

A Cultural Competency Standards Crosswalk

A tool to examine the relationship between the OMH CLAS Standards and Joint Commission/URAC/NCQA Accreditation Standards

The logo for UQIOSC, featuring the letters 'UQIOSC' in a dark brown, serif font, enclosed within a dark brown, curved, swoosh-like border.

A Cultural Competency Standards Crosswalk

A tool to examine the relationship between the OMH CLAS Standards and The Joint Commission/URAC/NCQA Accreditation Standards

Cultural competency is defined as the level of knowledge-based skills required to provide effective clinical care to patients from a particular ethnic or racial group. Linguistic competency is the capacity of an organization and its personnel to communicate effectively and convey information in a manner that is easily understood by diverse audiences including people of limited English proficiency, those who have low literacy skills or are not literate and individuals with disabilities. The importance of knowing how to properly treat patients from various cultures, religions and ethnicities can have a lasting impact on their health.

Many organizations have worked numerous hours examining the commonalities of individual standards. This crosswalk outlines the relationships between the National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health Care, issued by the Office of Minority Health, and the accreditation standards of the Joint Commission, URAC, and the National Committee for Quality Assurance (NCQA).

While this crosswalk provides some points of comparison and linkage, it should not be used in place of either the actual standards or any other governing documents issued by the accrediting agency to assess accreditation compliance or readiness. The crosswalk between the CLAS standards and the Joint Commission standards was provided by the Joint Commission. The Underserved Quality Improvement Organization Support Center (UQIOSC) compiled the crosswalk between the CLAS standards and the URAC and NCQA standards.

For additional information, visit these Web sites:

The Joint Commission (<http://www.jointcommission.org/>)

National Committee for Quality Assurance (www.ncqa.org)

URAC (www.urac.org)

The Office of Minority Health Resource Center (www.omhrc.gov/clas/)

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- A special "Thank You" to all those who contributed their time and effort in developing the Crosswalk.

CROSSWALK: OMH CLAS AND ACCREDITATION STANDARDS

OMH CLAS Standards to:

- The Joint Commission 2006 Standards for Hospitals, Ambulatory, Behavioral Health, Long Term Care, and Home Care;
- URAC Core Standards 2.0 and Applications to Accreditation Programs: Health Plan (P-NM, P-MR) Version 5.0, Health Network Version 5.0, Health Utilization Management (UM) Version 5.0, Workers' Compensation Utilization Management, Version 4.0, Case Management, Version 3.0, Disease Management, Version 2.0, Independent Review Organization, Version 3.0, CVO, Version 3.0, Health Call Center, Version 4.0, Claims Processing, Version 2.0, and Consumer Education and Support (CES), Version 2.0;
- NCQA 2007 Standards and Applications to Accreditation Programs: Quality Improvement (QI) and Members' Rights and Responsibilities (RR).

*Please note that the NCQA released the revised HEDIS Technical Specifications for 2006. The Diversity of Medicaid Membership measure was divided into two measures: 1) Race/Ethnicity Diversity of Membership that reports the number and percentage of members by race/ethnicity stratified by gender for the product population and 2) Language Diversity of Membership that reports the number and percentage of members by demand for a language interpreter services and spoken language stratified by gender for each product population. The two measures were expanded to include Medicare. Race/ethnicity categories were modified to be consistent with the U. S. Census and the Office of Management and Budget (OMB).

Joint Commission Standards			
Chapter/Manual Title Acronym	Manual/Chapter Title Expansion	Chapter/Manual Title Acronym	Manual/Chapter Title Expansion
RI	Rights, Responsibilities, and Ethics	AHC	Ambulatory Health Care
PC	Provision of Care, Treatment, and Services	BHC	Behavioral Health Care
LD	Leadership	LTC	Long Term Care
HR	Management of Human Resources	OME	Home Care
PI	Improving Organization Performance	HAP	Hospital
IM	Management of Information	OTP	Opiod Treatment Program
EP	Element of Performance		

CLAS STANDARDS CROSSWALK TO JOINT COMMISSION, URAC (CM, UM, CES, P-NM, P-MR), AND NCQA

OMH CLAS Standards

Standard 1.

Health care organizations should ensure that patients/consumers receive from all staff members effective, understandable, and respectful care that is provided in a manner compatible with their cultural health beliefs and practices and preferred language.

Comments

Standard 1 is the foundation on which other CLAS standards are based and incorporates a variety of the Joint Commission standards.

Comments from the Crosswalk of CLAS and Joint Commission:

OMH provides the following suggestions for implementing this standard:

- Cross-cultural education and training for staff
- Assessment of staff learning skills through testing, direct observation, monitor patient/personnel encounter
- Assess in staff performance review
- HCO should provide patients/consumers with information regarding existing laws and policies prohibiting disrespectful or discriminatory treatment or marketing/enrollment practices.

Joint Commission Standards	URAC (CM, UM, CES, P-NM, P-MR) Standards	NCQA Standards
<p>RI.2.10 The organization respects the rights of [patients/residents/clients]. EP.2</p> <p>RI.2.20 Patients receive information about their rights.</p> <p>EP. 15 (Applicable only to BHC-OTP)</p> <p>RI.2.100 Organization respects the [patient's/resident's/clients] right to and need for effective communication. EP.2, 3, 4</p> <p>RI.2.220 (LTC only) Residents receive care that respects their personal values, beliefs, cultural and spiritual preferences, and life-long patterns of living. EP.1</p> <p>PC.2.20 (AHC, HAP, LTC, OME only) The organization defines in writing the data and information gathered during assessment and reassessment.</p> <p>EP.4 (HAP and AHC only)</p> <p>EP.6 (OME only)</p> <p>EP.8 (OME only)</p> <p>EP.14 (LTC only)</p> <p>EP.17 (LTC only)</p>	<p>Core 20 Financial Incentive Policy If the organization has a system for reimbursement, bonuses, or incentives to staff or health care providers based directly on consumer utilization of health care services, then the organization implements mechanisms addressing how the organization will ensure that consumer health care is not compromised.</p> <p>Core 21 Communication Practices The organization follows marketing and communication practices that include:</p> <ul style="list-style-type: none"> (a) Mechanisms to clearly and accurately communicate information about services to consumer and clients; (b) Safeguards against misrepresentations about the organization's services; (c) A formal process of inter-departmental review of marketing materials before dissemination; and (d) Monitoring of existing materials for accuracy. <p>Core 26 Access to and Monitoring of Services The organization:</p> <ul style="list-style-type: none"> (a) Establishes standards to assure that consumers or clients have access to services: and (b) Defines and monitors its performance with respect to the access standards. <p>CES 2 Further Pre-Enrollment Consumer Information Requirements The information made available to potential</p>	<p>RR 1 A The organization's member rights and responsibilities statement states that members have:</p> <ul style="list-style-type: none"> • a right to receive information about the organization, its services, its practitioners and providers and member rights and responsibilities • a right to be treated with respect and recognition of their dignity and right to privacy • a right to participate with practitioners in making decisions about their health care • a right to a candid discussion of appropriate or medically necessary treatment options for their conditions, regardless of cost or benefit coverage <p>RR 2 A The organization, upon enrollment and annually thereafter, distributes its member rights and responsibilities statement to:</p> <ul style="list-style-type: none"> • existing members • new members <p>QI 4 A The organization assesses the cultural, ethnic, racial and linguistic needs of its members and adjusts the availability of practitioners within its network, if necessary.</p> <p>UM 2 A The organization:</p> <ul style="list-style-type: none"> • has written UM decision-making

