Guide to Reducing Behavioral Health Disparities

NE Department of Health and Human Services
Division of Behavioral Health

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- Nebraska DHHS Division of Behavioral Health

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October 8, 2015
# Table of Contents

Introduction ................................................................................................................................. 3

The Role of Cultural Competency in Addressing Health Disparities ........................................... 5
  What is Cultural Competence? .................................................................................................. 5

National Standards for Culturally and Linguistically Appropriate Services (CLAS) .................... 9
  Theme 1: Governance, Leadership and Workforce ................................................................. 9
  Theme 2: Communication and Language Assistance ............................................................. 10
  Theme 3: Engagement, Continuous Improvement and Accountability ..................................... 12

Applying the Strategic Prevention Framework (SPF) to Reduce Behavioral Health Disparities .... 13

Ensuring Culturally Responsive Evidence Based Prevention Strategies ........................................ 17
  The Cultural Adaptation Continuum ....................................................................................... 18
    A Multi-Stage Process for Culturally Adapting Evidence Based Strategies ......................... 19
    Figure 5. Stages of Cultural Adaptation .............................................................................. 20

Summary ...................................................................................................................................... 21

References .................................................................................................................................... 22

Additional Resources .................................................................................................................. 23

Appendix ....................................................................................................................................... 24
  National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health and Health Care .................................................................................................................. 24

Glossary ......................................................................................................................................... 26
Introduction:

Within the last 15 years, the elimination of health disparities within the U.S. has emerged as a national priority. Numerous research studies have documented poorer physical and behavioral health outcomes for many cultural and ethnic sub-populations. These differences have a significant social and economic impact on U.S. Society as a whole. A 2010 report by the Joint Center for Political and Economic Studies concluded that “the combined costs of health inequalities and premature death in the United States were $1.24 trillion between 2003 and 2006. The U.S. Department of Health and Human Services (HHS) defines health disparities as:

“A particular type of health difference that is closely linked with social, economic, and/or environmental disadvantage. Health disparities adversely affect groups of people who have systematically experienced greater obstacles to health based on their racial or ethnic group; religion; socioeconomic status; gender; age; mental health; cognitive, sensory, or physical disability; sexual orientation or gender identity; geographic location; or other characteristics historically linked to discrimination or exclusion.” (Healthy People 2020)

In November 2010, HHS Secretary Kathleen Sebelius charged Health and Human Services with the development of a comprehensive national action plan for reducing health disparities within the US. This action plan is predicated on the concept of health equity which holds that we should:

“...strive for the attainment of the highest level of health for all people through focused and ongoing societal efforts to address avoidable inequalities, historical and contemporary injustices” (U.S. HHS, 2012).

Nebraska’s DHHS Office of Health Disparities and Health Equity has made health equity for all Nebraskans a priority and is committed to improving health outcomes for culturally diverse populations of Nebraska. This Office provides support to the Division of Behavioral Health

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October 8, 2015
related to this goal and their work serving Nebraska communities with behavioral health prevention, treatment and recovery services.

Research has indicated that observed health disparities may be the result of differences in access to prevention and treatment services, cultural barriers to seeking care, lack of health insurance coverage discrimination or other social and/or environmental factors.

Within Nebraska’s behavioral health treatment and recovery service system, improving health equity includes utilizing strategies that impact the provider’s ability to serve disparate populations by ensuring access to quality culturally and linguistically competent services for individuals through an equipped workforce. Prevention strategies often also include environmental approaches that seek to empower communities and thus need to ensure that strategies to reduce health disparities consider a variety of factors that affect Nebraskans that can impact their access to prevention services.

These findings are consistent with prevention research which tells us that poor outcomes are usually the result of an individual’s exposure to multiple risk and/or protective factors. These risk and protective factors exist on multiple levels from individual characteristics and behaviors to those that exist in our family, community, and the larger society (Figure 1).

