

The Challenge of CLAS Standards

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CLAS standards are to systematically advance the health care of and services to a wide array of minority populations, particularly those whose culture, language, and social conditions pose challenges to policy-makers, public agencies, health care plans, provider organizations, and health educators.

However, the establishment of standards does not provide an automatic road-map to these persons and organizations in how to implement advances based on the standards. Indeed, the very establishment of numerous, clear, and wide-ranging standards make the challenge appear quite daunting. The National Project Advisory Committee recognized the need to ground these standards in the everyday life of health care provider organizations through developing and providing information about the applicability and adoption of CLAS services into standard health practice; its recommendation in the final report gave rise to this project.

The CLAS standards were based, in large part, on ideals that have a basis in policy and practice somewhere in the United States. Health-care organizations, including large hospitals and HMOs, community health centers, migrant health centers, rural health centers, tribal health centers, academic health centers, state Medicaid and Medicare agencies, Medicaid-dominated health plans, specialized health-care services, individual providers, and others, have implemented specific service advances based on certain governing principles and solutions to the immediate problems before them.

Many health care organizations without a history of implementing culturally and linguistically appropriate services view such advances as necessary, but as formidable as any they have encountered in their past, such as, for examples, continuous quality improvement, managed care, capitated services, and computerized records. These matters are so outside of their range of experience that many do not know where or how to start or even how to initiate assessment and planning.

The history of more culturally and linguistically competent organizations demonstrates that most did not pursue a systematic design or plan of action to construct their “best cultural and linguistic practices.” Rather, based on their service relationship to the special communities and populations they served, they encountered serious problems in providing equity, access, voice, and quality of service. They did not turn to theory to solve these problems but, in concert with their communities and service populations, devised local pragmatic solutions that appeared to meet their needs. Over time, they improved upon these solutions, often by intuition and trial-and-error and linked them into larger CLAS strategies; these organizations have become, often unintentionally, the model programs that others now seek to emulate.

In a few cases, new programs have been designed and constructed based on the key principles and practices derived from the analysis of these more competent organizations. However, more mature programs often have difficulty in seeing how they can become more like the model programs, which appear so different to them. It is like seeing a finished painting; they often do not realize that, to begin that painting, all that is needed is to brush on the first paint somewhere on the canvas and the rest, with effort, will follow.

The key to making advances, then, is for these persons and organizations to take a first step to implement an immediately-needed local advance with confidence that 1) others have already taken this step successfully, 2) the step produces the benefits that are desired, and 3) other steps can then be pursued in a systematic fashion to meet local needs.

By providing a sufficient array of examples of tested advances in each of the CLAS standards, the impact of this project should be evidenced in health care services organizations across the country beginning to take these initial steps.

The Product

We propose to create a road-map to guide local efforts in the accomplishment of each of the CLAS standards, to demonstrate that progress can actually be made toward each the standards to the direct benefit of patients, enrollees, and organizations. We will conduct a wide-ranging one-year inquiry to identify and explain a number of “best practices” *specific to each of the standards*. In terms of explanation, we will report, at a minimum:

- What the purpose of the “best practice” is
- For whom the “best practice” was deemed appropriate
- What the content of the “best practice” is
- What problem the “best practice” actually reduced or overcame
- What conditions gave rise and support to the “best practice”
- What evaluative methods demonstrate the actual benefits of the “best practice”
- What practical obstacles, if any, limited the ability to implement the “best practice” fully or at all
- Where more information about this “best practice” may be obtained readily

We intend to report only those “best practices” that demonstrate some evidence of their utility in achieving positive results consistent with the standards and/or have broader implications for the standards. We will be alert to the possibility of best culturally and linguistically appropriate practices that may lie outside of the 14 standards as currently defined and that may also support the process to refine the standards in the future.