<p>EP.20 (LTC only)</p> <p>EP.21 (LTC only)</p> <p>PC.2.60 (BHC only) The organization defines in writing the data and information gathered during the psychosocial assessment. EP. 3</p> <p>PC.6.10 The [patient/resident/client] receives education and training specific to patient’s needs and as appropriate to the care, treatment, and services provided. EP.2</p> <p>LD.2.10 An individual or designee(s) [leader(s) – for BHC] is responsible for operating the organization according to the authority conferred by governance. EP.5 (BHC OTP only)</p> <p>LD.3.60 Communication is effective throughout the organization.</p> <p>HR.2.10 Orientation provides initial job training and information. P.5</p> <p>HR.2.30 Ongoing education, including in-services, training, and other activities, maintains and improves competence. EP.3</p> <p>LD.3.20 Patients with comparable needs receive the same standard of care, treatment, and services throughout the org. EP.1, 2, 3</p>	<p>enrollees under CES 1 includes:</p> <p>(c) Descriptions of the processes the organization uses to provide information and support to consumers:</p> <p>(i) For whom English is not their primary language;</p> <p>(ii) From different cultural backgrounds; and</p> <p>(iii) With special needs, such as cognitive or physical impairments.</p> <p>CES 4 Post-Enrollment Communication with Consumers Upon enrollment, the organization informs consumers about available information resources and assistance.</p> <p>CES 13 Health Literacy Communication Requirement The organization has a process to provide information.</p> <p>CES 14 Cultural Sensitivity Communication Requirement Information is presented and delivered in ways that are sensitive to the diversity of the organization’s enrollment, including:</p> <p>(a) Literacy levels;</p> <p>(b) Language differences;</p> <p>(c) Cultural differences; and</p> <p>(d) Cognitive and/or physical impairment.</p> <p>P-NM 1 Scope of Services The organization defines the scope of its services with respect to:</p> <p>(a) The types of health care services offered</p>	<p>criteria that are objective and based on medical evidence</p> <ul style="list-style-type: none"> • has written policies for applying the criteria based on individual needs • has written policies for applying the criteria based on an assessment of the local delivery system <p>UM 4 D The organization distributes a statement to all members and to all practitioners, providers and employees who make UM decisions affirming that:</p> <ul style="list-style-type: none"> • UM decision making is based only on appropriateness of care and service and existence of coverage • the organization does not specifically reward practitioners or other individuals for issuing denials of coverage or care • financial incentives for UM decision makers do not encourage decisions that result in underutilization. <p>UM 2 C At least annually, the organization:</p> <ul style="list-style-type: none"> • evaluates the consistency with which health care professionals involved in UM apply criteria in decision making • acts on opportunities to improve consistency, if applicable. <p>RR 4 The organization provides each subscriber with the information necessary to understand benefit coverage and obtain care.</p>
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	<p>within the provider network; and (b) The geographic area served by the provider network.</p>	<p>RR 4 B The organization provides interpreter or bilingual services within its customer services telephone function based on the linguistic needs of its members.</p> <p>RR 7 A All organization materials and presentations accurately describe:</p> <ul style="list-style-type: none"> • covered benefits • noncovered benefits • practitioner and provider availability • a summary of key UM procedures the organization uses • potential network, service or benefit restrictions • pharmaceutical management procedures. <p>RR 7 C The organization systematically monitors new-member understanding of its procedures to ensure that marketing communications are accurate, and acts on opportunities for improvement.</p>
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CLAS STANDARDS CROSSWALK TO JOINT COMMISSION, URAC (CM, UM, CES, P-NM, P-MR), AND NCQA

OMH CLAS Standards

Standard 2.

Health care organizations should implement strategies to recruit, retain, and promote at all levels of the organization a diverse staff and leadership that are representative of the demographic characteristics of the service area.

Comments

Standard 2 emphasizes commitment and good faith effort rather than specific outcomes. Organizations should encourage retention by fostering a culture of responsiveness toward the challenges and ideas that a culturally diverse staff offers and should incorporate the goal of staff diversity into the organization's mission statement, strategic plans, and goals.

Comments from the Crosswalk of CLAS and Joint Commission:

The Joint Commission does not directly hold organizations accountable to recruit, retain, and promote diverse staff. The Joint Commission standards that support this are more general and expect that staffing is consistent with the organization's mission. In addition, the Joint Commission expects the organization leadership to define the qualifications and competencies of staff.

Comments from the Crosswalk of CLAS and NCQA:

NCQA in QI 4A recommends that practitioner networks are assessed based on cultural, ethnic, racial and linguistic needs. Additionally, it recommends that action is taken to adjust the networks. Examples:

- Female members may prefer to see only female practitioners.
- Members of a particular ethnic group may prefer to see only practitioners from the same ethnic group.
- Members who prefer to speak Spanish may prefer Spanish-speaking practitioners.

Help note:

NCQA in QI 4A does not specify that health care organizations provide care in a certain manner (as in CLAS Standard 1) or provide education and training in a certain manner (as in CLAS Standard 3).

Joint Commission Standards	URAC (CM, UM, CES, P-NM, P-MR) Standards	NCQA Standards
<p>HR.1.10 The organization provides an adequate number and mix of staff (and licensed independent practitioners applicable only to AHC and LTC) that are consistent with the organization’s staffing plan EP.1</p> <p>HR.1.20 The organization has a process to ensure that a person’s qualifications are consistent with his or her job responsibilities. EP.1</p> <p>HR.2.30 Ongoing education, including in-services, training, and other activities, maintains and improves competence. EP. 3, 7</p> <p>LD.3.10 The leaders engage in both short term and long term planning. EP.26</p> <p>LD.3.20 Patients with comparable needs receive the same standard of care, treatment, and services throughout the hospital. EP.1, 2</p> <p>LD.3.60 Communication is effective throughout the organization. EP.1, 2, 3</p> <p>LD.3.70 The leaders define the required qualifications and competence of those staff who provide care, treatment, and services, and recommend a sufficient number of qualified and competent staff to provide</p>	<p>Core 4 Job Descriptions The organization has written job descriptions for staff.</p> <p>Core 5 Staff Qualifications Staff meets qualifications as outlined in written job descriptions.</p> <p>Core 6 Credentialing The organization implements a policy to:</p> <ul style="list-style-type: none"> (a) Verify the current licensure and credentials of licensed or certified personnel/consultants upon hire, and thereafter no less than every 3 years; (b) Require staff to notify organization in a timely manner of an adverse change in licensure or certification status; and (c) Implement corrective action in response to adverse changes in licensure or certification status. <p>Core 8 Staff Operational Tools and Support The organization provides staff with:</p> <ul style="list-style-type: none"> (a) Written operational policies and procedures appropriate to their jobs; and (b) Clinical decision support tools as appropriate <p>P-NM 1 Scope of Services The organization defines the scope of its services with respect to:</p> <ul style="list-style-type: none"> (a) The types of health care services offered within the provider network; and (b) The geographic area served by the provider 	<p>QI 4 A The organization assesses the cultural, ethnic, racial and linguistic needs of its members and adjusts the availability of practitioners within its network, if necessary.</p> <p>QI 4 B To ensure the availability of primary care practitioners (PCP) within its delivery system, the organization:</p> <ul style="list-style-type: none"> • defines which practitioners serve as PCPs • establishes quantifiable and measurable standards for the number of PCPs • establishes quantifiable and measurable standards for the geographic distribution of PCPs • analyzes performance against the standards annually. <p>QI 4 C To ensure the availability of specialty care practitioners (SCP) within its delivery system, the organization:</p> <ul style="list-style-type: none"> • defines which practitioners serve as high-volume SCPs • establishes quantifiable and measurable standards for the number of SCPs • establishes quantifiable and measurable standards for the geographic distribution of SCPs • analyzes performance against the standards annually. <p>QI 4 D To ensure the availability of</p>

