 (HNJ2020).

Additionally, the U.S. Department of Health and Human Services' Office of the Assistant Secretary of Health's' (OASH) enhanced CLAS standards underscore the importance of the Healthy New Jersey 2020 overarching goals:

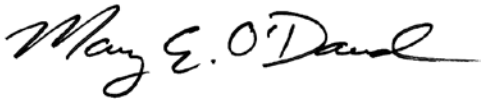
- Attain high-quality, longer lives free of preventable disease, disability, injury, and premature death.
- Achieve health equity, eliminate disparities, and improve health for all people.
- Create social and physical environments that promote good health for all.
- Promote quality of life, healthy development, and healthy behaviors across all life stages.

With the goals of the HNJ2020 in mind, we relate the importance of the principal standard of the CLAS - ***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***. We encourage all health care providers and agencies, community and faith-based organizations to consider the differences in culture, language, race, and ethnicity, as we move toward developing new and more culturally appropriate ways to achieve health equity for our residents.

The New Jersey Department of Health strives to ensure that all public health agencies have the most relevant information to meet the health care needs of all New Jersey residents regardless of their culture, religion, race, ethnicity, language, disability, age, socioeconomic status, gender and, or sexual orientation. We, therefore, encourage all public health agencies to consider culture and language as key influences in the delivery of care and the way in which people from different cultures approach and understand health. We believe the adoption of the U. S. Department of Health and Human Services Office of the Assistant Secretary of Health (OASH) enhanced CLAS standards and *The Blueprint*, in this condensed version, will help shape New Jersey's health services into a more accessible healthcare system for all people, particularly those from different cultures with limited English proficiency.

The New Jersey Department of Health offers this condensed version of the *National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care: A Blueprint for Advancing and Sustaining CLAS Policy and Practice (the Blueprint)*. The complete and comprehensive *Blueprint* can be downloaded from the US OMH website at https://www.thinkculturalhealth.hhs.gov/index.asp. We have elected to publish a condensed version of *The Blueprint* in table format highlighting each standard, the purpose of the standard and, strategies for implementing the standards. A glossary and bibliography are also included. More details concerning components of the standards and resources are available in the original version of the *Blueprint*.

We hope that you will be inspired by the implementation strategies outlined for each of the fifteen standards and that you will give serious consideration to incorporating culturally and linguistically appropriate services within your agency based on the CLAS standards. As recognized by the U.S. Department of Health and Human Services' Office Of The Assistant Secretary of Health, "adoption of the National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care will help advance better health and health care in the United States" (2013, HHS OMH).



Mary E. O'Dowd, M.P.H.
Commissioner

THE ENHANCED NATIONAL CLAS STANDARDS

The Enhanced National Culturally and Linguistically Appropriate Standards are organized as one Principal Standard and three themes:

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.

The Blueprint

The condensed version of *The Blueprint* has been compiled into an easy to read table format that includes a definition for each CLAS standard along with the identified purpose of the standard, and easy to adopt strategies for the implementation of each standard. The link to the comprehensive *Blueprint for Advancing and Sustaining CLAS Policy and Practice* is also included for your reference. https://www.thinkculturalhealth.hhs.gov/index.asp

Table 1: PROVIDE EFFECTIVE, EQUITABLE, UNDERSTANDABLE, AND RESPECTFUL QUALITY CARE AND SERVICES

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.
Purpose:	The purposes of providing effective, equitable, understandable, and respectful quality care and services are: • To create a safe and welcoming environment at every point of contact that both fosters appreciation of the diversity of individuals and provides patient- and family-centered care • To ensure that all individuals receiving health care and services experience culturally and linguistically appropriate encounters • To meet communication needs so that individuals understand the health care and services they are receiving, can participate effectively in their own care, and make informed decisions • To eliminate discrimination and disparities
Strategies for Implementation:	Standard 1 is the Principal Standard because, conceptually, the ultimate aim in adopting the remaining Standards is to achieve Standard 1. Standards 2 through 15 represent the practices and policies intended to be the fundamental building blocks of culturally and linguistically appropriate services that are necessary to achieve the Principal Standard. For this reason, Strategies for Implementation specific to Standard 1 are not listed here. If each of Standards 2 through 15 is implemented and maintained, organizations will be better positioned to achieve the desired goal of "effect, 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."

Table 2: ADVANCE AND SUSTAIN GOVERNANCE AND LEADERSHIP THAT PROMOTES CLAS AND HEALTH EQUITY

Standard 2:	Advance and sustain organizational governance and leadership that promotes CLAS and health equity through policy, practices, and allocated resources.
Purpose:	The purposes of advancing and sustaining governance and leadership that promotes CLAS and health equity are: • To ensure the provision of appropriate resources and accountability needed to support and sustain initiatives • To model an appreciation and respect for diversity, inclusiveness, and all beliefs and practices • To support a model of transparency and communication between the service setting and the populations that it serves
Strategies for Implementation:	The following are possible implementation strategies for advancing and sustaining governance and leadership that promotes CLAS and health equity: From the National Quality Forum (2009): • Create and sustain an environment of cultural competency through establishing leadership structures and systems or embedding them into existing structures and systems. • Identify and develop informed and committed champions of cultural competency throughout the organization in order to focus efforts around providing culturally competent care. • Ensure that a commitment to culturally competent care is reflected in the vision, goals, and mission of the organization and couple this with an actionable plan. • Implement strategies to recruit, retain, and promote at all levels of the organization a diverse leadership that reflects the demographic characteristics of the populations in the service area. • 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. • Commit to cultural competency through system-wide approaches that are articulated through written policies, practices, procedures and programs. • Actively seek strategies to improve the knowledge and skills that are needed to address cultural competency in the Organization. From the Joint Commission (Wilson-Stronks & Galvez,2007): • Provide for internal multidisciplinary dialogues about language and culture issues. • Create financial incentives to promote, develop, and maintain accessibility to qualified health care interpreters.

TABLE 3: RECRUIT, PROMOTE, AND SUPPORT A DIVERSE GOVERNANCE, LEADERSHIP, AND WORKFORCE

Standard 3	Recruit, promote, and support a culturally and linguistically diverse governance, leadership, and workforce that are responsive to the population in the service area.
Purpose	The purpose of recruiting, promoting, and supporting a diverse governance, leadership, and workforce are: • To create an environment in which culturally diverse individuals feel welcomed and valued • To promote trust and engagement with the communities and populations served • To infuse multicultural perspectives into planning, design, and implementation of CLAS • To ensure diverse viewpoints are represented in governance decisions • To increase knowledge and experience related to culture and language among staff
Strategies for Implementation	The following are possible implementation strategies for the recruitment, promotion, and support of a diverse governance, leadership, and workforce: **Recruitment** • Advertise job opportunities in targeted foreign language and minority health professional associations' job boards, publications, and other media (e.g. social media networks, professional organizations' email Listservs, etc.), and post information in multiple languages (QSource, 2005). • Develop relationships with local schools, training programs, and faith-based organizations to expand recruitment base (QSource, 2005). • Recruit at minority health fairs (QSource, 2005). • Collaborate with businesses, public school systems, and other stakeholders to build potential workforce capacities and recruit diverse staff. In particular, linkages between academic and service settings can help identify potential recruits already in the educational "pipeline" and provide them with additional academic support and resources necessary to meet job requirements (The Sullivan Commission on Diversity in the Healthcare Workforce, 2004). • Assess the language and communication proficiency of staff to determine fluency and appropriateness for serving as interpreters. **Promotion and Support** The Joint Commission's *Advancing Effective Communication, Cultural Competence, and Patient- and Family-Centered Care*: *A Roadmap for Hospitals* (2010) provides the following implementation strategies for the promotion and support of a diverse governance, leadership, and workforce: • Create a work environment that respects and accommodates the cultural diversity of the local workforce. • Develop, maintain, and promote continuing education and career development opportunities so all staff members may progress within the organization.

	• Cultivate relationships with organizations and institutions that offer health and human service career training to establish volunteer, work-study, and internship programs. **Other strategies for promoting and supporting a diverse governance, leadership, and workforce include (HHS OMH, 2001):** • Promote mentoring opportunities. • Conduct regular, explicit assessments of hiring and retention data, current workforce demographics, promotion demographics, and community demographics. • Monitor work assignments and hire sufficient personnel to ensure a manageable and appropriate workload for bilingual/bicultural staff members. • Use nonclinical support staff in cultural broker positions only after providing sufficient training and recognition (e.g., compensation, job title, or description). • Promote diverse staff members into administrative or managerial positions where their cultural and linguistic capabilities can make unique contributions to planning, policy, and decision-making. • Foster an environment in which differences are respected and that is responsive to the challenges a culturally and linguistically diverse staff brings into the workplace.