Figure 1. Multiple Contexts of Risk and Protective Factors
These levels are not mutually exclusive – individuals can be exposed to risks at multiple levels throughout their lifetime - sometimes concurrently. Eliminating health disparities will involve interventions at each of these levels.

The Role of Cultural Competency in Addressing Health Disparities
Research on health disparities has noted the significant impact of culture in shaping perceptions of health and healthcare systems. Individuals from minority cultural and linguistic backgrounds receive poorer quality care compared with more mainstream patients and are more likely to have negative and sometimes life threatening experiences because of miscommunication or other linguistic or cultural barriers encountered in the healthcare setting. While research on the impact of cultural competency on patient outcomes is still inconclusive, the available research suggests that cultural and linguistic adaptations to services can enhance recruitment, engagement and retention of participants.

What is Cultural Competence?
The Substance Abuse and Mental Health Services Administration (SAMHSA) defines cultural competency as:

“The ability of an individual or organization to interact effectively with people of different cultures.”

At the organizational level cultural competence requires a set of congruent behaviors, attitudes and policies that enables members of an organization to work effectively across cultures. For preventionists, the ultimate goal of enhancing cultural competency is to improve access, utilization and effectiveness of prevention services for underserved, high need clients and communities. Enhancing organizational cultural competence can improve


October 8, 2015
client recruitment, engagement and retention in prevention services and potentially enhance the overall positive impact of interventions.

It is important to understand that cultural competency, whether individual or organizational is an ongoing process. Progress toward competence can be assessed along a continuum from cultural destructiveness to competence (Figure 2). Organizations and individuals may move back and forth along this continuum depending upon their level of familiarity with a particular culture. It is perhaps unrealistic to expect that individuals or organizations can become equally competent in working cross culturally with all cultural groups they might encounter. However, willingness to recognize and act upon potential opportunities for movement along the continuum, along with the flexibility to adapt to changing cultural environments characterizes culturally responsive organizations. Enhancing organizational cultural competence is the first step toward eliminating health disparities.

Addressing the root causes of substance abuse and other behavioral health disorders requires an understanding of the complex interactions between the individual and his/her environment including cultural factors that may influence their ability and/or willingness to engage in and benefit from prevention services. Culturally competent prevention organizations have a greater capacity to identify and address the needs of diverse populations and, as a result a greater potential for facilitating individual and system-level change.
**Figure 2. The Cultural Competency Continuum**

- **Cultural Destructiveness**: Attitudes and practices (as well as policies and structures in organizations) are destructive to a cultural group.

- **Cultural Incapacity**: The capacity to respond effectively to the needs, interests and preferences of culturally and linguistically diverse groups is lacking.

- **Cultural Blindness**: The predominant philosophy is one that views and treats all people the same.

- **Cultural Pre-Competence**: There is awareness of strengths and areas for growth to respond effectively to culturally and linguistically diverse populations.

- **Cultural Competence**: Acceptance and respect for culture is consistently demonstrated in policies, structures, practices and attitudes.

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October 8, 2015
Case Example: A prevention coalition has decided to implement an evidence-based program in their county. Needs assessment data collected by the coalition indicated that approximately 30% of the highest risk community in the county is Hispanic. Many of the Hispanic families are first generation immigrants with limited English proficiency. Hispanic youth appear to have a higher rate of alcohol use and non-medical use of prescription drugs compared to other groups.

During one of the coalition’s early planning meetings there is discussion about the best strategy for recruiting and engaging youth in the county. During the discussion, several different points of view are shared. The comments below illustrate different positions on the cultural competency continuum.