<p>care, treatment, and services. EP.1</p>	<p>network.</p>	<p>behavioral health practitioners (BHP) within its delivery system, the organization:</p> <ul style="list-style-type: none"> • defines which practitioners serve as high-volume BHPs • establishes quantifiable and measurable standards for the number of BHPs • establishes quantifiable and measurable standards for the geographic distribution of BHPs • analyzes performance against the standards annually. <p>CR 1 A The organization’s credentialing policies and procedures specify:</p> <ul style="list-style-type: none"> • the process for ensuring that credentialing and recredentialing are conducted in a nondiscriminatory manner. <p>This requirement does not preclude the organization from including in its network practitioners who meet certain demographic or specialty needs; for example, to meet cultural needs of members.</p> <p>QI 1 The organization clearly defines its quality improvement (QI) structures and processes and assigns responsibility to appropriate individuals.</p> <p>UM 1 The organization clearly defines the structures and processes within its utilization management (UM) program</p>
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		<p>and assigns responsibility to appropriate individuals.</p> <p>UM 4 A The organization has written procedures:</p> <ul style="list-style-type: none"> • requiring appropriately licensed professionals to supervise all medical necessity decisions • specifying the type of personnel responsible for each level of UM decision making. <p>UM 4 B The organization has a written job description with qualifications for practitioners who review denials of care based on medical necessity. Practitioners are required to have:</p> <ul style="list-style-type: none"> • education, training or professional experience in medical or clinical practice • a current license to practice without restriction. <p>CR 3 A The organization verifies that a current, valid license to practice is present and within the prescribed time limits.</p> <p>The organization must confirm that the practitioner holds a valid, current license, which must be in effect at the time of the Credentialing Committee's decision.</p> <p>.</p>
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CLAS STANDARDS CROSSWALK TO JOINT COMMISSION, URAC (CM, UM, CES, P-NM, P-MR), AND NCQA

OMH CLAS Standards

Standard 3.

Health care organizations should ensure that staff at all levels and across all disciplines receive ongoing education and training in culturally and linguistically appropriate service delivery.

Comments

OMH suggests organizations involve community representatives in the development of CLAS education and training.

Comments from the Crosswalk of CLAS and Joint Commission:

The Joint Commission standards address orientation on cultural diversity and sensitivity, and expect ongoing in-services and other education and training offered to be appropriate to the needs of the population(s) served and in response to learning needs identified through performance improvement findings and other data analysis.

If an organization incorporates data regarding the CLAS standards in their regular performance improvement activities the educational needs may be addressed. However, the Joint Commission does not require ongoing education and training specific to culturally and linguistically appropriate service delivery.

Joint Commission Standards	URAC (CM, UM, CES, P-NM, P-MR) Standards	NCQA Standards
<p>HR.2.10 Orientation provides initial job training and information. EP. 5</p> <p>HR.2.30 Ongoing education, including in-services, training, and other activities, maintains and improves competence. EP. 3, 7</p>	<p>Core 7 Staff Training Program The organization has a training program.</p> <p>CM 8 Case Manager Professional Development The organization encourages professional development among case managers through:</p> <ul style="list-style-type: none"> (a) Providing the experience/knowledge needed to apply for professional certification; (b) Education regarding the quality management program; (c) Membership in or attendance at meetings of relevant professional organizations and (d) Education in cultural diversity appropriate to the populations served. 	

CLAS STANDARDS CROSSWALK TO JOINT COMMISSION, URAC (CM, UM, CES, P-NM, P-MR), AND NCQA

OMH CLAS Standards

Standard 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.

Comments

OMH specifies how to provide the services with the preferred method being a bilingual staff member who can communicate directly with patients/consumers. The next preferred method is face-to-face interpretation by a trained staff contract or volunteer interpreter and as a last resort a telephone interpreter. A telephone interpreter should be used as a supplement when services are needed instantly or for infrequently encountered languages.

Comments from the Crosswalk of CLAS and Joint Commission:

The Joint Commission standards recognize the need for effective communication. The elements of performance address the use of interpretation and translation services. However, the Joint Commission standards are less specific than OMH as to the provision of these services.

Comments from the Crosswalk of CLAS and NCQA:

NCQA in RR 4B provides these examples of data that can be used to determine the linguistic needs of members: (a) Health Department data on ethnicity; (b) Census Bureau data; (c) Member surveys; (d) Information from employer group analysis of member complaints. NCQA also gives these examples of actions that satisfy this element: (a) Contracting with translations services; (b) Installing TDD/TTY lines; (c) Hiring staff who speak languages prevalent in the population.

Help note:

Although NCQA recognizes the need for effective communication with consumers/patients who need language interpretation and translation services, NCQA does not specify how, when and what to charge for such services (as in CLAS Standards 4 and 5). NCQA does not stipulate if family or friends may be used as interpreters (as in CLAS Standard 6). Lastly, NCQA does not address the competence of language assistance provided or the quality of patient-related materials and signage (as in CLAS Standards 6 and 7).

Joint Commission Standards	URAC (CM, UM, CES, P-NM, P-MR) Standards	NCQA Standards
<p>RI.2.100 Organization respects the patient's/residents/client's] right to and need for effective communication. EP.3, 4</p> <p>LD.1.30 The organization complies with applicable law and regulation. EP.1</p>	<p>Core 21 Communication Practices The organization follows marketing and communication practices that include:</p> <ul style="list-style-type: none"> (a) Mechanisms to clearly and accurately communicate information about services to consumer and clients; (b) Safeguards against misrepresentations about the organization's services; (c) A formal process of inter-departmental review of marketing materials before dissemination; and (d) Monitoring of existing materials for accuracy. <p>Core 22 Consumer Communication Plan The organization documents and has a mechanism for informing consumers and clients of their rights and responsibilities, including:</p> <ul style="list-style-type: none"> (a) How to obtain services; and (b) How to submit a complaint or appeal. <p>Core 26 Access to and Monitoring of Services The organization:</p> <ul style="list-style-type: none"> (a) Establishes standards to assure that consumers or clients have access to services: and (b) Defines and monitors its performance with respect to the access standards <p>CES 2 Further Pre-Enrollment Consumer Information Requirements The information made available to potential enrollees under CES 1 includes:</p>	<p>RR 4 B Members Rights and Responsibilities: The organization provides translation services within its member services telephone function based on the linguistic needs of its members</p>