Table 4: EDUCATE AND TRAIN GOVERANCE, LEADERSHIP, AND WORKFORCE IN CLAS

Standard 4	Educate and train governance, leadership, and workforce in culturally and linguistically appropriate policies and practices on an ongoing basis.
Purpose	The purpose of educating and training governance, leadership, and workforce in CLAS are: • To prepare and support a workforce that demonstrates the attitudes, knowledge, and skills necessary to work effectively with diverse populations • To increase the capacity of staff to provide services that are culturally and linguistically appropriate • To assess the progress of staff in developing cultural, linguistic, and health literacy competency • To foster an individual's right to respect and nondiscrimination by developing and implementing education and training programs that address the impact of culture on health and health care.
Strategies for Implementation	The following are possible implementation strategies for educating and training governance, leadership, and workforce on CLAS: • Engage staff in dialogues about meeting the needs of diverse populations (Wilson-Stronks & Galvez, 2007). • Provide ongoing in-service training on ways to meet the unique needs of the population, including regular in-services on how and when to access language services for individuals with limited English proficiency (Wilson-Stronks & Galvez, 2007). • Take advantage of internal and external resources available to educate governance, leadership, and workforce on cultural beliefs they may encounter (Wilson-Stronks & Galvez, 2007). • Allocate resources to train current staff in cultural competency or as medical interpreters if they speak a second language, have completed language assessments, and show an interest in interpretation (QSource, 2005). • Incorporate cultural competency and CLAS into staff evaluations (QSource, 2005). • Provide opportunities for CLAS training that include regular in-services, brown-bag lunch series, orientation materials for new staff, and annual update meetings (QSource, 2005). • Encourage staff to volunteer in the community and to learn about community members and other cultures (QSource, 2005), and work with community leaders and cultural brokers to create opportunities for such interactions. • Evaluate education and training (see Standard 10). • Take advantage of live and Web-based health disparities and cultural competency continuing education programs for clinicians and practitioners (Like, 2011)

Table 5: OFFER COMMUNICATION AND LANGUAGE ASSISTANCE

Standard 5	Offer language assistance to individuals who have limited English proficiency and/or other communication needs, at no cost to them, to facilitate timely access to all health care and services.
Purpose	The purposes of offering communication and language assistance are: • To ensure that individuals with limited English proficiency and/or other communication needs have equitable access to health services • To help individuals understand their care and service options and participate in decisions regarding their health and health care • To increase individuals' satisfaction and adherence to care and services • To improve patient safety and reduce medical error related to miscommunication • To help organizations comply with requirements such as Title VI of the Civil Rights Act of 1964; the Americans with Disabilities Act of 1990; and other relevant federal, state, and local requirements to which they may need to adhere
Strategies for Implementation	The following are possible implementation strategies for offering communication and language assistance: • Ensure that staff is fully aware of, and trained in, the use of language assistance services, policies, and procedures (see Standard 4) (HHS OMH, 2005). • Develop processes for identifying the language(s) an individual speaks (e.g., language identification flash cards or "I speak" cards) and for adding this information to that person's health record (QSource, 2005). • Use qualified and trained interpreters to facilitate communication (Wilson-Stronks & Galvez, 2007), including ensuring the quality of the language skills of self-reported bilingual staff who use their non-English language skills during patient encounters (Regenstein, Andres, & Wynia, in press). • Establish contracts with interpreter services for in-person, over-the-phone, and video remote interpreting (HHS OMH, 2005). • Use cultural brokers when an individual's cultural beliefs impact care communication (Wilson-Stronks & Galvez, 2007). • Provide resources onsite to facilitate communication for individuals who experience impairment due to a changing medical condition or status (e.g., augmentative and alternative communication resources or auxiliary aids and services) as noted in *Advancing Effective Communication, Cultural Competence, and Patient- and Family-Centered Care: A Roadmap for Hospitals (The Joint Commission, 2010)*.

Table 6: INFORM INDIVIDUALS OF THE AVAILABILITY OF LANGUAGE ASSISTANCE

Standard	Inform all individuals of the availability of language assistance services clearly and in their preferred language, verbally and in writing.
Purpose	The purposes of informing individuals of the availability of language assistance are: • To inform individuals with limited English proficiency, in their preferred language, that language services are readily available at no cost to them • To facilitate access to language services • To help organizations comply with requirements such as Title VI of the Civil Rights Act of 1964; the Americans with Disabilities Act of 1990; and other relevant federal, state, and local requirements to which they may need to adhere.
Strategies for Implementation	The following are possible implementation strategies for informing individuals of the availability of language assistance: The HHS Office of Minority Health's *A Patient-Centered Guide to Implementing Language Access Services in Healthcare Organization (2005)* identified the following strategies to effectively inform individuals of the availability of language assistance: • Determine the content and language of notices • Decide how to communicate or provide notice to individuals • Decide where to provide notice to individuals about the availability of assistance In determining the content and languages of the notices, organizations should consider the following: • Notification should describe what communication and language assistance is available, in what languages the assistance is available, and to whom they are available. It should clearly state that communication and language assistance is provided by the organization free of charge to individuals (HHS OMH, 2005). • Notification should be easy to understand at a low literacy level (HHS OMH, 2005). In deciding how to communicate or provide notice to individuals about the availability of language services, organizations should consider the following: • **Signage, Materials, and Multimedia:** Organizations should reflect the languages regularly encountered in the service area in their signs, materials, and multimedia resources (Berger, 2005; HHS OCR, 2003). For those who may not be literate, information can be conveyed orally or through signage using symbols or pictures (HHS OMH, 2005; Kashiwagi, 2004). • **Cultural Mediation:** Another method for promoting quality communication is through the development of a cultural mediation program. A cultural mediator can act as a liaison between the culture of the organization and the culture of the individual. An additional strategy for notifying individuals of language services through mediation is by developing a health promotion program (e.g. community health workers and promotores de salud) that includes bilingual staff who train community members to share health and resource information with other community members (HHS OMH, 2005; Youdelman & Perkins,2005) • **Community Outreach:** Providing notification throughout the community is also important for reaching those who may be unaware of the organization

	or what services the organization may provide. In accordance with Standard 13, consider sending notification through local health departments, community-based organizations, faith-based organizations, schools, or any other stakeholders who would benefit from having information on health services (HHS OCR, 2003; HHS OMH, 2005). • **Initial Point of Contact:** It is recommended that organizations standardize procedures for staff members who serve as the initial point of contact for individuals, whether that is by telephone or in person. It may be appropriate to provide staff with a script to ensure that they inform individuals of the availability of language assistance and to inquire whether they will need to utilize any of the available services. Multilingual phone trees and voice mail should also be used to inform individuals of the available language assistance service and how to access them (HHS OCR, 2003; HHS OMH, 2005). • **Non-English Media:** Organizations should publicize availability of language assistance services in local foreign language media, such as ethnic radio, newspapers, and television (HHS OMH, 2005; Youdelman et al., 2007). In deciding where to provide notice to individuals about the availability of language services, organizations should consider the following: • Points of entry or intake, including: o **Registration desks** o **Front desks** o **Waiting rooms** o **Financial screening rooms, where individuals may need to discuss and resolve billing issues** o **Pharmacy reception, where individuals may pick up prescriptions** (HHS OMH, 2005; Kashiwagi, 2004). • Areas where clinical work is performed, such as triage and medical exam rooms (HHS OMH, 2005).

Table 7: ENSURE THE COMPETENCE OF INDIVIDUALS PROVIDING LANGUAGE ASSISTANCE

<table>
<tr><td>Standard 7</td><td>Ensure the competence of individuals providing language assistance, recognizing that the use of untrained individuals and/or minors as interpreters should be avoided</td></tr>
<tr><td>Purpose</td><td>The purposes of ensuring the competence of individuals providing language assistance are:
To provide accurate and effective communication between individuals and providers
To reduce misunderstanding, dissatisfaction, omission of vital information, misdiagnoses, inappropriate treatment, and patient safety issues due to reliance on staff or individuals that lack interpreter training
To empower individuals to negotiate and advocate, on their own behalf, for important services via effective and accurate communication with health and health care staff
To help organizations comply with requirements such as Title VI of the Civil Rights Act of 1964; the Americans with Disabilities Act of 1990; and other relevant federal, state, and local requirements to which they may need to adhere</td></tr>
<tr><td>Strategies for Implementation</td><td>Depending upon an organization’s size, scope, and mission, its language assistance strategies will differ. Organizations may opt to provide interpretation services through in-person interpreters and bilingual staff and providers or through technological or electronic means, including telephonic or video remote interpreting. Translation may be conducted primarily internally or may be contracted to external organizations.

The following are possible implementations strategies for ensuring the competence of individuals providing language assistance:
Assess the individual’s language ability. There exist many options for testing an individual’s ability to communicate in a foreign language. The following table summarizes two of the leading language proficiency scales, the American Council on the Teaching of Foreign Language scale (ACTFL) and the Interagency Language Roundtable (ILR) scale (LinguaLinks Library, 1999):
<table>
<tr><th>ILR Scale</th><th>ACTFL Scale</th><th>Definition</th></tr>
<tr><td>5</td><td>Native</td><td>Able to speak like an educated native speaker</td></tr>
<tr><td>4+
4</td><td>Distinguished</td><td>Able to speak with a great deal of fluency, grammatical accuracy, precision of vocabulary and idiomaticity</td></tr>
<tr><td>3+
3</td><td>Superior</td><td>Able to speak the language with sufficient structural accuracy and vocabulary to participate effectively in most formal and informal conversations</td></tr>
<tr><td>2+</td><td>Advanced Plus</td><td>Able to satisfy most work requirements and show some ability to communicate on concrete topics</td></tr>
</table></td></tr>
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2	Advanced	Able to satisfy routine social demands and limited work requirements
1+	Intermediate-High	Able to satisfy most survival needs and limited social demands
1	Intermediate-Mid Intermediate-Low	Able to satisfy some survival needs and some limited social demands Able to satisfy basic survival needs and minimum courtesy requirements
0+	Novice-High	Able to satisfy immediate needs with learned utterances
0	Novice-Mid Novice-Low 0	Able to operate in only a very limited capacity Unable to function in the spoken language No ability whatsoever in the language

- Assess the individual's ability to provide language assistance. The American Translators Association upholds standards of practice for translation services (n.d.). Similarly; the National Council on Interpreting in Health Care has issued standards of practice that define expectations of performance and outcomes for health care interpreters (2005). In addition, the Certification Commission for Healthcare Interpreters and the National Board for Certification of Medical Interpreters provide national certification for interpreters.
- The standards of practice identified by these professional organizations may offer promising practices in the provision of linguistically appropriate services. Keeping these standards at the core of hiring, training, and evaluating individuals will help ensure their competence in providing language assistance.
- Employ a "multifaceted model" of language assistance. Organizations may provide language assistance according to a variety of models, including bilingual staff or dedicated language assistance (e.g., a contract interpreter or video remote interpreting). A combination of models, or a multifaceted model, offers the organization a "comprehensive and flexible system [for] facilitating communication" (National Council on Interpreting in Health Care, 2002, p.4). Under a multifaceted model, for example, telephonic interpreting will supplement the language assistance provided by bilingual staff to ensure that at all times, language assistance is being provided by competent individuals.