- Advisory Board member: “The program materials are in English - I don’t see why we should be concerned about translating them. After all, if these kids want to benefit from the services being offered they need to learn English.” (Cultural destructiveness)
- Program Administrator: I am sure that having some resources in English would be helpful for the Hispanic participants, I just don’t see how we will be able to translate them- we don’t have any bilingual staff!” (Incapacity)
- Religious Leader: “All youth have basically the same needs. This program has already been evaluated and found effective for most youth. There really isn’t any reason to change it.” (Blindness)
- Parent: “There are a number of Hispanic families that go to my church. Perhaps we should involve them in this discussion. They may also know of some resources to help with translation or other ways that we might make the program more attractive to Hispanic youth.” (Pre-competence)
National Standards for Culturally and Linguistically Appropriate Services (CLAS)

The National CLAS Standards were developed by the Office of Minority Health in the U.S. Department of Health and Human Services (HHS) as a resource for advancing health equity, improving the quality of health services and help eliminate health disparities by providing a blueprint for the implementation of culturally and linguistically appropriate services. The CLAS Standards are organized into three primary themes, predicated on a Principal Standard which frames the goal for all the Standards: *Provide effective, equitable, understandable, respectful, and quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy and other communication needs.* The three organizing themes of the CLAS Standards are:

- Governance, Leadership and Workforce
- Communication and Language Assistance
- Engagement, Continuous Improvement and Accountability

The following sections describe the individual CLAS Standards as well as suggestions on how to apply them to substance abuse prevention.

**Theme 1: Governance, Leadership and Workforce**

The CLAS Standards related to this theme focus on the importance of organizational investment in provision of culturally competent services. These Standards include:

- Advance and sustain governance and leadership that promotes CLAS and health equity.
- Recruit, promote and support a diverse governance, leadership and workforce.
- Educate and train governance, leadership and workforce in CLAS.

The Standards related to this theme emphasize the importance of ongoing capacity building within the organization. This includes ongoing training of leadership, management and line staff and providing access to resources to encourage continuous professional growth.

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8 A complete list of the CLAS Standards can be found in Appendix

Organizational cultural competence is also reflected in deliberate strategies to recruit, support and sustain a diverse workforce. Periodic assessments of staff knowledge and skills in providing culturally and linguistically appropriate services should be conducted, as well as assessments of their knowledge of and ability to address diverse levels of health literacy in the populations that they serve. Effective application of these Standards also requires ongoing assessment of the service area to identify cultural and demographic changes and emerging needs of the populations served. The purpose of the Standards under this theme is to create an organizational environment which welcomes diversity, promotes trust within communities and populations served and infuses multicultural perspectives into the design and implementation of organizational activities.

**CLAS Strategy Checklist:**

- Workforce development plan to enhance and monitor staff capacity to provide culturally and linguistically appropriate services to the population served?

- Deliberate strategies in place to recruit, support and sustain a diverse workforce that reflects the cultural diversity of clients, communities and intended audiences?

- Periodic assessments of the service area to identify changes in demographics, emerging issues and needs?

**Theme 2: Communication and Language Assistance**

Standards related to communication and language assistance apply to all communication services, programs and needs. The goal of these Standards is to create and implement services that are understandable and respectful of linguistic diversity including culturally influenced
meanings and interpretations, literacy levels and communication needs related to physical disability. These Standards include:

- Offering competent and appropriate communication and language assistance and ensuring that individuals are aware that assistance is available.
- Creating materials and signage that takes into account literacy, cultural and linguistic diversity of communities served, program participants and/or intended audiences.

One way to ensure the cultural and linguistic appropriateness of programs, strategies and associated materials is to partner with representatives from the communities that are the intended recipients of services. Potential partners might include organizations within the community that provide services to a particular sub-population including faith-based or other grass roots organizations, healthcare providers or “cultural brokers”. Cultural brokers are individuals from the community who can serve as a bridge between an organization and people of different cultural backgrounds. These individuals should be familiar with both the community and the system of care. They can also function as mediators, advocates and navigators to assist individuals in accessing and effectively utilizing services and programs. Other strategies for obtaining community input are community forums, focus groups and interviews with key stakeholders from the communities and sub-populations of interest.