	<ul style="list-style-type: none"> (a) Data about member satisfaction with services provided by the organization; (b) Condition-specific criteria for benefits coverage; (c) Descriptions of the processes the organization uses to provide information and support to consumers: <ul style="list-style-type: none"> (i) For whom English is not their primary language; (ii) From different cultural backgrounds; and (iii) With special needs, such as cognitive or physical impairments. <p>CES 4 Post-Enrollment Communication with Consumers Upon enrollment, the organization informs consumers about available information resources and assistance.</p> <p>CES 14 Cultural Sensitivity Communication Requirement Information is presented and delivered in ways that are sensitive to the diversity of the organization’s enrollment, including:</p> <ul style="list-style-type: none"> (a) Literacy levels; (b) Language differences; (c) Cultural differences; and (d) Cognitive and/or physical impairment <p>CM 11 Consumer Rights The organization establishes and implements policies to promote the autonomy of consumers and support consumer and family decision-making. Such policies address:</p> <ul style="list-style-type: none"> (a) Education of consumers on their rights; 	
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	<ul style="list-style-type: none"> (b) The process by which consumers are informed of choices regarding services; (c) The right of consumers to have input into the case management plan; (d) The right of consumers to refuse treatment or services, including case management services and the implications of such refusal relating to benefits eligibility and/or health outcomes; (e) The use of end of life and advance care directives by the organization as applicable; (f) The right of consumers to obtain information regarding the organization's criteria for case closure; (g) The right of consumers to receive notification and a rationale when case management services are changed or terminated; and (h) Alternative approaches when the consumer and/or family is unable to fully participate in the assessment phase. 	
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CLAS STANDARDS CROSSWALK TO JOINT COMMISSION, URAC (CM, UM, CES, P-NM, P-MR), AND NCQA

OMH CLAS Standards

Standard 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.

Comments

OMH suggests informing patients/consumers by using the following:

- Using language identification cards
- Posting and maintaining signs with regularly encountered languages at all entry points
- Creating uniform procedures for timely and effective telephone communication between staff and patients
- Including statements about services available and right to free language assistance services

Comments from the Crosswalk of CLAS and Joint Commission:

The Joint Commission standards are not this specific. The Joint Commission expects that patients/consumers receive information on their rights and it must be in a manner that they understand. However, the Joint Commission does not dictate that the information be provided in writing.

Joint Commission Standards	URAC (CM, UM, CES, P-NM, P-MR) Standards	NCQA Standards
<p>RI.2.20 Patients receive information about their rights. EP.1.</p> <p>EP.2 (AHC only)</p> <p>EP.3 (LTC only)</p> <p>RI.2.100 Organization respects the patient's/resident's/client's] right to and need for effective communication. EP.1, 2, 3,4</p>	<p>Core 22 Consumer Communication Plan The organization documents and has a mechanism for informing consumers and clients of their rights and responsibilities, including:</p> <ul style="list-style-type: none"> (a) How to obtain services; and (b) How to submit a complaint or appeal. <p>Core 26 Access to and Monitoring of Services The organization:</p> <ul style="list-style-type: none"> (a) Establishes standards to assure that consumers or clients have access to services: and (b) Defines and monitors its performance with respect to the access standards. <p>CES 2 Further Pre-Enrollment Consumer Information Requirements The information made available to potential enrollees under CES 1 includes:</p> <ul style="list-style-type: none"> (a) Data about member satisfaction with services provided by the organization; (b) Condition-specific criteria for benefits coverage; (c) Descriptions of the processes the organization uses to provide information and support to consumers: <ul style="list-style-type: none"> (i) For whom English is not their primary language; (ii) From different cultural backgrounds; and (iii) With special needs, such as cognitive or physical impairments. 	<p>RR 4 The organization provides each subscriber with the information necessary to understand benefit coverage and obtain care.</p> <p>RR 4 B The organization provides interpreter or bilingual services within its customer services telephone function based on the linguistic needs of its members.</p> <p>The organization's member rights and responsibilities statement states that members have:</p> <ul style="list-style-type: none"> • a right to receive information about the organization, its services, its practitioners and providers and member rights and responsibilities • a right to be treated with respect and recognition of their dignity and right to privacy • a right to participate with practitioners in making decisions about their health care • a right to a candid discussion of appropriate or medically necessary treatment options for their conditions, regardless of cost or benefit coverage • a right to voice complaints or appeals about the organization or the care it provides • a right to make recommendations regarding the organization's member

	<p>CES 14 Cultural Sensitivity Communication Requirement Information is presented and delivered in ways that are sensitive to the diversity of the organization’s enrollment, including:</p> <ul style="list-style-type: none"> (a) Literacy levels; (b) Language differences; (c) Cultural differences; and (d) Cognitive and/or physical impairment. <p>.</p> <p>CM 11 Consumer Rights The organization establishes and implements policies to promote the autonomy of consumers and support consumer and family decision-making. Such policies address:</p> <ul style="list-style-type: none"> (a) Education of consumers on their rights; (b) The process by which consumers are informed of choices regarding services; (c) The right of consumers to have input into the case management plan; (d) The right of consumers to refuse treatment or services, including case management services and the implications of such refusal relating to benefits eligibility and/or health outcomes; (e) The use of end of life and advance care directives by the organization as applicable; (f) The right of consumers to obtain information regarding the organization’s criteria for case closure; (g) The right of consumers to receive notification and a rationale when case management services are changed or terminated; and (h) Alternative approaches when the consumer 	<p>rights and responsibilities policy</p> <p>RR 2 The organization distributes its member rights and responsibilities statement to members and participating practitioners.</p>
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	<p>and/or family is unable to fully participate in the assessment phase.</p> <p>P-MR3 Consumer Communications Plan The communications plan (required under Core 22) provides that, at the time of enrollment, consumers are provided with materials that clearly explain:</p> <ul style="list-style-type: none"> (a) The scope of covered benefits; (b) How to access covered benefits, including: <ul style="list-style-type: none"> (i) Requirements for prior authorization; (ii) Accessing emergency services and out-of-service-area services; and (iii) On-going access to current drug formulary; (c) Cost-sharing features under the benefits plan; (d) The consumer's obligations to cooperate with the organization's medical management programs; (e) Coverage exclusions; and (f) Complaint and appeals processes available to consumers. 	
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CLAS STANDARDS CROSSWALK TO JOINT COMMISSION, URAC (CM, UM, CES, P-NM, P-MR), AND NCQA

OMH CLAS Standards		
<p>Standard 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).</p>		
Comments		
<p>OMH suggestions include:</p> <ul style="list-style-type: none"> ▪ Patient/consumer may choose family member after being informed of free services available ▪ Suggest trained interpreter be present to ensure accurate translation ▪ Minor children should never be used as interpreters <p><i>Comments from the Crosswalk of CLAS and Joint Commission:</i> The Joint Commission expects that staff are able to perform job responsibilities. Although not specific to the competence of interpreters, organizations are expected to define the competencies and have a mechanism to assess competency. This OMH standard would also be supported with the Joint Commission standard that addresses the appropriateness of communication.</p>		
Joint Commission Standards	URAC (CM, UM, CES, P-NM, P-MR) Standards	NCQA Standards
<p>HR.1.20 The organization has a process to ensure that a person’s qualifications are consistent with his job responsibilities. EP.5</p> <p>HR.3.10 Competence to perform job responsibilities is assessed, demonstrated, and maintained. EP.1</p>	<p>Core 22 Consumer Communication Plan The organization documents and has a mechanism for informing consumers and clients of their rights and responsibilities, including: (a) How to obtain services; and (b) How to submit a complaint or appeal.</p> <p>Core 26 Access to and Monitoring of Services</p>	<p>RR 4 The organization provides each subscriber with the information necessary to understand benefit coverage and obtain care.</p> <p>RR 4 B The organization provides interpreter or bilingual services within its customer services telephone function</p>