Table 8: PROVIDE EASY-TO-UNDERSTAND MATERIALS AND SIGNAGE

Standard	Provide easy-to-understand print and multimedia materials and signage in the languages commonly used by the populations in the service area.
Purpose	The purpose of providing easy-to-understand materials and signage are: • To ensure that readers of other languages and individuals with various health literacy levels are able to access care and services • To provide access to health-related information and facilitate comprehension of, and adherence to, instructions and health plan requirements • To enable all individuals to make informed decisions regarding their health and their care and services options • To offer an effective way to communicate with large numbers of people and supplement information provided orally by staff members • To help organizations comply with requirements such as Title VI of the Civil Rights Act of 1964: the Americans with Disabilities Act of 1990; and other relevant federal, state, sand local requirements to which they may need to adhere
Strategies for Implementation	The following are possible implementation strategies for providing easy-to-understand materials and signage: • Issue plain language guidance and create documents that demonstrate best practices in clear communication and information design (HHS ODPHP, 2010). • Create forms that are easy to fill out, and offer assistance in completing forms (AHRQ, 2010) • Consult local librarians to help build an appropriate collection of health materials (HHS ODPHP, 2010) • Train staff to develop and identify easy-to-understand materials, and establish processes for periodically re-evaluating and updating materials (AHRQ, 2010). • Formalize processes for translating materials into languages other than English and for evaluating the quality of these translations (Wilson-Stronks & Galvez, 2007). • Develop materials in alternative formats for individuals with communication needs, including those with sensory, developmental, and/or cognitive impairments as noted in *Advancing Effective Communication, Cultural Competence, and Patient – and Family-Centered Care: A Roadmap for Hospitals* (The Joint Commission, 2010) • Test materials with target audiences. For example, focus group discussions with members of the target population can identify content in the material that might be embarrassing or offensive, suggest cultural practices that provide more appropriate examples, and assess whether graphics reflect the diversity of the target community. Organizations should consider providing financial compensation or in-kind services to community members who help translate and review materials (HHS OMH, 2001).

Table 9: INFUSE CLAS GOALS, POLICIES, AND MANAGEMENT ACCOUNTABILITY THROUGHOUT THE ORGANIZATION'S PLANNING AND OPERATIONS

Standard 9	Establish culturally and linguistically appropriate goals, policies, and management accountability, and infuse them throughout the organization's planning and operations
Purpose	The purposes of infusing CLAS throughout the organization's planning and operations are: • To make CLAS central to the organization's service, administrative, and supportive functions • To integrate CLAS throughout the organization (including the mission) and highlight its importance through specific goals • To link CLAS to other organizational activities, including policy, procedures, and decision-making related to outcomes accountability
Strategies for Implementation	The following are possible implementation strategies for infusing CLAS goals, policies, and management accountability throughout the organization's planning and operations: • Engage the support of governance and leadership, and encourage the allocation of resources to support the development, implementation, and maintenance of culturally and linguistically appropriate services. • Encourage governance and leadership to establish education and training requirements relating to culturally and linguistically appropriate services for all individuals in the organization, including themselves. • Identify champions within and outside the organization to advocate for CLAS, to emphasize the business case and rationale for CLAS, and encourage full-scale implementation. • Hold organizational retreats to identify goals, objectives and timelines to provide culturally and linguistically appropriate services. • Establish accountability mechanisms throughout the organization, including staff evaluations, individuals' satisfaction measures, and quality improvement measures (QSource, 2005). • Utilize the data gathered based on Standards 10, 11, and 12 to guide plan development. • In accordance with Standard 13, involve the populations in the service area in the implementation of CLAS through the strategic plan.

Table 10: CONDUCT ORGANIZATIONAL ASSESSMENTS

Standard 10	Conduct ongoing assessments of the organization's CLAS-related activities and integrate CLAS-related measures into measurement and continuous quality improvement activities.
Purpose	The purposes of conducting organizational assessments are: • To assess performance and monitor progress in implementing the National CLAS Standards. • To obtain information about the organization and the people it serves, which can be used to tailor and improve services. • To assess the value of CLAS-related activities relative to the fulfillment of governance, leadership, and workforce responsibilities.
Strategies for Implementation	The following are possible implementation strategies for conducting organizational assessments: • Conduct an organizational assessment or a cultural audit using existing cultural and linguistic competency assessment tools to inventory structural policies, procedures, and practices. These tools can provide guidance to determine whether the core structures and processes (e.g., management, governance, delivery systems, and customer relation functions) necessary for providing CLAS are in place. • Use results from assessments to identify assets (e.g., bilingual staff members who could be used as interpreters, existing relationships with community-based ethnic organizations), weaknesses (e.g., no translated signage or cultural competency training), and opportunities to improve the organization's structural framework and capacity to address cultural and linguistic competence in care (e.g., revise mission statement, recruit people from diverse cultures into policy and management positions). • Following the assessment, prepare adequate plans for developing CLAS (see Standard 9). Subsequent ongoing assessment helps organizations to monitor their progress in implementing the enhanced National CLAS Standards and to refine their strategic plans. The following are implementation strategies for integrating CLAS-related measures into measurement and continuous quality improvement activities (QSource, 2005): • Implement ongoing organizational assessment of CLAS-related activities • Provide individuals with CLAS-oriented feedback forms and include self-addressed, stamped envelopes to improve receipt of feedback • Conduct focus groups with individuals to monitor progress and identify barriers to full-scale CLAS implementation • Assess the standard of care provided for various chronic conditions to determine whether services are uniformly provided across cultural groups • Add CLAS-related questions to staff orientation materials and yearly reviews • Develop a system of reviewing and incorporating feedback and suggestions received and for monitoring their effect on CLAS implementation and outcomes • Identify outcome goals, including metrics, regarding cultural and linguistic competency and assess at regular intervals

Table 11: COLLECT AND MAINTAIN DEMOGRAPHIC DATA

<table>
<tr><td>Standard 11</td><td>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.</td></tr>
<tr><td>Purpose</td><td>• The purposes of collecting and maintaining demographic data are:
• To accurately identify population groups within a service area
• To monitor individual needs, access, utilization, quality of care, and outcome patterns
• To ensure equal allocation of organizational resources
• To improve service planning to enhance access and coordination of care
• To assess and improve to what extent health care services are provided equitably</td></tr>
<tr><td>Strategies for Implementation</td><td>The following are possible implementation strategies for collecting and maintaining demographic data:
<table>
<tr><td>When?</td><td>Ask for data early – ideally, during admission or registration</td></tr>
<tr><td>Who?</td><td>Properly trained admissions or reception staff could collect data</td></tr>
<tr><td>What will you tell Individuals?</td><td>Before obtaining information, develop a script to communicate that:
• This information is important.
• It will be used to improve care and services and to prevent discrimination.
• This information will be kept confidential.
In addition, address any concerns up front and clearly.</td></tr>
<tr><td>How?</td><td>Individual self-report – select their own race, ethnicity, language, etc.</td></tr>
<tr><td>What information will you collect? (Individual Data)</td><td>• Race
• Ethnicity
• Nationality
• Nativity
• Ability to speak English
• Language(s) other than English spoken
• Preferred spoken/written languages or other mode of communication
• Age
• Gender
• Sexual orientation
• Gender identity</td></tr>
</table>
</td></tr>
</table>

		• Income • Education • Informed of right to interpreter services • Request for, and/or use of, interpreter services • Treatment history • Medical history • Outcome data (service type utilization, length of stay) • Client satisfaction	
	What information will you collect? (Staff Data)	• Race • Ethnicity • Nationality • Nativity • Primary/preferred language • Gender • Records of cultural and linguistic competency training participation and evaluations	
	Tools to collect and store data	Use standard collection instruments. Store data in a standard electronic format.	
	Training	Provide ongoing data training and evaluation to staff	

(Massachusetts Department of Public Health, Office of Health Equity, 2009) Adapted from the Health Research and Evaluation Trust Health Disparities Toolkit (Hasnain-Wynia et al., 2007)

Table 12: CONDUCT ASSESSMENTS OF COMMUNITY HEALTH ASSETS AND NEEDS

Standard 12	Conduct regular assessments of community health assets and needs and use the results to plan and implement services that respond to the cultural and linguist diversity of population in the service area.
Purpose	The purposes of conducting assessments of community health assets and needs are: • To determine the service assets and needs of the populations in the service areas (needs assessment) • To identify all of the services available and not available to the populations in the service areas (resource inventory and gaps analysis) • To determine what services to provide and how to implement them, based on the results of the community assessment • To ensure that health and health care organizations obtain demographic, cultural, linguistic, and epidemiological baseline data (quantitative and qualitative) and update the data regularly to better understand the populations in their service areas
Strategies for Implementation	The following are possible implementation strategies for assessing community health assets and needs. • Partner with other organizations to negotiate a data sharing agreement, which could facilitate the linking of different types of data. • Collaborate with other organizations and stakeholders in data collection, analysis, and reporting efforts to increase data reliability and validity. • Conduct focus groups with individuals in the community (QSource, 2005). • Review demographic data collected with local health and health care organizations (QSource, 2005). • Use multiple sources in the community to collect data, including faith-based organizations, social workers, and managed care organizations (QSource, 2005). The HHS Administration for Children and Families' Head Start initiative recommends the following Outline for Assessing Community Needs and Resources (HHS Administration for Children and Families, 2008; University of Kansas, n.d.): 1. Describe the makeup and history of the community to provide a context within which to collect data on its current concerns. • Comment on the types of information that best describe the community (e.g., demographic, historical, political, civic participation, key leaders, past concerns, geographic, assets) • Describe the sources of information used (e.g., public records, local people, Internet, maps, phone book, library, newspaper) • Comment on whether there are sufficient resources available to collect this information (e.g., time, personnel, resources) • Describe the methods used to collect descriptive information (e.g., public forums, listening sessions, focus groups, interviews, surveys, observation)

- Assess the quality of the information
- Describe the strengths and difficulties identified

2. Describe what matters to people in the community, including a description of:

- Issues that people in the community care about (e.g., safety, education, housing, health)
- How important these issues are to the community (e.g., perceived importance, consequences for the community)
- Methods the organization will (did) use to listen to the community (e.g., listening sessions, public forums, interviews, concerns surveys, focus groups)

3. Describe what matters to key stakeholders, including:

- Who else cares about the issue (the stakeholders) and what they care about
- What stakeholders want to know about the situation (e.g., who is affected, how many, what factors contribute to the problem)
- Prioritized populations and subgroups to whom stakeholders are targeting benefits
- Methods used to gather information (e.g., surveys, interviews)

4. (For each identified problem/goal) Describe the evidence indicating whether the problem/goal should be a priority issue, including:

- The community-level indicators related to the issue (e.g., rate of infant deaths or vehicle crashes)
- How frequently the problem (or related behavior) occurs (e.g., number of youth reporting alcohol use in the past 30 days)
- How many people are affected by the problem and the severity of its effects
- How feasible it is to address the issue
- Possible impact and/or consequences of addressing the problem/goal

5. Describe the barriers and resources for addressing the identified issue(s), including:

- Barriers or resistance to solving the problem or achieving the goal (e.g., denial or discounting of the problem) and how they can be minimized (e.g., reframing the issue)
- What resources and assets are available and how the organization can tap into those resources to address the issue
- Community context or situation that might make it easier or more difficult to address this issue
- (Based on the assessment) Select and state the priority issue (or issues) to be addressed by the organization.

