

# Introduction to the CLAS Standards

Presented by:

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## Introductions:

- Name
- Work
- What drew you to this presentation?
- Do you speak a second language? A third?



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## So, what are the CLAS Standards?

- The **CLAS Standards** stand for:

**C** = Culturally  
**L** = Linguistically  
**A** = Appropriate  
**S** = Services

**STANDARDS**



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**Goals For Session:**

1. Familiarization with the CLAS Standards & one Continuum of Cultural Competence
2. An enhanced understanding of the role of interpretation/interpreters within the healthcare context



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**Why this topic?**

- **The Office of Minority Health**, under the **U.S. Department of Health & Human Services**, was mandated by the **United States Congress in 1994** to develop the capacity of health care professionals to address the cultural and linguistic barriers to health care delivery and increase access to health care for limited English-proficient people.



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**What are Health Disparities?**

"Health disparities are differences in the incidence, prevalence, mortality, and burden of diseases and other adverse health conditions that exist among specific population groups in the United States"

NIH



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## The CLAS Standards

### A total of 14 standards:

- 4 (#s 4,5,6,7) are Federal mandates for recipients of Federal funds (***LANGUAGE***)
- 9 (#s1,2,3,8,9,10,11,12,13) are OMH recommended for Federal, State & national accrediting agencies (***Organizational Development & Accountability***)
- 1 (#14) is an OMH recommendation for voluntary adoption by health care orgs. (***Community Education***)



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**The CLAS Standards were finalized in 2000!**



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## **Health Disparities Nationwide:**

- Minorities are less likely to be tested routinely for cancer
- For all cancers combined, cancer deaths among Latinos and Blacks are disproportionately high
- The incidence of 100% preventable cervical cancer is more than 5 times higher in Vietnamese women in the US than in White women

--AHRQ



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### Health Disparities Nationwide:

- Native Americans have more than 2 times the rate of diabetes and heart disease than Whites
- African American diabetics are 7 times more likely to have amputations than White diabetics

--AHRQ



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### Health Disparities Nationwide:

- There is a 22% gap between Whites and African Americans for flu shot vaccinations
- Infant mortality rate for babies of African descent is double the rate of those of European descent

--AHRQ



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### Health Disparities Nationwide:

- Minorities are less likely to have a consistent source of health care
- Preventive care opportunities are frequently missed:  
Latinos are less likely to have blood pressure and cholesterol screening as well as counseling and treatment for cardiac risk factors
- Minority children are less likely to have dental care

--AMA



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### Health Disparities in NY:

- Hispanic and Black women, adolescents and children are disproportionately affected by obesity
- African American women are more than twice as likely to die of cervical cancer than are white women and more likely to die of breast cancer than are women of any other racial or ethnic group

---NYSDOH



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### Health Disparities in NY:

- In 2001, life expectancy in NYC's poorest neighborhoods was 8 years shorter than in its wealthiest neighborhoods
- The rate of new HIV diagnosis is approximately 6x times higher among blacks as among whites
- 94% of lead poisoning cases in children in NYC are among Blacks, Hispanics, and Asians



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**What disparities have you experienced or witnessed in your personal or professional life, if any?**



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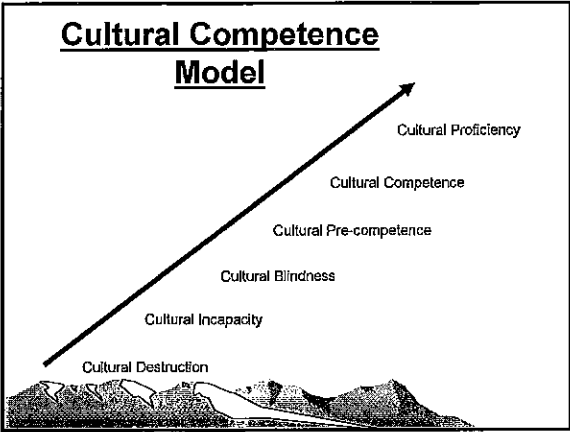
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**Cultural Destructiveness**

- Blatant attempts to destroy the culture of a group
- Assumption that one group is superior to another
- Acknowledges as legitimate only one way of being
- Purposefully denies or outlaws any other cultural approaches