<p>RI.2.100 Organization respects the patient's/resident's/client's] right to and need for effective communication. EP.1, 2, 3, 4</p>	<p>The organization:</p> <ul style="list-style-type: none"> (a) Establishes standards to assure that consumers or clients have access to services: and (b) Defines and monitors its performance with respect to the access standards. <p>CES 2 Further Pre-Enrollment Consumer Information Requirements The information made available to potential enrollees under CES 1 includes:</p> <ul style="list-style-type: none"> (a) Data about member satisfaction with services provided by the organization; (b) Condition-specific criteria for benefits coverage; (c) Descriptions of the processes the organization uses to provide information and support to consumers: <ul style="list-style-type: none"> (i) For whom English is not their primary language; (ii) From different cultural backgrounds; and (iii) With special needs, such as cognitive or physical <p>CES 4 Post-Enrollment Communication with Consumers Upon enrollment, the organization informs consumers about available information resources and assistance.</p> <p>CES 14 Cultural Sensitivity Communication Requirement Information is presented and delivered in ways that are sensitive to the diversity of the organization's enrollment, including:</p>	<p>based on the linguistic needs of its members.</p> <p>The organization must consider data about the linguistic needs of its members, and may use the same linguistic data used to satisfy QI 4: Availability of Practitioners, Element A, to meet this requirement. An organization that serves population groups whose principal spoken and written language is not English must be able to provide interpreter or bilingual language services for those groups.</p> <p>QI 4 A The organization assesses the cultural, ethnic, racial and linguistic needs of its members and adjusts the availability of practitioners within its network, if necessary.</p> <p>UM 3 A The organization provides the following communication services for members and practitioners:</p> <ul style="list-style-type: none"> • staff are available at least eight hours a day during normal business hours for inbound calls regarding UM issues • staff can receive inbound communication regarding UM issues after normal business hours • staff can send outbound communication regarding UM inquiries during normal business hours, unless otherwise agreed upon • staff members identify themselves by name, title and organization name
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	<p>(a) Literacy levels; (b) Language differences; (c) Cultural differences; and (d) Cognitive and/or physical impairment.</p> <p>.</p> <p>P-MR 3 Consumer Communications Plan The communications plan (required under Core 22) provides that, at the time of enrollment, consumers are provided with materials that clearly explain:</p> <p>(a) The scope of covered benefits; (b) How to access covered benefits, including: (i) Requirements for prior authorization; (ii) Accessing emergency services and out-of-service-area services; and (iii) On-going access to current drug formulary; (c) Cost-sharing features under the benefits plan; (d) The consumer’s obligations to cooperate with the organization’s medical management programs; (e) Coverage exclusions; and (f) Complaint and appeals processes available to consumers.</p> <p>P-MR 5 Provider Network Directory Mechanism The communications plan (required under Core 22) provides that:</p> <p>(a) Upon enrollment in the organization, consumers are provided a mechanism to access a directory of participating providers; and (b) Consumers have on-going access to a current list of participating providers.</p>	<p>when</p> <ul style="list-style-type: none"> • a toll-free number or staff who accept collect calls regarding UM issues • access to staff for callers with questions about the UM process. <p>Using valid methodology, the organization collects and performs an annual analysis of data to measure its performance against standards for access to:</p> <ul style="list-style-type: none"> • regular and routine care appointments • urgent care appointments • after-hours care • Member Services by telephone.
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CLAS STANDARDS CROSSWALK TO JOINT COMMISSION, URAC (CM, UM, CES, P-NM, P-MR), AND NCQA

OMH CLAS Standards

Standard 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.

Comments

OMH standards are written in a broader context especially in the general environment where patients/consumers would be going to a specific part of the organization. Suggestions for meeting compliance should include:

- A written policy and/or procedure to ensure development of quality non- English signage and patient related materials
- A minimum translation process that includes translation by trained individual, back translation, and/or review by target audience group and periodic updates
- Compliance with existing state or local nondiscrimination laws

Comments from the Crosswalk of CLAS and Joint Commission:

The Joint Commission standards require organizations to assess the learning needs of patients with consideration given to cultural beliefs and barriers to communication related to patient education. The leadership standards also specify providing the necessary resources for patient education.

Joint Commission Standards	URAC (CM, UM, CES, P-NM, P-MR) Standards	NCQA Standards
<p>PC.6.10 The patient/resident/client] receives education and training specific to patient’s needs and as appropriate to the care, treatment, and services provided. EP.2</p> <p>LD.3.120 The leaders plan for and support the provision and coordination of patient education activities. EP.2</p>	<p>Core 22 Consumer Communication Plan The organization documents and has a mechanism for informing consumers and clients of their rights and responsibilities, including:</p> <ul style="list-style-type: none"> (a) How to obtain services; and (b) How to submit a complaint or appeal <p>CES 2 Further Pre-Enrollment Consumer Information Requirements The information made available to potential enrollees under CES 1 includes:</p> <ul style="list-style-type: none"> (a) Data about member satisfaction with services provided by the organization; (b) Condition-specific criteria for benefits coverage; (c) Descriptions of the processes the organization uses to provide information and support to consumers: <ul style="list-style-type: none"> (i) For whom English is not their primary language; (ii) From different cultural backgrounds; and (iii) With special needs, such as cognitive or physical impairments. <p>CES 2 Further Pre-Enrollment Consumer Information Requirements The information made available to potential enrollees under CES 1 includes:</p> <ul style="list-style-type: none"> (a) Data about member satisfaction with services provided by the organization; (b) Condition-specific criteria for benefits coverage; (c) Descriptions of the processes the 	<p>RR 4 The organization provides each subscriber with the information necessary to understand benefit coverage and obtain care.</p> <p>The organization, upon enrollment and annually thereafter, provides written information to its subscribers addressing:</p> <ul style="list-style-type: none"> • benefits and services included in, and excluded from, coverage • pharmaceutical management procedures, if they exist • co-payments and other charges for which the member is responsible • restrictions on benefits that apply to services obtained outside the organization’s system or service area • how to submit a claim for covered services, if applicable • how to obtain information about practitioners who participate in the organization • how to obtain primary care services, including points of access • how to obtain specialty care and behavioral health services and hospital services • how to obtain care after normal office hours • how to obtain emergency care, including the organization’s policy on when to directly access emergency care or use 911 services