Table 13: PARTNER WITH THE COMMUNITY

Standard 13	Partner with the community to design, implement, and evaluate policies, practices, and services to ensure cultural and linguistic appropriateness.
Purpose	The purpose of partnering with the community is: • To provide responsive and appropriate service delivery to a community • To ensure that services are informed and guided by community interests, expertise, and needs • To increase use of services by engaging individuals and groups in the community in the design and improvement of services to meet their needs and desires • To create an organizational culture that leads to more responsive, efficient, and effective services and accountability to the community • To empower members of the community in becoming active participants in the health and health care process

Strategies for Implementation	The following are implementation strategies for partnering with the community:
	
	• Partner with local culturally diverse media to promote better understanding of available care and services and of appropriate routes for accessing services among all community members (Wilson-Stronks & Galvez, 2007).
	• Build coalitions with community partners to increase reach and impact in identifying and creating solutions. For example:
	  • Work on joint steering committees and coalitions.
	  • Sponsor or participate in health fairs, cultural festivals, and celebrations.
	  • Offer education and training opportunities.
	• Convene town hall meetings, hold community forums, and/or conduct focus groups (Prevention by Design, 2006).
	• Develop opportunities for capacity building initiatives, action research, involvement in service development, and other activities to empower the community (Equality and Human Rights Commission, 2009).
	• Collaborate to reach more people, to share information and learn, and to improve services. Work with partners to advertise job openings, identify interpreting resources, and organize health promotion activities. Successful partnerships benefit all.
	
	In addition, the following professionals and volunteers may facilitate communication between an organization and the community it serves:
	
	• Cultural brokers are individuals from the community who can serve as a bridge between an organization and people of different cultural backgrounds. Cultural brokers should be familiar with the health system and with the community in which they live and/or from where they originated.

	They can become a valuable source of cultural information and serve as mediators in conflicts and as agents for change (Massachusetts Department of Public Health, 2009). • Promotores de salud/community health workers are volunteer community members and paid front-line public health workers who are trusted members of the community served or have an unusually close understanding of that community. They generally share the ethnicity, language, socio-economic status, and life experiences of the community members. These social attributes and trusting relationships enable community health workers to serve as liaisons, links, or intermediaries between health and social services and the community to facilitate access to and enrollment in services and improve the quality and cultural competency of services (HHS OMH, 2011).

Table 14: CREATE CONFLICT AND GRIEVANCE RESOLUTION PROCESSES

Standard 14	Create conflict and grievance resolution processes that are culturally and linguistically appropriate to identify, prevent, and resolve conflicts or complaints.
Purpose	The purposes of creating conflict and grievance resolution processes that are culturally and linguistically appropriate are: • To facilitate open and transparent two-way communication and feedback mechanisms between individuals and organizations • To anticipate, identify, and respond to cross-cultural needs • To meet federal and/or state level regulations that address topics such as grievance procedures, the use of ombudspersons, and discrimination policies and procedures
Strategies for Implementation	The following are possible implementation strategies for creating conflict and grievance resolution processes that are culturally and linguistically appropriate: • Provide cross-cultural communication training, including how to work with an interpreter, and conflict resolution training to staff who handle conflicts, complaints, and feedback • Provide notice in signage, translated materials, and other media about the right of each individual to provide feedback, including the right to file a complaint or grievance • Develop a clear process to address instances of conflict and grievance that includes follow-up and ensures that the individual is contacted with a resolution and next steps (QSource, 2005) • Obtain feedback via focus groups, community council or town hall meetings, meetings with community leaders, suggestion and comment systems, open houses, and/or listening sessions • Hire patient advocates or ombudspersons (QSource, 2005). • Include oversight of conflict and grievance resolution processes to ensure their cultural and linguistic appropriateness as part of the organization's overall quality assurance program

Table 15: COMMUNICATE THE ORGANIZATION'S PROGRESS IN IMPLEMENTING AND SUSTAINING CLAS

Standard 15	Communicate the organization's progress in implementing and sustaining CLAS to all stakeholders, constituents, and the general public.
Purpose	The purposes of communicating the organization's progress in implementing and sustaining CLAS to all stakeholders, constituents, and the general public are: • To convey information to intended audiences about efforts and accomplishments in meeting the National CLAS Standards • To learn from other organizations about new ideas and successful approaches to implementing the National CLAS Standards • To build and sustain communication on CLAS priorities and foster trust between the community and the service setting • To meet community benefits and other reporting requirements, including accountability for meeting health care objectives in addressing the needs of diverse individuals or groups
Strategies for Implementation	The following are implementation strategies for being accountable to the community by presenting to the public progress in implementing culturally and linguistically appropriate services. Items on which to report may include (HHS OMH, 2001): • Demographic data about the populations • Utilization and availability statistics related to interpreters and translated materials • Level of staff training in cultural and linguistic competency • CLAS-related expenditures and cost-benefit data • Assessment results based on activities suggested from Standard 10, community data collected in accordance with Standard 12, and the number of complaints and their resolution as collected pursuant to Standard 14. • Results from performance measures, satisfaction ratings, quality improvement and clinical outcome data analyses, and cost-effectiveness analyses Strategies for presenting CLAS-related progress include: • Draft and distribute materials that demonstrate efforts to be culturally and linguistically responsive (QSource, 2005). The materials should be easy to understand and in accordance with Standard 8 • Partner with community organizations to lead discussions about the services provided and progress made (QSource, 2005); see also Standard 13 • Create advisory boards to consult with community partners on issues affecting diverse populations and how best to serve and reach them (National Consensus Panel on Emergency Preparedness and Cultural Diversity, 2011). • Engage community-based workers to help craft and deliver messages and implications of data. Community outreach that is culturally and linguistically tailored and provided by trusted messengers is central to ensuring

	messages are received, understood, and adhered to by local members of the community. Community-based workers are seen as trusted sources of health information and can help with reaching and educating communities (National Consensus Panel on Emergency Preparedness and Cultural Diversity, 2011) • Convene educational forums. Agencies may consider partnering with well-respected and trusted community-based organizations to host regional educational forums, inviting local community representatives to participate. Educational forums are intended to provide education, materials, and information on topics of most concern to communities — whether regarding public health, public safety, or primary care. At the same time, they include feedback sessions, where community partners and representatives can assess and evaluate the validity and application of recommendations, resources, and materials to their communities' cultural, social, and economic circumstances (National Consensus Panel on Emergency Preparedness and Cultural Diversity, 2011)

https://www.thinkculturalhealth.hhs.gov/index.asp.

Bibliography, Glossary and Glossary Bibliography

The Bibliography is included for your reference and relates to the citations found throughout *The Blueprint*. Also included for your use and reference is Appendix A: Glossary –References, and Appendix B: Glossary Bibliography. Both documents are copied in the original format. However, we suggest referring to the website link for additional clarification.
https://www.thinkculturalhealth.hhs.gov/index.asp.

BIBLIOGRAPHY

Beach, M. C., Cooper, L. A., Robinson, K. A., Price, E. G., Gary, T. L., Jenckes, M. W., … Powe, N. R. (2004). Strategies for improving minority healthcare quality. (AHRQ Publication No. 04-E008-02). Retrieved from the Agency of Healthcare Research and Quality website: http://archive.ahrq.gov/downloads/pub/evidence/pdf/minqual/minqual.pdf

Berger, C. (2005). Universal symbols in health care workbook. Retrieved from Hablamos Juntos website: http://www.hablamosjuntos.org/signage/PDF/Best%20Practices-FINALDec05.pdf

Equality and Human Rights Commission. (2009). Good practice in community engagement from an equality perspective. Retrieved from http://www.equalityhumanrights.com/uploaded_files/good_practice_in_community_engagement.pdf

Goode, T. D., Dunne, M. C., & Bronheim, S. M. (2006). The evidence base for cultural and linguistic competency in health care. (Commonwealth Fund Publication No. 962). Retrieved from The Commonwealth Fund website: http://www.commonwealthfund.org/usr_doc/Goode_evidencebasecultlinguisticcomp_962.pdf

The Joint Commission. (2010). Advancing effective communication cultural competence, and patient- and family-centered care: A roadmap for hospitals. Retrieved from http://www.jointcommission.org/assets/1/6/ARoadmapforHospitalsfinalversion727.pdf

Kashiwagi, S. (2004). A functional manual for providing linguistically competent health care services as developed by a community health center. Los Angeles, CA: Asian Pacific Health Care Venture, Inc.

Like, R.C. (2011). Educating clinicians about cultural competence and disparities in health and health care. Journal of Continuing Education in the Health Professions, 31(3), 196-206.