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Theme 3: Engagement, Continuous Improvement and Accountability

The Standards related to this theme are primarily concerned with ensuring the sustainability of culturally appropriate services through individual and organizational accountability. Essentially this means institutionalizing the Standards through policy as well as practice and holding individuals within the organization accountable for them through personnel evaluations, quality improvement processes and strategic planning. The use of data to monitor and improve organizational performance is an important aspect of these standards. This activity might include organizational audits to ensure policies, procedures and other organizational structures necessary to support the implementation of CLAS Standards are in place. They also include gathering feedback from the communities and populations served. This set of Standards encourages the dissemination of lessons learned and best practices through printed materials, educational forums and community discussions. The Standards under this theme include:

- Infusing CLAS goals, policies and management accountability throughout the organization’s planning and operations
- Conducting organizational assessments
- Collecting and maintaining demographic data
- Conducting assessments of community health assets and needs
- Partnering with the community
- Communicating the organization’s progress in implementing and sustaining CLAS Standards
- Creating organizational conflict and grievance resolution procedures.
Applying the Strategic Prevention Framework (SPF) to Reduce Behavioral Health Disparities

The Strategic Prevention Framework (SPF) developed by the Substance Abuse and Mental Health Services Administration (SAMHSA) to guide communities in strategic planning for comprehensive substance abuse prevention can also be applied to health disparities. The SPF is a 5 stage planning process for the selection, planning, implementation and evaluation of culturally appropriate and sustainable prevention activities. The five steps of the SPF are: Assessment, Capacity, Planning, Implementation, and Evaluation. The 5 steps of the SPF are consistent with the CLAS Standards. Note that cultural competency and sustainability are considered critical to effective implementation of the SPF (Figure 3).

CLAS Strategy Checklist

✓ Accountability mechanisms for cultural appropriateness exist across the organization including processes for conflict and grievance resolution?

✓ Process for ongoing monitoring and evaluation of organizational performance related to CLAS Standards?

✓ Policies and procedures for soliciting feedback from communities and program participants on the cultural appropriateness of programs, strategies and associated materials?

✓ Epidemiologic and needs assessment data includes information on sub-populations within the service area including needs, access, utilization, quality of services provided and health outcomes?

✓ Individuals and/or groups from the community are engaged in the design, planning, implementation and evaluation of prevention activities?

✓ Mechanisms for disseminating information on lessons learned, performance and
Figure 3. SAMHSA’s Strategic Prevention Framework (SPF)\textsuperscript{11}

At each stage of the SPF there are specific strategies that will help to identify and impact health disparities (Table 1).


October 8, 2015
Table 1. Using the SPF to Address Health Disparities

<table>
<thead>
<tr>
<th>SPF STEP</th>
<th>Health Disparity Strategy</th>
<th>CLAS Standard</th>
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</thead>
</table>
| Assessment | • Use data to identify sub-populations within a region or community that appear to be at higher risk for the targeted behaviors (e.g. underage alcohol use). Collect data on risk and protective factors that may be contributing to higher rates of use.  
• Assess the readiness of high need populations to engage in substance abuse prevention activities including the perceived barriers to engagement.  
• Inventory community resources in high need areas – including cultural experts from within the community who may be able to serve in an advisory capacity as you develop and pilot culturally adapted materials and programs. | #10: Conduct ongoing assessments of the organization’s CLAS-related activities and integrate CLAS-related measures into measurement and continuous quality improvement activities.  
#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. |
| Capacity | • Build organizational capacity to provide culturally appropriate services to groups that appear to be experiencing higher rates of poor outcomes.  
• Utilize local resources to review and/or pilot adaptations before they are rolled out to the community. | #13: Partner with the community to design, implement, and evaluate policies, practices and services to ensure linguistic appropriateness. |