	<p>organization uses to provide information and support to consumers:</p> <ul style="list-style-type: none"> (i) For whom English is not their primary language; (ii) From different cultural backgrounds; and (iii) With special needs, such as cognitive or physical impairments. <p>CES 14 Cultural Sensitivity Communication Requirement Information is presented and delivered in ways that are sensitive to the diversity of the organization's enrollment, including:</p> <ul style="list-style-type: none"> (a) Literacy levels; (b) Language differences; (c) Cultural differences; and (d) Cognitive and/or physical impairment. <p>P-MR 3 Consumer Communications Plan The communications plan (required under Core 22) provides that, at the time of enrollment, consumers are provided with materials that clearly explain:</p> <ul style="list-style-type: none"> (a) The scope of covered benefits; (b) How to access covered benefits, including: <ul style="list-style-type: none"> (i) Requirements for prior authorization; (ii) Accessing emergency services and out-of-service-area services; and (iii) On-going access to current drug formulary; (c) Cost-sharing features under the benefits plan; (d) The consumer's obligations to cooperate with the organization's medical management programs; 	<ul style="list-style-type: none"> • how to obtain care and coverage when members are out of the organization's service area • how to voice a complaint • how to appeal a decision that adversely affects coverage, benefits or their relationship with the organization • how the organization evaluates new technology for inclusion as a covered benefit. <p>RR 4 B The organization provides interpreter or bilingual services within its customer services telephone function based on the linguistic needs of its members.</p> <p>RR 5 A The organization has a Web-based physician directory that includes the following information to assist members and prospective members in choosing physicians:</p> <ul style="list-style-type: none"> • name • gender • specialty • hospital affiliations • medical group affiliations, if applicable • board certification with expiration date • acceptance of new patients • languages spoken by the practitioner or clinical staff • office locations. <p>RR 5 I The organization evaluates its</p>
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	<p>(e) Coverage exclusions; and (f) Complaint and appeals processes available to consumers.</p> <p>P-MR 5 Provider Network Directory Mechanism The communications plan (required under Core 22) provides that:</p> <p>(a) Upon enrollment in the organization, consumers are provided a mechanism to access a directory of participating providers; and (b) Consumers have on-going access to a current list of participating providers.</p>	<p>Web-based physician and hospital directories for understandability and usefulness to members and prospective members, including:</p> <ul style="list-style-type: none"> • font size • reading level • intuitive content organization • ease of navigation • directories in additional languages, if applicable to the membership.
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CLAS STANDARDS CROSSWALK TO JOINT COMMISSION, URAC (CM, UM, CES, P-NM, P-MR), AND NCQA

OMH CLAS Standards

Standard 8.

Health care organizations should develop, implement, and promote a written strategic plan that outlines clear goals, policies, and operational plans, and management accountability/oversight mechanisms to provide culturally and linguistically appropriate services.

Comments

OMH suggests the following activities to meet the intent of this standard:

- Designated personnel or department should have authority to implement CLAS specific activities as well as monitor responsiveness of whole organization
- Strategic plan developed with participation of consumers, community and staff
- Results of data gathering and self assessment processes should informed the development and refinement of goals, plans, and policies

Comments from the Crosswalk of CLAS and Joint Commission:

Although the Joint Commission requires organizational leadership to engage in long and short term planning there is no requirement for a written strategic plan to provide culturally and linguistically appropriate services.

Joint Commission Standards	URAC (CM, UM, CES, P-NM, P-MR) Standards	NCQA Standards
<p>LD.2.20 Each organizational program, service, site, or department has effective leadership. EP.1, 2, 3, 4, 5</p> <p>LD.3.10 The leaders engage in both short-term and long-term planning. EP.1, 2</p> <p>LD.4.10 The leaders set expectations, plan, and manage processes to measure, assess, and improve the hospital’s governance, management, clinical, and support activities. EP.1, 2, 3, 4, 5</p>	<p>Core 3 Policy and Procedure Maintenance, Review, and Approval The organization:</p> <ul style="list-style-type: none"> (a) Maintains and complies with written policies and procedures that govern all aspects of its operations; (b) Maintains a master list of all such policies and procedures; (c) Reviews policies and procedures no less than annually and revises as necessary; and (d) Includes the following on all policies and procedures: <ul style="list-style-type: none"> (i) Effective dates, review dates, including the date of the most recent revision; and (ii) Identification of approval authority. <p>Core 8 Staff Operational Tools and Support The organization provides staff with:</p> <ul style="list-style-type: none"> (a) Written operational policies and procedures appropriate to their jobs; and (b) Clinical decision support tools as appropriate <p>Core 34 Quality Management Documentation The organization, as part of its quality management program, provides written documentation of:</p> <ul style="list-style-type: none"> (a) Ongoing monitoring for compliance with URAC Standards; (b) Objectives and approaches utilized in the monitoring and evaluation of activities; (c) Identification and tracking and trending of key indicators relevant to the scope of the entire organization and related to: <ul style="list-style-type: none"> (i) Consumer and health care services; or 	<p>QI 1 (Intent) The organization has the QI infrastructure necessary to improve the quality and safety of clinical care and services it provides to its members.</p> <p>QI 1 The organization clearly defines its quality improvement (QI) structures and processes and assigns responsibility to appropriate individuals.</p> <p>The organization’s QI program structure includes:</p> <ul style="list-style-type: none"> • a written description of the QI program • behavioral health care is specifically addressed in the program description • patient safety is specifically addressed in the program description • the QI program is accountable to the governing body • a designated physician has substantial involvement in the QI program • a designated behavioral health care practitioner is involved in the behavioral health care aspects of the QI program • a QI Committee oversees the QI functions of the organization • the specific role, structure and function of the QI Committee and other committees, including meeting frequency, are addressed in the program description • an annual work plan

	<ul style="list-style-type: none"> (ii) For organizations who do not interact with consumers, client services; (d) The implementation of action plans to improve or correct identified problems; (e) The mechanisms to communicate the results of such activities to staff; and (f) The mechanisms to communicate the results of such activities to the quality management committee. <p>CM 1 Case Management Program Description The case management program's description and/or written policies and procedures include a definition of case management consistent with these Standards.</p> <p>CM 11 Consumer Rights The organization establishes and implements policies to promote the autonomy of consumers and support consumer and family decision-making. Such policies address:</p> <ul style="list-style-type: none"> (a) Education of consumers on their rights; (b) The process by which consumers are informed of choices regarding services; (c) The right of consumers to have input into the case management plan; (d) The right of consumers to refuse treatment or services, including case management services and the implications of such refusal relating to benefits eligibility and/or health outcomes; (e) The use of end of life and advance care directives by the organization as applicable; (f) The right of consumers to obtain information regarding the organization's criteria for case 	<ul style="list-style-type: none"> • a description of resources that the organization devotes to the QI program. <p>Accountability to the governing body The governing body is the organization's board of directors, which is responsible for organizational governance. In instances where its participation in QI activities is indirect, the board may designate a subcommittee or the</p>
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	<p>closure;</p> <ul style="list-style-type: none"> (g) The right of consumers to receive notification and a rationale when case management services are changed or terminated; and (h) Alternative approaches when the consumer and/or family is unable to fully participate in the assessment phase. <p>P-NM 2 Provider Network Access and Availability With respect to both access and availability of providers to provide care to consumers, the organization:</p> <ul style="list-style-type: none"> (a) Establishes goals; (b) Measures actual performance in comparison to those goals: and (c) Makes improvements where necessary for the provider network <p>P-NM 5 Participating Provider Representation The organization develops and implements a formal strategy to ensure that the perspective of participating providers is represented in provider network management processes, with an emphasis on:</p> <ul style="list-style-type: none"> (a) Participation by non-employee participating providers on committees that address clinical and provider payment policies; and (b) Representation of the types of practitioners that most frequently provide services to consumers. 	
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	<p>P-MR 5 Provider Network Directory Mechanism The communications plan (required under Core 22) provides that:</p> <ul style="list-style-type: none"> (a) Upon enrollment in the organization, consumers are provided a mechanism to access a directory of participating providers; and (b) Consumers have on-going access to a current list of participating providers 	
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CLAS STANDARDS CROSSWALK TO JOINT COMMISSION, URAC (CM, UM, CES, P-NM, P-MR), AND NCQA

OMH CLAS Standards

Standard 9.