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**Cultural Incapacity**

- Lacking in the capacity to be responsive to different groups, though not intentionally
- Ignorance and/or unfounded fear is often the underpinning of the problem
- Can consist of the failure to recognize when mistreatment is due to cultural differences, thereby perpetuating its occurrence

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### **Cultural Blindness**

- Views self as “unbiased”
- Believes that culture makes no difference in relation to the way human beings act and react
- Fosters the assumption that everyone is alike, so that what works for one culture (own) should work for all cultures



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### **Cultural Pre-competence**

- Marks the beginning of movement toward cultural sensitivity
- There is active pursuance of knowledge about differences
- Differences are viewed as just differences vs. signifiers of a particular value
- There is effort to integrate above information into actions / delivery of services



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### **Cultural Competence**

- Accepts & respects differences
- Reflects capacity to function effectively with groups outside of own culture
- Engages in continual self-assessment and expansion of knowledge about cultural issues
- Seeks advice & consultation
- Is committed to incorporating new knowledge and experience into behavior



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## Cultural Proficiency

- Most positive end of spectrum
- Acts pro-actively regarding cultural differences
- Holds culture in high esteem
- Promotes improved cultural relations among diverse groups
- Works to develop culturally sensitive practices in self & profession



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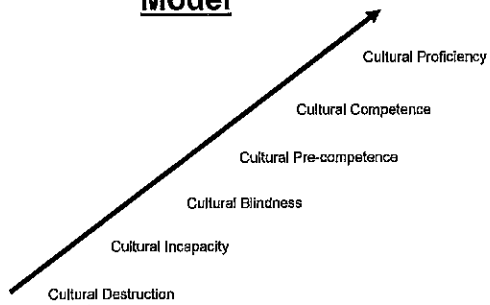
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## Cultural Competence Model



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# BREAK



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## Exercise

Cross-Cultural Communication Assessment



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## Language

- A language barrier is considered a contributing factor to "health disparities"...[It is] defined as a population-specific difference with the potential to result in access to care issues, disease incidence and outcomes.



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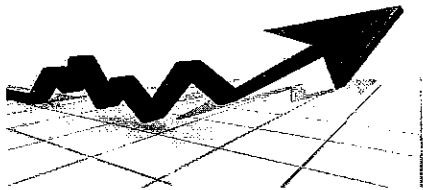
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## Examining Demographics



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**In Central New York**

Approximately **40,000** residents speak English "less than very well."



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**Some Demographics Regarding Language in the USA**

- 46 million + are ESL
- 21 million + speak Engl. less than "very well"
- 25 million adults are estimated to encounter **language barriers** when receiving health care



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**The Mandated: # 4**

4. Health care organizations **must offer and provide language assistance services**, including **bilingual staff** and **interpreter services**, at no cost to each patient/consumer with limited English proficiency **at all points of contact**, in a **timely manner during all hours of operation**.



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**Standard # 5**

5. Health care organizations must **provide** to patients/consumers in their **preferred language** both **verbal** offers and **written** notices informing them of their **right to receive language assistance services**



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**Standard # 6**

6. Health care organizations must **assure the competence of language assistance** provided to limited English proficient patients/consumers by interpreters and bilingual staff. Family and friends should not be used to provide interpretation services (except on request by the patient/consumer)



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**Standard # 7**

7. Health care organizations must make available **easily understood patient-related materials and post signage** in the languages of the commonly encountered groups and/or groups represented in the service area.



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**Where Language & Culture Intersect:**

"People who speak different languages live in different worlds, not the same world with different labels."

Edward Sapir, Linguist  
1928



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**What Language Reflects:**

- How the world works
- What is important in life
- The correct way to act
- What causes illness & how it is cured
- Etc.



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**INTERPRETING ON FILM**



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**Interpreting Considerations:**

- **Tone and mode**  
*Voice volume and/or speed*
- **Idioms**  
*Being "under the weather"*
- **Technicalities**  
*Embarazada (Spanish) / Angina (Russian)*
- **Concept of time**  
*Respecting providers' time*  
*Other notions of keeping appointments*



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**Ad Hoc Resources**

**Ad Hoc** ('ad-'hak, -hok) *adverb*: for the case at hand, apart from other applications  
*(Merriam-Webster)*

- As needed...(anyone around?)  
(Untrained and untested?)