12 Center for the Application of Prevention Technologies (CAPT)
<table>
<thead>
<tr>
<th>SPF STEP</th>
<th>Health Disparity Strategy</th>
<th>CLAS Standard</th>
</tr>
</thead>
<tbody>
<tr>
<td>Planning</td>
<td>• Identify outside resources to assist with linguistic translations if necessary.</td>
<td>#4: Educate and train governance, leadership, and workforce in culturally and linguistically appropriate policies and practices on an ongoing basis.</td>
</tr>
<tr>
<td></td>
<td>• Use established standards such as the National Standards for Culturally and Linguistically Appropriate Services (CLAS) to guide planning efforts.</td>
<td>#7: Ensure the competence of individuals providing language assistance, recognizing that the use of untrained individuals and/or minors as interpreters should be avoided.</td>
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<td></td>
<td>• If you are using an evidence based program, you should contact the developer to see if program materials have already been adapted for specific groups. Some developers may be willing to work with you to develop and evaluate cultural adaptations of their programs.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>#4: Educate and train governance, leadership, and workforce in culturally and linguistically appropriate policies and practices on an ongoing basis.</td>
<td>#7: 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>
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<td></td>
<td>#8: Provide easy to understand print and multimedia materials and signage in the languages commonly used by the populations in the service area.</td>
<td>#13: Partner with the community to design, implement, and evaluate policies, practices and services to ensure linguistic appropriateness.</td>
</tr>
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<td></td>
<td>#13: Partner with the community to design, implement, and evaluate policies, practices and services to ensure linguistic appropriateness.</td>
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<td></td>
<td>• Create guidelines for program implementers to ensure that the core elements of evidence based programs are implemented consistently and in concordance with the original design.</td>
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<td></td>
<td>• Collaborate with key stakeholders from the target community to ensure that prevention activities are implemented in a culturally appropriate manner.</td>
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<td>• Create a process for tracking critical benchmarks in the</td>
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<tr>
<td><strong>SPF STEP</strong></td>
<td><strong>Health Disparity Strategy</strong></td>
<td><strong>CLAS Standard</strong></td>
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| **Evaluation** | implementation process, such as completion of core activities, attendance/dropout rates, etc.  
- Conduct periodic performance reviews to assess the quality and consistency of culturally-specific services being provided. | #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.  
#13: Partner with the community to design, implement, and evaluate policies, practices and services to ensure linguistic appropriateness. |

**Ensuring Culturally Responsive Evidence Based Prevention Strategies**

The CLAS Standards provide a foundation for creating and maintaining a culturally responsive organization with the capacity to identify and address prevention needs of diverse communities. Both the SPF and the CLAS Standards recognize that the first step in this process is the collection of information about the characteristics, assets, needs and potential cultural and linguistic barriers within communities and sub-populations being served. This information is used to inform service planning, illuminating the areas where it may be necessary to make adjustments to evidence based interventions that have not previously been implemented or evaluated with specific cultural groups. This process can require adjustments that range from minor (e.g. linguistic translation of signage and materials) to development, pilot testing and evaluation of interventions in collaboration with communities being served.
The Cultural Adaptation Continuum

The ultimate goal of cultural adaptation is to ensure that prevention strategies are effective in realizing intended behavioral outcomes in all program participants. Cultural adaptations to evidence-based strategies must also ensure that the core elements of those strategies remain intact during the implementation process. This is often referred to as fidelity. Adaptations should always be made in collaboration with the communities and groups from which program participants will be recruited.

The decision of whether or not to make adaptations may be based on the following:

- The extent to which adaptations will eliminate or reduce cultural barriers that may inhibit recruitment, retention, and/or the effectiveness of the proposed strategy;
- The feasibility of making the necessary adjustments to the program based on organizational capacity, budgetary, time, and manpower constraints;
- The extent to which proposed adjustments may compromise core elements of the evidence-based strategy.