LinguaLinks Library. (1999). Correspondence of proficiency scales. Retrieved from http://www.sil.org/lingualinks/LANGUAGELEARNING/MangngYrLnggLrnngPrgrm/CorrespondenceOfProficiencySca.htm

Massachusetts Department of Public Health, Office of Health Equity. (2009). Making CLAS happen: Six areas for action. Retrieved from http://www.mass.gov/eohhs/provider/guidelines-resources/services-planning/workforce-development/health-equity/clas/making-clas-happen.html

National Consensus Panel on Emergency Preparedness and Cultural Diversity. (2011). Guidance for integrating culturally diverse communities into planning for and responding to emergencies: A toolkit. Recommendations of the National Consensus Panel on Emergency Preparedness and Cultural Diversity (HHS Office of Minority Health Publication No. OMH-NHMA-5-10). Retrieved from http://www.hhs.gov/ocr/civilrights/resources/specialtopics/emergencypre/omh_diversitytoolkit.pdf

National Council on Interpreting in Health Care. (2002). Models for the provision of language access in health care settings. Retrieved from

http://data.memberclicks.com/site/ncihc/NCIHC%20Working%20Paper%20-%20Models%20for%20Provision%20of%20Language%20Access.pdf

National Quality Forum. (2009). A comprehensive framework and preferred practices for measuring and reporting cultural competency: A consensus report. Retrieved from http://www.qualityforum.org/Publications/2009/04/A_Comprehensive_Framework_and_Preferred_Practices_forMeasuring_and_Reporting_Cultural_Competency.aspx

QSource, Underserved Quality Improvement Organization Support Center. (2005). CLAS Standards implementation tips. Retrieved from http://wwww.qsource.org/uqiosc/CLAS%20Standards%20Strategies%5B7AUG-2005%5D.pdf

Prevention by Design. (2006). Community engagement strategies: Tip sheet. Retrieved from http://socrates.berkeley.edu/~pbd/pdfs/Community_Engagement_Strategies.pdf

U.S. Department of Health and Human Services, Agency for Healthcare Research and Quality. (2010). Health literacy universal precautions toolkit (AHRQ Publication No. 10-0046-EF). Retrieved from http://www.ahrq.gov/qual/literacy/

U.S. Department of Health and Human Services, Office for Civil Rights. (2003). Guidance to federal financial assistance recipients regarding Title VI and the prohibition against national origin discrimination affecting limited English proficient persons. Retrieved from http://www.hhs.gov/ocr/civilrights/resources/laws/revisedlep.html

U.S. Department of Health and Human Services, Office of Disease Prevention and Health Promotion. (2010). National action plan to improve health literacy. Retrieved from http://www.health.gov/communication/HLActionPlan/pdf/Health_Literacy_Action_Plan.pd

U.S. Department of Health and Human Services, Office of Minority Health. (2005). A patient-centered guide to implementing language access services in healthcare organizations. Retrieved from http://minorityhealth.hhs.gov/Assets/pdf/Checked/HC-LSIG.pdf

U.S. Department of Health and Human Services, Office of Minority Health. (2011). Definition of promotoras de salud. Retrieved from http://minorityhealth.hhs.gov/templates/content.aspx?lvl=2&lvlid=207&ID=8930

U.S. Department of Health and Human Services, Office of Minority Health. (2001). National standards for culturally and linguistically appropriate services in health care: Final report. Retrieved from http://minorityhealth.hhs.gov/assets/pdf/checked/finalreport.pdf

Wilson-Stronks, A., & Galvez, E. (2007). Hospitals, language, and culture: A snapshot of the nation. Retrieved from The Joint Commission website: http://www.jointcommission.org/assets/1/6/hlc_paper.pdf

Wynia, M., Hasnain-Wynia, R., Hotze, T. D., & Ivey, S. L. (2011). Collecting and using race, ethnicity and language data in ambulatory settings: A white paper with recommendations from the Commission to End Health Care Disparities. Retrieved from American Medical Association website: http://www.ama-assn.org/resources/doc/public-health/cehcd-redata.pdf

Youdelman, M., & Perkins, J. (2005). Providing language services in small health care provider settings: Examples from the field (Commonwealth Fund Publication No. 810). Retrieved from The Commonwealth Fund website: http://www.commonwealthfund.org/usr_doc/810_Youdelman_providing_language_services.pdf

Youdelman, M., Perkins, J., Brooks, J. D., & Reid, D. (2007). Providing language services in state and local health-related benefits offices: Examples from the field (Commonwealth Fund Publication No. 995). Retrieved from The Commonwealth Fund website: http://www.commonwealthfund.org/~/media/Files/Publications/Fund%20Report/2007/Jan/Providing%20Language%20Services%20in%20State%20and%20Local%20Health%20Related%20Benefits%20Offices%20%20Examples%20From%20the%20Fi/Youdelman_providinglanguagesvcsstatelocalbenefitsoffices_995%20pdf.pdf

Appendix A: Glossary – References

Acculturation:[1] The exchange of cultural features that results when groups of individuals having different cultures come into continuous firsthand contact; the original cultural patterns of either or both groups may be altered, but the groups remain distinct.

Augmentative and Alternative Communication (AAC) Resources:[2] Systems or devices that attempt to temporarily or permanently compensate for and facilitate the impairment and disability of individuals with severe expressive or language comprehension disorders. AAC may be required for individuals demonstrating impairments in gestural, spoken, and/or written modalities.

Auxiliary Aids and Services:[3] Devices or services that enable effective communication for people with disabilities. Examples include qualified interpreters, note takers, transcription services, written materials, assistive listening devices and systems, telephone communication devices for deaf persons, telephone handset amplifiers, video interpretive services, and open and closed captioning.

Bilingual:[4] A term describing a person who has some degree of proficiency in two languages. A high level of bilingualism is the most basic of the qualifications of a competent interpreter but, by itself, does not ensure the ability to interpret.

Bisexual:[5] One whose sexual or romantic attractions and behaviors are directed at members of both sexes to a significant degree.

Caregiver:[6] An individual who assists another person who because of physical disability, chronic illness, or cognitive impairment is unable to perform certain activities on his/her own. So-called informal care can be offered by family members or friends, often in a home setting. Paid or volunteer professional care, or so-called formal care, can be obtained at home, in the community, or from institutions such as nursing facilities or government institutions.

Certification:[7] A process by which a certifying body (usually a governmental or professional organization) attests to an individual's qualifications to provide a particular service. Certification calls for formal assessment using an instrument that has been tested for validity and reliability so that the certifying body can be confident that the individuals it certifies have the qualifications needed to do the job.

Certified Interpreter:[8] An interpreter who is certified as competent by a professional organization or government entity through rigorous testing based on appropriate and consistent criteria. Interpreters who have had limited training — or have only taken a screening test administered by an employing health, interpreter, or referral agency — are not considered certified.

Communication Needs:[9] Difficulty with some aspects of communicating. This difficulty may be minor and temporary or more complex and long term. The term "needs" refers both to the individual's needs and to what society can do to support the individual by examining the individual and the environments in which he/she interacts.

Requirements of the Americans with Disabilities Act communication needs extend beyond spoken language capability to include barriers imposed by disabilities affecting hearing, speech, and vision.[10]

Community Health Assessment/Community Health Needs Assessment (CHNA):[11] Community health assessment is a systematic examination of the health status indicators for a given population that is used to identify key problems and assets in a community. The ultimate goal of a community health assessment is to develop strategies to address the community's health needs and identified issues.

Community Needs Assessment:[12] A community needs assessment identifies the strengths and resources available in the community to meet its needs. The assessment focuses on the capabilities of the community, including its citizens, agencies, and organizations. It provides a framework for developing and identifying services and solutions and building communities that support and nurture health and wellness.

A community needs assessment may be limited to a compilation of demographic data from census records, results of surveys conducted by others, and informal feedback from community partners. Alternatively, assessments may be expanded to include focus group discussions, town meetings, interviews with stakeholders and telephone or mailed surveys to partnership members and the community.

Continuous Quality Improvement:[13] The complete process of identifying, describing, and analyzing strengths and problems and then testing, implementing, learning from, and revising solutions. It relies on an organizational and/or system culture that is proactive and supports continuous learning. Continuous quality improvement is firmly grounded in the overall mission, vision, and values of the agency/system. Perhaps most important, it is dependent upon the active inclusion and participation of staff at all levels of the agency/system — children, youth, families, and stakeholders — throughout the process.

CLAS: See "Culturally and Linguistically Appropriate Services."

CLAS Standards: See "National CLAS Standards."

Cultural Broker:[14] Individuals from the community who serve as bridges between an organization and people of different cultural backgrounds.

Cultural and Linguistic Competency:[15] The capacity for individuals and organizations to work and communicate effectively in cross-cultural situations through the adoption and implementation of strategies to ensure appropriate awareness, attitudes, and actions and through the use of policies, structures, practices, procedures, and dedicated resources that support this capacity.

- Cultural Competency: A developmental process in which individuals or institutions achieve increasing levels of awareness, knowledge, and skills along a cultural competence continuum. Cultural competence involves valuing diversity, conducting self-assessments, avoiding stereotypes, managing the dynamics of difference, acquiring and institutionalizing cultural knowledge, and adapting to diversity and cultural contexts in communities.

- Linguistic Competency: The capacity of individuals or institutions to communicate effectively at every point of contact. Effective communication includes the ability to convey information — both written and oral — in a manner that is easily understood by diverse groups, including persons of limited English proficiency, those who have low literacy skills or who are not literate, those having low health literacy, those with disabilities, and those who are deaf or hard of hearing.

Culturally and Linguistically Appropriate Services (CLAS):[16] Services that are respectful of and responsive to individual cultural health beliefs and practices, preferred languages, health literacy levels, and communication needs and employed by all members of an organization (regardless of size) at every point of contact.

Culture:[17, 18] The integrated pattern of thoughts, communications, actions, customs, beliefs, values, and institutions associated, wholly or partially, with racial, ethnic, or linguistic groups as well as religious, spiritual, biological, geographical, or sociological characteristics. Culture is dynamic in nature, and individuals may identify with multiple cultures over the course of their lifetimes.