Health care organizations should conduct initial and ongoing organizational self-assessments of CLAS related activities and are encouraged to integrate cultural and linguistic competence-related measures into their internal audits, performance improvement programs, patient satisfaction assessments, and outcomes based evaluations.

Comments

OMH standards note that surveys are a good tool for collecting data; however, the surveys should be culturally and linguistically appropriate. Findings from surveys should be integrated into the existing QI activities.

Comments from the Crosswalk of CLAS and Joint Commission:

The Joint Commission standards do not directly address this OMH standard. However, an organization may choose to conduct assessments of these activities as part of their performance improvement activities.

Joint Commission Standards	URAC (CM, UM, CES, P-NM, P-MR) Standards	NCQA Standards
<p>PI.1.10 The organization collects data to monitor its performance. EP.3</p>	<p>Core 9 Staff Assessment Program The organization maintains a formal assessment program for individual staff members that includes an annual performance appraisal and a review of relevant documentation produced by that individual staff member</p> <p>Core 25 Consumer Satisfaction The organization implements a mechanism to collect or obtain information about consumer satisfaction with services provided by the organization.</p> <p>Core 26 Access to and Monitoring of Services The organization: <ul style="list-style-type: none"> (a) Establishes standards to assure that consumers or clients have access to services: and (b) Defines and monitors its performance with respect to the access standards </p> <p>Core 30 Quality Management Program The organization maintains a quality management program that promotes objective and systematic measurement, monitoring, and evaluation of services and implements quality improvement activities based upon the finding.</p> <p>Core 32 Quality Management Program Requirements The organization has a written description for its quality management program that: <ul style="list-style-type: none"> (a) Is approved by the organization’s governing </p>	<p>QI 1 B There is an annual written evaluation of the QI program that includes:</p> <ul style="list-style-type: none"> • a description of completed and ongoing QI activities that address quality and safety of clinical care and quality of service • trending of measures to assess performance in the quality and safety of clinical care and quality of service • analysis of the results of QI initiatives, including barrier analysis • evaluation of the overall effectiveness of the QI program, including progress toward influencing network wide safe clinical practices. <p>UM 1 D The organization annually evaluates and updates the UM program, as necessary.</p> <p>QI 6 The organization implements mechanisms to assess and improve member satisfaction.</p> <p>Intent The organization monitors member satisfaction with its services and identifies potential areas for improvement.</p>

	<p>body;</p> <ul style="list-style-type: none"> (b) Defines the scope, objectives, activities, and structure of the quality management program; (c) Is reviewed and updated by the Quality Management Committee at least annually; (d) Defines the roles and responsibilities of the Quality Management Committee; and (e) Designates a member of senior management program and who serves on the Quality Management Committee. <p>Core 34 Quality Management Documentation The organization, as part of its quality management program, provides written documentation of:</p> <ul style="list-style-type: none"> (a) Ongoing monitoring for compliance with URAC Standards' (b) Objectives and approaches utilized in the monitoring and evaluation of activities; (c) Identification and tracking and trending of key indicators relevant to the scope of the entire organization and related to: <ul style="list-style-type: none"> (i) Consumer and health care services; or (ii) For organizations who do not interact with consumers, client services; (d) The implementation of action plans to improve or correct identified problems; (e) The mechanisms to communicate the results of such activities to staff; and (f) The mechanisms to communicate the results of such activities to the quality management committee. 	
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	<p>Core 35 Quality Improvement Project Requirements For each quality improvement project, the organization utilizes valid techniques to comparable over time to:</p> <ul style="list-style-type: none"> (a) Develop quantifiable measures; (b) Measure baseline level of performance; and re-measure level of performance at least annually; and (c) Establish measurable goals for quality improvement. <p>Core 36 Quality Improvement Project Goals and Measurement For each quality improvement project, the organization:</p> <ul style="list-style-type: none"> (a) Designs and implements strategies to improve performance; (b) Establishes projected time frames for meeting goals for quality improvement; (c) Documents changes or improvements relative to the baseline measurement; (d) Conducts at least one re-measurement prior to re-accreditation; and (e) Conducts a barrier analysis, if the performance goals are not met. <p>Core 37 Clinical, Error Reduction, and Consumer Safety Requirements At any given time, the organization maintains no less than two quality improvement projects.</p> <ul style="list-style-type: none"> (a) At least one quality improvement project that: <ul style="list-style-type: none"> (i) Focuses on consumers; or for organizations who do not interact with consumers, client 	
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	<p>services;</p> <ul style="list-style-type: none"> (ii) Relates to key indicators of quality as described in 34 and (iii) Involves a senior clinical staff person in judgments about clinical aspects of performance, if the quality improvement project is clinical in nature; and <p>(b) At least one quality improvement project focuses on error reduction and/or consumer safety.</p> <ul style="list-style-type: none"> (i) Consumer safety QIPs are required of the following programs: HUM, WCUM, HCC, HP, DM, IRO, and CM. (ii) Error reduction QIPs are required of all accreditation programs that do not conduct consumer safety QIPs. <p>CES 17 Consumer Feedback Mechanism The organization has processes to:</p> <ul style="list-style-type: none"> (a) Collect consumer feedback about communication, education, and support; and (b) Analyze feedback (including analysis by relevant sub-populations) to identify trends and opportunities for improvement. <p>.</p> <p>CES 18 Consumer Feedback Quality Management The organization reports the data collected under CES 17 to a quality management committee (see Core 33).</p> <p>CES 19 Consumer Outreach Measurement The organization has a process to measure the results of its consumer outreach efforts with regard to:</p>	
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	(a) Consumer understanding of information; and (b) The impact of outreach efforts on consumer behavior.	
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CLAS STANDARDS CROSSWALK TO JOINT COMMISSION, URAC (CM, UM, CES, P-NM, P-MR), AND NCQA

OMH CLAS Standards

Standard 10.

Health care organizations should ensure that data on the individual patient's/consumer's race, ethnicity, and spoken and written language are collected in health records, integrated into the organization's management information systems, and periodically updated.

Comments

OMH suggests collecting data about race, ethnicity and language at the first point of contact from the patients/consumers. The organization should also be sensitive when requesting this information and emphasize with patients/consumers that this information is confidential and not intended to be used for discriminatory purposes.

Comments from the Crosswalk of CLAS and Joint Commission:

The Joint Commission standards require organizations to provide access to all relevant information from a patient's record however this information does not include the items specific to the OMH standard. The Joint Commission does require organizations to define their assessment process relevant to the care, treatment and services of the individual patient. Cultural and language barriers are listed as possible barriers to the patient reaching specific goals.

Note:

The Joint Commission is conducting a field review on a proposed standard for the collection of information on race, ethnicity, and primary language in the medical record.