Okamoto et al. (2014) have proposed a conceptual model of cultural adaptation which views such adaptations along a continuum from no adaptations to those which are culturally grounded and truly reflective of a cultural worldview and place the culture and social context of the target population at the center of the intervention. (Figure 4). At the low end of the continuum are evidence-based strategies that are implemented without any cultural adaptations. At this level, strategies are considered appropriate for all audiences and do not require adaptations or culturally adapted versions of the programs or strategies are already available. It is always a good idea to review the recent research literature on a selected strategy or consult with program developers to determine if the program has been successfully adapted by others for a particular population.

Some programs or strategies may require minor adjustments such as changes to images, language, and terms. These types of adjustments are considered surface or structural adaptations. Most adaptations that occur in the prevention field fall in this category due to capacity, time, or budgetary constraints. In many cases, minor modifications can yield positive outcomes for diverse cultural groups.

Adaptations that involve more substantial changes to reflect complex cultural elements tied to the core elements of the intervention are considered deep structure adaptations in Okamoto’s

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14 Ibid
model. These types of modifications represent a deliberate attempt to infuse cultural worldviews, values and beliefs into the core elements of the program or strategy. Such adaptations can be time consuming and require close collaboration with the communities and populations for which they are intended. However, adaptations at this level may significantly improve the engagement of intended participants. For example, the importance of recognizing tribal identities and cultures as well as social pressures related to assimilation and discrimination have been found to be important adaptations for strategies that target Native Americans.

At the more intense level are programs that are built around evidence based strategies, but incorporate activities, materials, approaches that emerge from the culture in which they will be implemented. These adaptations, which Okamoto et.al. refer to as culturally grounded are most closely connected to the values, behaviors, norms and worldviews of the populations and communities from which participants will be recruited. The creation of culturally grounded adaptations may be necessary when there are no empirically validated programs available for specific underserved sub-populations such as Native Alaskan or Native Hawaiian youth.

Figure 4. The Cultural Adaptation Continuum

A Multi-Stage Process for Culturally Adapting Evidence Based Strategies
Both the CLAS Standards and the SPF model emphasize the critical importance of ongoing collaboration with high need communities and sub-populations from which program participants will be recruited. Outreach and partnership with individuals and groups who are knowledgeable about both the strengths and needs of the population of interest as well as cultural barriers and other relevant social and contextual factors is critical to the success of any prevention strategy.

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15 Adapted from Okamoto et.al. (2014)
Cultural adaptation requires a considerable commitment of organizational time and resources, however even modest structural adaptations to a program can yield a sizable return for the investment made. Cultural adaptation should be viewed as a multi-stage process that involves information gathering, collaborative planning, pilot testing and implementation as well as performance monitoring and evaluation (Figure 5).

Figure 5. Stages of Cultural Adaptation

The first step in this process is to gather information on the characteristics, risk and protective factors, cultural barriers and other factors that may influence participant acceptance, engagement, participation or achievement of the program’s behavioral outcomes. This information can be obtained from community needs assessments and readiness surveys, focus groups, interviews with key members of the community or through community forums. Once this information is collected, a decision must be made as to whether cultural adaptations are needed and the level of adaptation that will be required. These activities correspond to the first 2 steps of the SPF (Assessment and Capacity). At this stage, it may be advisable to contact the program’s developer as you consider the modifications that will need to be made to ensure that core elements of the program would not be compromised.

Cultural adaptations should also only be made with ongoing feedback from individuals and groups who are knowledgeable about the community and sub-populations from which participants will be recruited. It is highly recommended that the modified program then be tested with a limited number of participants to be sure that no further modifications are needed. Participant insights on promotion, materials and other aspects of implementation can also be helpful. Feedback can be obtained through survey questionnaires, focus groups or interviews with participants. This corresponds to the third step in the SPF (Planning).