Elements of culture include, but are not limited to, the following:

- Age
- Cognitive ability or limitations
- Country of origin

- Degree of acculturation
- Educational level attained
- Environment and surroundings
- Family and household composition
- Gender identity
- Generation
- Health practices, including use of traditional healer techniques such as Reiki and acupuncture
- Linguistic characteristics, including language(s) spoken, written, or signed; dialects or regional variants; literacy levels; and other related communication needs.
- Military affiliation
- Occupational groups
- Perceptions of family and community
- Perceptions of health and well-being and related practices
- Perceptions/beliefs regarding diet and nutrition
- Physical ability or limitations
- Political beliefs
- Racial and ethnic groups include — but are not limited to — those defined by the U.S. Census Bureau.
- Religious and spiritual characteristics, including beliefs, practices, and support systems related to how an individual finds and defines meaning in his/her life.
- Residence (i.e., urban, rural, or suburban)
- Sex
- Sexual orientation
- Socioeconomic status

Determinants of Health:[19] Determinants of health care factors that influence health status and determine health differentials or health inequalities. They are many and varied and include, for example, natural biological factors, such as age, gender, and ethnicity; behavior and lifestyles, such as smoking, alcohol consumption, diet, and physical exercise; the physical and social environment, including housing quality, the workplace, and the wider urban and rural environment; and access to health care.

Effective Communication: [20] The successful joint establishment of meaning wherein patients and health care providers exchange information, enabling patients to participate actively in their care from admission through discharge and ensuring that the responsibilities of both patients and providers are understood. To be truly effective, communication requires a two-way process (expressive and receptive) in which messages are negotiated until the information is correctly understood by both parties. Successful communication takes place only when providers understand and integrate the information gleaned from patients and when patients comprehend accurate, timely, complete, and unambiguous messages from providers in a way that enables them to participate responsibly in their care.

Ethnicity:[21] The Office of Management and Budget requires federal agencies to use a minimum of two ethnicities: Hispanic or Latino and Not Hispanic or Latino. Hispanic origin can be viewed as the heritage, nationality group, lineage, or country of birth of the person or the person's parents or ancestors before their arrival in the United States. People who identify their origin as Hispanic, Latino, or Spanish may be of any race.

Gay:[22] An attraction and/or behavior focused exclusively or mainly on members of the same sex or gender identity; a personal or social identity based on one's same-sex attractions and membership in a sexual-minority community.

Gender Expression:[23] Characteristics in appearance, personality, and behavior culturally defined as masculine or feminine.
Gender Identity:[24] One's basic sense of being a man, woman, or other gender.
Health:[25, 26, 27] Health encompasses many aspects, including physical, mental, social, and spiritual well-being. The World Health Organization also notes that health is "not merely the absence of disease or infirmity."
Health Care:[28] According to the Health Insurance Portability and Accountability Act of 1996, health care refers to the care, services, or supplies related to the health of an individual, including but not limited to, the following:

- Preventive, diagnostic, therapeutic, rehabilitative, maintenance, or palliative care, and counseling, service, assessment, or a procedure with respect to the physical or mental condition, or functional status, of an individual or that affects the structure or function of the body; and

- Sale or dispensing of a drug, device, equipment, or other item in accordance with a prescription.

Health Care Disparities:[29] Differences in the receipt of, experiences with, and quality of health care that are not due to access-related factors or clinical needs, preferences, or appropriateness of intervention.
Health Care Organization:[30] Any public or private institution involved in any aspect of delivering health care services.
Health Disparity:[31] 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; socio-economic 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.
Health Equity:[32, 33] 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.
Health Inequality:[34] Difference in health status or in the distribution of health determinants among different population groups. For example, differences in mobility between elderly people and younger populations or differences in mortality rates among people from different social classes. It is important to distinguish between a health inequality and a health inequity. Some health inequalities are attributable to biological variations or free choice, while others are attributable to the external environment and conditions mainly outside the control of the individuals concerned. In the first case, it may be impossible or ethically or ideologically unacceptable to change the health determinants, and so the resultant health inequality is unavoidable. In the second case, the uneven distribution may be unnecessary and avoidable as well as unjust and unfair so that the resulting health inequalities also lead to an inequity in health.
Health Inequities:[35] Differences in health status or in the distribution of health determinants among different population groups.
Health Literacy:[36] The degree to which an individual has the capacity to obtain, process, and understand basic health information and services needed to make appropriate health decisions.
Health Numeracy:[37] The degree to which an individual has the capacity to access, process, interpret, communicate, and act on numerical, quantitative, graphical, biostatistical, and probabilistic health information needed to make effective health decisions.

Health Organization:[38] Any public or private institution addressing individual or community health and well-being.
Individuals and Groups:[39] Patients, clients, or consumers, including accompanying family members, guardians, or companions, seeking physical, mental, or other health-related services.
Interpreter:[40] An individual who renders a message spoken or signed in one language into a second language and who abides by a code of professional ethics.

Types of Interpreters:

- Ad Hoc Interpreter:[41] An untrained individual who is called upon to interpret, such as a family member interpreting for his/her parents, a bilingual staff member pulled away from other duties to interpret, or a self-declared bilingual in a hospital waiting room who volunteers to interpret. Also called a chance interpreter or lay interpreter.

- Bilingual Provider:[42] An individual with proficiency in more than one language, enabling the person to provide services directly to limited English proficient patients in their non-English language.

- Bilingual Worker/Employee:[43] An employee who is a proficient speaker of two languages and who may provide direct services in both languages but who, without additional training, is not qualified to serve as an interpreter.

- Dual-Role Interpreter:[44] A bilingual employee in health care who has been tested for language skills and trained as a medical interpreter and who assumes the task of part-time medical interpreting willingly.

- Qualified Interpreter:[45] An individual who has been assessed for professional skills, demonstrates a high level of proficiency in at least two languages, and has the appropriate training and experience to interpret with skill and accuracy while adhering to the National Code of Ethics and Standards of Practice published by the National Council on Interpreting in Health Care.

Types of Interpreting:

- Community Interpreting:[47] Interpreting that takes place in the course of communication in the local community among speakers of different languages. The community interpreter may or may not be a trained interpreter. Community settings include schools, social service agencies, clinics, legal services, and businesses that serve a diverse clientele.

- Consecutive Interpreting:[48] A highly complex cognitive activity that requires the interpreter to listen, analyze, comprehend, convert, edit, and reproduce the original message, after the speaker or signer pauses, in a specific social context. Consecutive interpretation is likely to take longer than simultaneous, because the interpreter does not interpret while the speaker or signer is speaking or signing.

- Face-to-Face Interpreting:[49] Interpreting in which the interpreter is present, in person, with both, or at least one, of the persons for whom interpreting is provided.

- First-Person Interpreting:[50] The promotion by the interpreter of direct communication between the principal parties in the interaction through the use of direct utterances of each of the speakers, as though the interpreter were the voice of the person speaking, albeit in the language of the listener. For example, if the patient says "My stomach hurts," the interpreter says (in the second language), "My stomach hurts," not "She says her stomach hurts."

- Health Care Interpreting:[51] Interpreting that takes place in health care settings of any sort, including doctors' offices, clinics, hospitals, home health visits, mental health clinics, and public health presentations. Typically, the setting is an interview between a health care provider (doctor, nurse, lab technician) and a patient (or the patient and one or more family members).

- Simultaneous Interpretation:[52] Highly complex cognitive activity that requires the interpreter to listen, analyze, comprehend, convert, edit, and reproduce in real time a speaker or signer's message while the speaker or signer continues to speak or sign, in a specific social context.

- Telephone or Telephonic Interpreting:[53] Interpreting carried out remotely, with the interpreter connected by telephone to the principal parties, typically provided through a speakerphone or headsets. In health care settings, the principal parties, e.g., doctor and patient, are normally in the same room, but telephone interpreting can be used to serve individuals who are also connected to each other only by telephone.

- Video Remote Interpreting (VRI):[54] An interpreting service that uses video conference technology over dedicated lines or wireless technology offering a high-speed, wide-bandwidth video connection that delivers high-quality video images. To ensure that VRI is effective, the Department of Justice has established performance standards for VRI and requires training for users of the technology and other individuals involved with its use so that they may quickly and efficiently set up and operate the VRI system.

Language:[55] While the Office of Budget and Management has not established a list of language categories, the collection of language data has been pivotal in determining whether there has been discrimination by "national origin" under Title VI of the Civil Rights Act of 1964, and federal policies state that "reasonable steps" need to be taken so that persons of limited English proficiency can have "meaningful access" to programs or activities without charge for language services. Additionally, in 2000, the Department of Health and Human Services released its National Standards on Culturally and Linguistically Appropriate Services, which encourages all health care organizations and individual providers "to make their practices more culturally and linguistically accessible," including the use of race, ethnicity, and language data in program assessments and incorporation of these data into health records and organizational management systems.

Language Assistance Services:[56] Mechanisms used to facilitate communication with individuals who do not speak English, those who have limited English proficiency, and those who are deaf or hard of hearing. These services can include in-person interpreters, bilingual staff, or remote interpreting systems such as telephone or video interpreting. Language services also refer to processes in place to provide translation of written materials or signage, sign language, or braille materials.
Language Concordance:[57] Occurs when the individual seeking services or care and the provider of said services are able to speak the same primary language well.

Lesbian:[58] A woman who self-identifies as having an emotional, sexual, and/or relational attraction to other women.
Limited English Proficiency:[59, 60] A concept referring to a level of English proficiency that is insufficient to ensure equal access to public services without language assistance with respect to a particular type of service, benefit, or encounter.
Meaningful Access:[61] Recipients of federal financial assistance are required to take reasonable steps to ensure meaningful access to their programs and activities by limited English proficient (LEP) persons. The HHS Office of Civil Rights Guidance explains that the obligation to provide meaningful access is fact dependent and starts with an individualized assessment that balances four factors: (1) the number or proportion of LEP persons eligible to be served or likely to be encountered by the program or grantee; (2) the frequency with which LEP individuals come into contact with the program; (3) the nature and importance of the program, activity, or service provided by the recipient to its beneficiaries; and (4) the resources available to the grantee/recipient and the costs of interpretation/translation services. There is no one-size-fits-all solution for Title VI compliance with respect to LEP persons, and what constitutes "reasonable steps" for large providers may not be reasonable where small providers are concerned.

National CLAS Standards:[62] The framework for culturally and linguistically appropriate services issued by the U.S. Department of Health and Human Services, Office of Minority Health. The National CLAS Standards are intended to inform, guide, and facilitate practices related to culturally and linguistically appropriate health service delivery.
Numeracy:[63] A part of literacy that implies a facility with basic probability and numerical concepts.
Plain Language:[64] A strategy for making written and oral information easier to understand; communication that users can understand the first time they read or hear it. A plain language document is one in which people can find what they need, understand what they find, and act appropriately on that understanding.
Primary Language:[65] The language that a limited English proficient individual identifies as the one that he/she uses to communicate effectively and would prefer to use to communicate with service providers.