Joint Commission Standards	URAC (CM, UM, CES, P-NM, P-MR) Standards	NCQA Standards
<p>IM.6.20 Records contain [patient/resident/client]-specific information, as appropriate, to the care, treatment, and services provided. EP. 2, EP. 6 (OME only)</p> <p>IM.6.60 The organization can provide access to all relevant information from a patient’s record when needed for use in patient care, treatment, and services. EP.1, 2</p>	<p>CES 18 Consumer Feedback Quality Management The organization reports the data collected under CES 17 to a quality management committee (see Core 33).</p>	<p>QI 14 A The organization has policies and procedures that address the following factors, and distributes them to practice sites:</p> <ul style="list-style-type: none"> • confidentiality of medical records • medical record documentation standards • an organized medical record keeping system and standards for the availability of medical records • performance goals to assess the quality of medical record keeping. <p>UM 6 When making a determination of coverage based on medical necessity, the organization obtains relevant clinical information and consults with the treating practitioner.</p> <p>Eligibility for Accreditation (P&Ps) Any organization that provides managed care services may apply for an NCQA MCO Accreditation Survey. To be eligible, it must meet the following criteria.</p> <ul style="list-style-type: none"> • The organization must annually report audited Health Plan Employer Data and Information Set (HEDIS) results for designated HEDIS measures

		<p>CAHPS 4.0H Questions</p> <p>56. Are you of Hispanic or Latino origin or descent?</p> <p>57. What is your race? Please mark one or more.</p> <ul style="list-style-type: none"> • White • Black or African-American • Asian • Native Hawaiian or other Pacific Islander <p>15. In the last 12 months, how often did your personal doctor explain things in a way that was easy to understand?</p>
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CLAS STANDARDS CROSSWALK TO JOINT COMMISSION, URAC (CM, UM, CES, P-NM, P-MR), AND NCQA

OMH CLAS Standards		
<p>Standard 11. Health care organizations should maintain a current demographic, cultural, and epidemiological profile of the community as well as a needs assessment to accurately plan for and implement services that respond to the cultural and linguistic characteristics of the service area.</p>		
Comments		
<p>OMH suggests an HCO involve the community in the design and implementation of the community profile and needs assessment.</p> <p><i>Comments from the Crosswalk of CLAS and Joint Commission:</i> The Joint Commission Behavioral Health Care program is the only program that requires a needs assessment of its community or population served. Specifically, the needs assessment should include:</p> <ul style="list-style-type: none"> ▪ A definition of the community or population served ▪ The number of people in the community or population served ▪ The distribution of community or population by age or age group, gender, socioeconomic status, ethnic and cultural background, and/or level of functioning ▪ An inventory of behavioral health promotion services appropriate to the age, gender, community need, and level-of functioning distributions of the population or community served. The only other related Joint Commission standard is the leadership planning standard. 		
Joint Commission Standards	URAC (CM, UM, CES, P-NM, P-MR) Standards	NCQA Standards
<p>LD.3.10 The leaders engage in both short-term and long-term planning. EP.1</p>		<p>QI 4 A The organization assesses the cultural, ethnic, racial and linguistic needs of its members and adjusts the availability of practitioners within its network, if necessary.</p> <p>RR 4 The organization provides each</p>

		<p>subscriber with the information necessary to understand benefit coverage and obtain care.</p> <p>RR 4 B The organization provides interpreter or bilingual services within its customer services telephone function based on the linguistic needs of its members.</p> <p>The organization must consider data about the linguistic needs of its members, and may use the same linguistic data used to satisfy QI 4: Availability of Practitioners, Element A, to meet this requirement. An organization that serves population groups whose principal spoken and written language is not English must be able to provide interpreter or bilingual language services for those groups</p>
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CLAS STANDARDS CROSSWALK TO JOINT COMMISSION, URAC (CM, UM, CES, P-NM, MR), AND NCQA

OMH CLAS Standards		
<p>Standard 12. Health care organizations should develop participatory, collaborative partnerships with communities and utilize a variety of formal and informal mechanisms to facilitate community and patient/consumer involvement in designing and implementing CLAS-related activities.</p>		
Comments		
<p>OMH suggests involving relevant community groups and patients/consumers in the implementation of the community profile and needs assessment.</p> <p><i>Comments from the Crosswalk of CLAS and Joint Commission:</i> There are no Joint Commission standards that address this OMH standard, however an organization might consider incorporating CLAS standards as an agenda item in a community council if one exists.</p>		
Joint Commission Standards	URAC (CM, UM, CES, P-NM, P-MR) Standards	NCQA Standards

CLAS STANDARDS CROSSWALK TO JOINT COMMISSION, URAC (CM, UM, CES, P-NM, P-MR), AND NCQA

OMH CLAS Standards

Standard 13.

Health care organizations should ensure that conflict and grievance resolution processes are culturally and linguistically sensitive and capable of identifying, preventing and resolving cross-cultural conflicts or complaints by patients/consumers.

Comments

OMH suggests an organization can meet the intent of this standard by considering some of the following:

- Provide cultural competence training to staff who handle complaints and grievances or other legal or ethical conflict issues
- Provide notice in other languages about the right to file a complaint or grievance
- Provide name and number of individual responsible for disposition of grievance
- Offer ombudsperson services
- Include oversight and monitoring of culturally or linguistically related complaints/grievances are part of organization quality program

Comments from the Crosswalk of CLAS and Joint Commission:

The Joint Commission addresses this item in the Ethics, Rights and Responsibilities chapter but does not specifically address the need for the processes to be culturally and linguistically sensitive.

Joint Commission Standards	URAC (CM, UM, CES, P-NM, P-MR) Standards	NCQA Standards
<p>RI.2.120 The hospital addresses the resolution of complaints from patients and their families. EP.1, 2</p>		<p>RR 3 The organization has written policies and procedures for thorough, appropriate and timely resolution of member complaints and appeals.</p> <p>UM 8 The organization has written policies and procedures for thorough, appropriate and timely resolution of member appeals. Intent: There is a full and fair process for resolving member disputes and responding to member requests to reconsider a decision they find unacceptable regarding their care and service.</p> <p>QI 6 At a minimum, the organization must aggregate samples of member complaints and appeals by reason, showing rates related to the total member population. The organization must collect and report complaints and appeals relating to at least the following major categories.</p> <ul style="list-style-type: none"> • Quality of Care • Access • Attitude and Service • Billing and Financial Issues

CLAS STANDARDS CROSSWALK TO JOINT COMMISSION, URAC (CM, UM, CES, P-NM, P-MR), AND NCQA

OMH CLAS Standards		
<p>Standard 14. Health care organizations are encouraged to regularly make available to the public information about their progress and successful innovations in implementing the CLAS standards and to provide public notice in their communities about the availability of this information.</p>		
Comments		
<p>OMH suggests organizations can report CLAS standards implementation progress in a stand-alone document or existing organizational reports or documents. In order to provide information to the public about their progress organizations may use newsletters, newspaper articles, television, radio or posting on a web site.</p> <p><i>Comments from the Crosswalk of CLAS and Joint Commission:</i> The Joint Commission standards do not require an organization to publish this type of information, nor does the Joint Commission expect organizations to make public any of their performance improvement information.</p>		
Joint Commission Standards	URAC (CM, UM, CES, P-NM, P-MR) Standards	NCQA Standards