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**Some Complications...**

Untrained interpreters may do the following:

- Add, omit & edit
- Interject advice
- Veil conflicts of interest
- Be unable to clarify culturally based misunderstandings
- Violate confidentiality
- Inhibit conversation (of the interpreted)



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**The CLAS Standards require that interpreters be competent.**

So what does competence in interpretation look / sound like?



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**Professional Interpretation**

**AD HOC**

- Hide/veil conflicts of interest
- Add, omit & edit
- Interject advice
- Be unable to clarify culturally based misunderstandings
- Violate confidentiality

**TRAINED**

- Declare conflicts of interest
- Accurate & complete
- No interjected advice
- Be able to clarify cultural nuances
- Adhere to confidentiality rules



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**The multiple roles of an interpreter:**

**Conduit:** Basic rendering of what has been said in one language into another

**Clarifier:** When enhanced interpreting assistance is provided via communication adjustments by the interpreter to facilitate understanding when exact rendering is not possible

**Cultural Broker:** When interpreter provides necessary cultural framework for understanding

**Advocate:** When interpreters takes actions on behalf of patients outside of the bounds of the interpreted interview



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### The Recommended...

- |  |   |
|--|---|
| 1. Effective, understandable & respectful care               | 8. Develop, implement & promote a written strategic plan                        |
| 2. Strategies to recruit, retain and promote a diverse staff | 9. Initial & on-going org. self- assessments                                    |
| 3. Ongoing education & training re CLAS delivery             | 10. Race, ethnicity & written/spoken lang. of patient incorporated into records |



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### Continued...

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| 11. Maintain current demographic, cultural & epidemiological profile of community | 13. Ensure grievance processes are C&L aware & appropriate       |
| 12. Develop participatory & collaborative partnership w/ community                | 14. Publicize progress & successful innovations in CLAS delivery |



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### We Are Here:

- **NCIH:** National Council of Interpreting in Healthcare
- National Code of Ethics for Interpreters in Health Care does exist! (Handout)
- There is no national or New York certification.
- State process has just begun for court reporting interpretation standards.



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**Local Interpreting Resources**

- Aurora
- Empire Interpreting Service LLC
- MAMI  
(Multicultural Association of Medical Interpreters)
- Spanish Action League



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**A Few Personal Challenges:**

- Recognizing our own culture(s)
- Acknowledging our biases/prejudices
- Valuing knowledge about other cultures
- Developing the capacity to step out of our comfort zones
- Nurturing our patience & commitment

*What else?*



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**Organizational Challenges:**

- Leadership: Development of Boards & Management
- Human Resources: Staff & Community Partnerships
- Policy
- Training
- Marketing / Community Partnerships
- Outcomes / Community Partnerships



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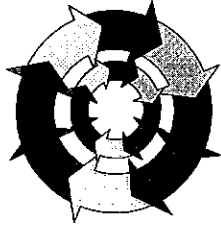
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## Stages of Cross Cultural Learning

- Awareness
- Sensitivity
- Knowledge
- Adaptability
- Competence



(Roe, K. 1993)

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## Our Goal

100% Access  
Zero Health Disparities

“Goals for the Nation,”  
“Healthy People 2010”



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## Why this direction?

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**The United Nations Universal Declaration of Human Rights...**

...for all members of the human family were first articulated in 1948.

Following the horrific experiences of the Holocaust & WWII, and amid the grinding poverty of much of the world's population, the UN sought to create a document that would capture **the hopes, aspirations, and protections to which every person** in the world was **entitled** and ensure that the future of humankind would be different.



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**HUMAN RIGHTS:**

- EQUALITY
- DIGNITY
  
- THE STANDARD IS FOR INDIVIDUALS & INSTITUTIONS
  
- ALL MUST ACCEPT THE RESPONSIBILITY



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"Do not be daunted by the enormity of the world's grief. Do justly, now. Love mercy, now. Walk humbly, now. You are not obligated to complete the work, but neither are you free to abandon it."

The Talmud



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**Gracias!**  
**Thank you!**



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