Race:[66] The Department of Health and Human Services and its agencies follow the racial categories developed by the Office of Management and Budget and used by the U.S. census. These categories generally reflect a social definition of race recognized in this country and are not an attempt to define race biologically, anthropologically, or genetically. People may choose to report more than one race to indicate their racial mixture, such as “American Indian and White.”
People who identify their origin as Hispanic, Latino, or Spanish may be of any race. Racial categories can include national origin or sociocultural groups.
Information on race is required for many federal programs and is important for making policy decisions, particularly for civil rights. States use these data to meet legislative redistricting principles. Race data also are used to promote equal employment opportunities and to assess environmental risks and racial disparities in health.
Reasonable Steps: For guidance on how to determine whether the steps taken to provide language access are “reasonable,” providers or organizations should refer to the Department of Health and Human Services’ Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons.
Sex:[67] The Department of Health and Human Services and its agencies follow the sex categories developed by the Office of Management and Budget and used by the U.S. census. The census operationalizes sex as “male” or “female.” The census question regarding sex remains unchanged from the previous census. Information on the sex of individuals is one of the few items obtained in the original 1790 census and in every census since.

It is important to note that sex differs from the concepts of gender, gender identity, and gender expression.

Sexual Identity:[68] Encompasses attraction, behavior, and identity. Most researchers studying sexual orientation have defined it operationally in terms of one or more of the following components. Defined in terms of behavior, sexual orientation refers to an enduring pattern of sexual or romantic activity with men, women, or both sexes. Defined in terms of attraction (or desire), it denotes an enduring pattern of experiencing sexual or romantic feelings for men, women, or both sexes. Identity encompasses both personal identity and social identity. Defined in terms of personal identity, sexual orientation refers to a conception of the self-based on one's enduring pattern of sexual and romantic attractions and behaviors toward men, women, or both sexes. Defined in terms of social (or collective) identity, it refers to a sense of membership in a social group based on a shared sexual orientation and a linkage of one's self-esteem to that group.

Social Determinants of Health:[69] The conditions in which people are born, grow, live, work, and age, including the health system.

Staff:[70] The group of individuals formally affiliated with an institution, including paid employees, contractors, and unpaid volunteers.

Threshold Population:[71] A threshold population is a linguistic group that makes up 15% or more of a program's clients and who share a common language other than English as a primary language. For example, if program XYZ serves 200 clients and at least 30 of them speak Haitian-Creole as a primary language, that group would be considered a threshold population for that program, and Haitian-Creole would be considered a threshold language. Some programs may target multiple groups and, therefore, may have multiple threshold populations and threshold languages; some programs may have no threshold populations.

Traditional Healer Services:[72] The application of knowledge, skills, and practices based on the experiences indigenous to different cultures. These services are directed towards the maintenance of health, as well as the prevention, diagnosis, and improvement of physical and mental illness. Examples of traditional healers include herbalists, faith healers, and practitioners of Chinese or Ayurvedic medicine. In contrast, allopathic service providers are those trained in western medicine.

Transgender:[73] A person whose gender identity and/or expression is different from that typically associated with their assigned sex at birth.

Translation:[74] The conversion of a written text into a corresponding written text in a different language.

Translator:[75] A person who translates written texts.

TTY:[76] TTY stands for text telephone. It is also sometimes called a TDD, or telecommunication device for the deaf. TTY is the more widely accepted term, however, as TTYs are used by many people, not just people who are deaf.

Vital Documents:[77] For the purposes of ensuring language access, vital documents are written documents that are "vital" to programs or limited English proficient populations. Examples include signs, directions, and notices about the availability of interpreter services, client intake forms, and legal documents (e.g., consent forms, notices of client rights and responsibilities, privacy notices, complaint forms, grievance policies).

Appendix B: Glossary Bibliography

1 Kottak, C. P. (2007). Windows on humanity (3rd ed.). New York: McGraw Hill.
2 The Joint Commission. (2010). Advancing effective communication, cultural competence, and patient- and family-centered care: A roadmap for hospitals. Retrieved from http://www.jointcommission.org/assets/1/6/ARoadmapforHospitalsfinalversion727.pdf
3 The Joint Commission. (2010). Advancing effective communication, cultural competence, and patient- and family-centered care: A roadmap for hospitals. Retrieved from http://www.jointcommission.org/assets/1/6/ARoadmapforHospitalsfinalversion727.pdf
4 National Council on Interpreting in Health Care. (2008). The terminology of health care interpreting: A glossary of terms. Retrieved from http://data.memberclicks.com/site/ncihc/NCIHC%20Terms%20Final080408.pdf
5 Institute of Medicine. (2011). The health of lesbian, gay, bisexual, and transgender people: Building a foundation for better understanding. Washington, DC: The National Academies Press.
6 Day, T. (n.d.). About caregiving. Retrieved from http://www.longtermcarelink.net/eldercare/caregiving.htm
7 National Council on Interpreting in Health Care. (2008). The terminology of health care interpreting: A glossary of terms. Retrieved from http://data.memberclicks.com/site/ncihc/NCIHC%20Terms%20Final080408.pdf
8 National Council on Interpreting in Health Care. (2008). The terminology of health care interpreting: A glossary of terms. Retrieved from http://data.memberclicks.com/site/ncihc/NCIHC%20Terms%20Final080408.pdf
9 Talking point: The first step for information on children's communication. (2010). Speech, language and communication needs. In Glossary. Retrieved from http://www.communicationhelppoint.org.uk/da/Glossary.aspx
10 Institute of Medicine. (2009). Defining language need and categories for collection. In Race, ethnicity, and language data: Standardization for health care quality improvement (pp. 93–126). Retrieved from http://www.nap.edu/openbook.php?record_id=12696&page=93
11 Consensus Statement from American Public Health Association (APHA), Association of Schools of Public Health (ASPH), Association of State and Territorial Health Officials (ASTHO), National Association of County and City Health Officials (NACCHO), National Association of Local Boards of Health (NALBOH), National Network of Public Health Institutes (NNPHI), and Public Health Foundation (PHF). (2012). Maximizing the Community Health Impact of Community Health Needs Assessments Conducted by Tax-exempt Hospitals http://www.naccho.org/topics/infrastructure/mapp/loader.cfm?csModule=security/getfile&pageID=228911
12 U.S. Department of Health and Human Services, Administration for Children and Families. (n.d.). Community needs assessment. Retrieved from http://www.childwelfare.gov/systemwide/assessment/community.cfm
13 National Child Welfare Resource Center for Organizational Improvement & Casey Family Programs. (2005). Using continuous quality improvement to improve child welfare practice. Retrieved from http://muskie.usm.maine.edu/helpkids/rcpdfs/CQIFramework.pdf
14 Massachusetts Department of Public Health, Office of Health Equity. (2009). Making CLAS happen: Six areas for action. Retrieved from http://www.mass.gov/eohhs/provider/guidelines-resources/services-planning/workforce-development/health-equity/clas/making-clas-happen.html
15 Cross, T. L., Bazron, B. J., Dennis, K. W., & Isaacs, M. R. (1989). Towards a culturally competent system of care volume I: A monograph on effective services for minority children who are severely emotionally

disturbed. Washington, DC: Georgetown University Child Development Center, Child and Adolescent Service System Program Technical Assistance Center.
16 U.S. Department of Health and Human Services, Office of Minority Health. (2001). National standards for culturally and linguistically appropriate services in health care: Final report. Retrieved from http://www.minorityhealth.hhs.gov/assets/pdf/checked/finalreport.pdf
17 Gilbert, J., Goode, T. D., & Dunne, C. (2007). Cultural awareness. In Curricula enhancement module series. Retrieved from the National Center for Cultural Competence website: http://www.nccccurricula.info/awareness/index.html
18 U.S. Department of Health and Human Services, Office of Minority Health. (2005). What is cultural competency? Retrieved from http://minorityhealth.hhs.gov/templates/browse.aspx?lvl=2&lvlID=11
19 World Health Organization. (2012). Health impact assessment: Glossary of terms used, A–E. Retrieved from http://www.who.int/hia/about/glos/en/index.html
20 The Joint Commission. (2010). Advancing effective communication, cultural competence, and patient- and family-centered care: A roadmap for hospitals. Retrieved from http://www.jointcommission.org/assets/1/6/ARoadmapforHospitalsfinalversion727.pdf
21 Humes, K. R., Jones, N. A., & Ramirez, R. R. (2011, March). Overview of race and Hispanic origin: 2010. 2010 Census Briefs. Retrieved from http://www.census.gov/prod/cen2010/briefs/c2010br-02.pdf
22 Institute of Medicine. (2011). The health of lesbian, gay, bisexual, and transgender people: Building a foundation for better understanding. Washington, DC: The National Academies Press.
23 Institute of Medicine. (2011). The health of lesbian, gay, bisexual, and transgender people: Building a foundation for better understanding. Washington, DC: The National Academies Press.
24 Bockting, W. O. (1999). From construction to context: Gender through the eyes of the transgendered. SIECUS Report 1(Oct./Nov.):3–7.
25 U.S. Department of Health and Human Services, Indian Health Services. (n.d.). Our mission. Retrieved from http://www.ihs.gov/index.cfm?module=ihsIntro
26 U.S. Department of Health and Human Services, Office of the Surgeon General and National Action Alliance for Suicide Prevention. (2012). 2012 National strategy for suicide prevention: Goals and objectives for action. Retrieved from http://www.surgeongeneral.gov/library/reports/national-strategy-suicide-prevention/full_report-rev.pdf
27 World Health Organization. (1946). Definition of health in preamble to the constitution of the World Health Organization. Geneva, Switzerland: World Health Organization.
28 Health Insurance Portability and Accountability Act of 1996, Pub. L. No. 102-168, § 160.103, 110 Stat. 1936 (1996)
29 Institute of Medicine (2003). Unequal treatment: Confronting racial and ethnic disparities in health care. Retrieved from http://www.nap.edu/openbook.php?record_id=10260&page=R1
30 U.S. Department of Health and Human Services, Office of Minority Health. (2001). National standards for culturally and linguistically appropriate services in health care: Final report. Retrieved from http://www.minorityhealth.hhs.gov/assets/pdf/checked/finalreport.pdf
31 U.S. Department of Health and Human Services, Office of Minority Health, National Partnership for Action to End Health Disparities. (2011). Health equity & disparities. Retrieved from http://minorityhealth.hhs.gov/npa/templates/browse.aspx?lvl=1&lvlid=34
32 U.S. Department of Health and Human Services, Office of Minority Health, National Partnership for Action to End Health Disparities. (2011). Health equity & disparities. Retrieved from http://minorityhealth.hhs.gov/npa/templates/browse.aspx?lvl=1&lvlid=34
33 Braveman, P. A. (2003). Monitoring equity in health and healthcare: A conceptual framework. Journal of Health, Population, and Nutrition, 21, 181–192.
34 World Health Organization. (2012). Health impact assessment: Glossary of terms used, F–P. Retrieved from http://www.who.int/hia/about/glos/en/index1.html