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October 8, 2015
Ongoing performance monitoring and evaluation are critical both during the early stages of implementation (SPF step 4, Implementation) and after the program is fully implemented. Tracking information such as the number of promotional events, the number of participants recruited/enrolled, attendance and drop-out rates can help you determine whether the adaptations are likely to achieve the desired outcomes. At this stage you may also identify the need to make additional adjustments to the program. Ultimately, you should conduct an impact evaluation to see if the culturally adapted program has resulted in improved behavioral outcomes (SPF step 5, Evaluation).

**Summary**

The U. S. Department of Health and Human Services has made the reduction of health disparities a national priority. Nebraska’s DHHS has made health equity for all Nebraskans a priority and is committed to improving health outcomes for culturally diverse populations of Nebraska. At the community level, this requires a commitment to increase individual and organizational cultural competency. In many cases it may be necessary to modify existing evidence based interventions in order to improve their effectiveness for individuals from historically underserved communities. The goal of such modifications should be to improve access, participation and effectiveness of health interventions including, prevention services for all members of the community. Achieving this goal this requires a commitment from community prevention providers to identify, and address the root causes of behavioral health disparities through systematic capacity building, community collaboration, ongoing assessment and evaluation. The Strategic Prevention Framework and the National CLAS standards can help guide communities through the process of serving these at-need populations.
References


Additional Resources

- [www.thinkculturalhealth.hhs.gov/index.asp](http://www.thinkculturalhealth.hhs.gov/index.asp) U. S. Department of Health and Human Services, Office of Minority Health website. In addition to information about the enhanced CLAS Standards, this site offers a wealth of information on health disparities and cultural competence including online trainings and case studies and other downloadable resources.
- [http://www.samhsa.gov/kap/about](http://www.samhsa.gov/kap/about) SAMHSA Knowledge Application Program (KAP) works with constituent groups to produce culturally appropriate materials. Through its Multi-Language Initiative provides translations of educational and information materials.
Appendix

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

The National CLAS Standards are intended to advance health equity, improve quality, and help eliminate health care disparities by establishing a blueprint for health and health care organizations to:

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.

October 8, 2015
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.
Glossary

- **Behavioral Health**: A state of mental/emotional wellbeing and/or choices and actions that affect wellness (SAMHSA, 2011. *Leading Change: A Plan for SAMHSA’s Role and Actions*)

- **Cultural Competence**: The ability of an individual or organization to interact effectively with people of different cultures. SAMHSA’s Center for the Application of Prevention Technologies (2012) Cultural Competence retrieved August 26, 2015 from http://captus.samhsa.gov/access/resources/about-strategic-prevention-framework-spf#cultural


- **Health Disparity**: A particular type of health difference that is closely linked with social, economic and/or environmental disadvantage. Health disparities adversely affect groups of people who have systematically experienced greater obstacles to health based on their racial or ethnic group; religion; socioeconomic status; gender; age; mental health; cognitive, sensory, or physical disability; sexual orientation or gender identity; geographic location; or other characteristics historically linked to discrimination or exclusion.” (Healthy People 2020) ¹⁷

- **Health Equity**: The highest level of health for all people through the elimination of health and health care disparities (Healthy People 2020)

- **Protective Factor**: A characteristic at the individual, family or community level that is associated with a lower likelihood of problem outcomes. (National Research Council and Institute of Medicine, 2009. *Preventing Mental, Emotional, and Behavioral Disorders Among Young People: Progress and Possibilities*; Washington, DC; National Academies Press)

- **Risk Factor**: A characteristic at the biological, psychological, family, community, or cultural level that precedes and is associated with a higher likelihood of problem

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- outcomes (National Research Council and Institute of Medicine, 2009. *Preventing Mental, Emotional, and Behavioral Disorders Among Young People: Progress and Possibilities*; Washington, DC; National Academies Press)

- **Strategic Prevention Framework (SPF):** A 5 stage planning process for the selection, planning, implementation, and evaluation of culturally appropriate and sustainable prevention activities. (Substance Abuse and Mental Health Services Administration. https://captus.samhsa.gov/prevention-practice/strategic-prevention-framework)