35 World Health Organization. (2012). Health impact assessment: Glossary of terms used, F–P. Retrieved from http://www.who.int/hia/about/glos/en/index1.html
36 U.S. Department of Health and Human Services, Office of Disease Prevention and Health Promotion. (2000). Health communication and health IT. In Healthy people 2010. Retrieved from http://www.healthypeople.gov/2010/hp2020/Objectives/TopicArea.aspx?id=25&TopicArea=Health+Communication+and+Health+IT
37 Golbeck, A. L., Ahlers-Schmidt, C. R., Paschal, A. M., & Dismuke, M. C. (2005). A definition and operational framework for health numeracy. American Journal of Preventive Medicine, 29, 375–376. doi:10.1016/j.amepre.2005.06.012
8 U.S. Department of Health and Human Services, Office of Minority Health. (2001). National standards for culturally and linguistically appropriate services in health care: Final report. Retrieved from http://www.minorityhealth.hhs.gov/assets/pdf/checked/finalreport.pdf
39 U.S. Department of Health and Human Services, Office of Minority Health. (2001). National standards for culturally and linguistically appropriate services in health care: Final report. Retrieved from http://www.minorityhealth.hhs.gov/assets/pdf/checked/finalreport.pdf
40 National Health Law Program (2010). What's in a word? A guide to understanding interpreting and translation in health care. Retrieved from http://www.healthlaw.org/images/stories/whats_in_a_word_guide.pdf
41 National Council on Interpreting in Health Care. (2008). The terminology of health care interpreting: A glossary of terms. Retrieved from http://data.memberclicks.com/site/ncihc/NCIHC%20Terms%20Final080408.pdf
42 National Council on Interpreting in Health Care. (2008). The terminology of health care interpreting: A glossary of terms. Retrieved from http://data.memberclicks.com/site/ncihc/NCIHC%20Terms%20Final080408.pdf
43 National Council on Interpreting in Health Care. (2008). The terminology of health care interpreting: A glossary of terms. Retrieved from http://data.memberclicks.com/site/ncihc/NCIHC%20Terms%20Final080408.pdf
44 National Council on Interpreting in Health Care. (2008). The terminology of health care interpreting: A glossary of terms. Retrieved from http://data.memberclicks.com/site/ncihc/NCIHC%20Terms%20Final080408.pdf
45 National Health Law Program (2010). What's in a word? A guide to understanding interpreting and translation in health care. Retrieved from http://www.healthlaw.org/images/stories/whats_in_a_word_guide.pdf
46 National Health Law Program (2010). What's in a word? A guide to understanding interpreting and translation in health care. Retrieved from http://www.healthlaw.org/images/stories/whats_in_a_word_guide.pdf
47 National Council on Interpreting in Health Care. (2008). The terminology of health care interpreting: A glossary of terms. Retrieved from http://data.memberclicks.com/site/ncihc/NCIHC%20Terms%20Final080408.pdf
48 ASTM, International. (2007). Standard guide for language interpretation services. doi:10.1520/F2089-01R07
49 National Council on Interpreting in Health Care. (2008). The terminology of health care interpreting: A glossary of terms. Retrieved from http://data.memberclicks.com/site/ncihc/NCIHC%20Terms%20Final080408.pdf
50 National Council on Interpreting in Health Care. (2008). The terminology of health care interpreting: A glossary of terms. Retrieved from http://data.memberclicks.com/site/ncihc/NCIHC%20Terms%20Final080408.pdf

51 National Council on Interpreting in Health Care. (2008). The terminology of health care interpreting: A glossary of terms. Retrieved from http://data.memberclicks.com/site/ncihc/NCIHC%20Terms%20Final080408.pdf
52 ASTM, International. (2007). Standard guide for language interpretation services. doi:10.1520/F2089-01R07
53 National Council on Interpreting in Health Care. (2008). The terminology of health care interpreting: A glossary of terms. Retrieved from http://data.memberclicks.com/site/ncihc/NCIHC%20Terms%20Final080408.pdf
54 U.S. Department of Justice. (2011). Highlights of the final rule to amend the Department of Justice's regulation implementing Title II of the ADA [Fact sheet]. Retrieved from http://www.ada.gov/regs2010/factsheets/title2_factsheet.html
55 Institute of Medicine. (2009). Race, ethnicity, and language data: Standardization for health care quality improvement. Retrieved from http://iom.edu/Reports/2009/RaceEthnicityData.aspx
56 The Joint Commission. (2010). Advancing effective communication, cultural competence, and patient- and family-centered care: A roadmap for hospitals. Retrieved from http://www.jointcommission.org/assets/1/6/ARoadmapforHospitalsfinalversion727.pdf
57 Institute of Medicine. (2009). Defining language need and categories for collection. In Race, ethnicity, and language data: Standardization for health care quality improvement (pp. 93–126). Retrieved from http://www.nap.edu/openbook.php?record_id=12696&page=93
58 U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration. (2012). Top Health Issues for LGBT Populations Information & Resource Kit. (HHS Publication No. (SMA) 12-4684). Retrieved from http://store.samhsa.gov/shin/content/SMA12-4684/SMA12-4684.pdf
59 The Joint Commission. (2010). Advancing effective communication, cultural competence, and patient- and family-centered care: A roadmap for hospitals. Retrieved from http://www.jointcommission.org/assets/1/6/ARoadmapforHospitalsfinalversion727.pdf
60 U.S. Department of Health and Human Services, Office for Civil Rights. (2004). Limited English proficiency (LEP). Retrieved from http://www.hhs.gov/ocr/civilrights/resources/specialtopics/lep/index.html
61 U.S. Department of Health and Human Services, Office for Civil Rights. (2003). Guidance to federal financial assistance recipients regarding Title VI and the prohibition against national origin discrimination affecting limited English proficient persons: Summary. Retrieved from http://www.hhs.gov/ocr/civilrights/resources/laws/summaryguidance.html
62 U.S. Department of Health and Human Services, Office of Minority Health. (2001). National standards for culturally and linguistically appropriate services in health care: Final report. Retrieved from http://www.minorityhealth.hhs.gov/assets/pdf/checked/finalreport.pdf
63 Schwartz, L. M., Woloshin, S., Black, W. C., & Welch, H. G. (1997). The role of numeracy in understanding the benefit of screening mammography. Annals of Internal Medicine, 127, 966–972.
64 Plain Language Action and Information Network. (n.d.). What is plain language? Retrieved from http://www.plainlanguage.gov/whatisPL/index.cfm
65 U.S. Department of Health and Human Services. (2008). Hawaii Department of Human Services Resolution Agreement. Retrieved from http://www.hhs.gov/ocr/civilrights/activities/agreements/hawaiiagree.html
66 U.S. Department of Commerce, Census Bureau. (2011). Overview of race and Hispanic origin: 2010. Retrieved from http://www.census.gov/prod/cen2010/briefs/c2010br-02.pdf
67 U.S. Department of Commerce, Census Bureau. (2011, May). Age and sex composition, 2010 [2010 Census Brief No. C2010BR-03]. Retrieved from http://www.census.gov/prod/cen2010/briefs/c2010br-03.pdf

68 Institute of Medicine. (2011). The health of lesbian, gay, bisexual, and transgender people: Building a foundation for better understanding. Washington, DC: The National Academies Press.
69 World Health Organization. (2012). Social determinants of health. Retrieved from http://www.who.int/social_determinants/en
70 U.S. Department of Health and Human Services, Office of Minority Health. (2001). National standards for culturally and linguistically appropriate services in health care: Final report. Retrieved from http://www.minorityhealth.hhs.gov/assets/pdf/checked/finalreport.pdf
71 Massachusetts Department of Public Health, Office of Health Equity. (2009). Glossary and list of acronyms. In Making CLAS happen: Six areas for action (pp. 171–183). Retrieved from http://www.mass.gov/eohhs/docs/dph/health-equity/clas-appendices-glossary.pdf
72 The World Bank. (2011). Traditional healer services. Retrieved from http://go.worldbank.org/433PVWTQL0
73 U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration. (2012). Top Health Issues for LGBT Populations Information & Resource Kit. (HHS Publication No. (SMA) 12-4684). Retrieved from http://store.samhsa.gov/shin/content/SMA12-4684/SMA12-4684.pdf
74 National Council on Interpreting in Health Care. (2008). The terminology of health care interpreting: A glossary of terms. Retrieved from http://data.memberclicks.com/site/ncihc/NCIHC%20Terms%20Final080408.pdf
75 National Council on Interpreting in Health Care. (2008). The terminology of health care interpreting: A glossary of terms. Retrieved from http://data.memberclicks.com/site/ncihc/NCIHC%20Terms%20Final080408.pdf
76 AboutTTY.com: The power of connecting. (n.d.). What is a TTY? Retrieved from http://www.abouttty.com
77 Massachusetts Department of Public Health, Office of Health Equity. (2009). Glossary and list of acronyms. In Making CLAS happen: Six areas for action (pp. 171–183). Retrieved from http://www.mass.gov/eohhs/docs/dph/health-equity/clas-appendices-glossary.pdf