

CLAS Standards — Culturally and Linguistically Appropriate Services Walk-Through

The National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health and Health Care are a set of 15 action steps published by the U.S. Department of Health and Human Services (HHS) Office of Minority Health (OMH) and available through Think Cultural Health (thinkculturalhealth.hhs.gov) (<https://thinkculturalhealth.hhs.gov/clas>). The CLAS Standards were first published in 2000 and comprehensively updated in 2013 ("Enhanced CLAS Standards").

Content

CLAS Standards — Culturally and Linguistically Appropriate Services Walk-Through

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Adapted from: HHS Office of Minority Health (OMH); Think Cultural Health (thinkculturalhealth.hhs.gov); National CLAS Standards (2013 Enhanced); CLAS Standards PDF (HHS/OMH)

Library home: L10 CLAS and Language Access Library

Companion to: T04_04 Cultural Humility; T04_15 Universal Design; T04_11 Intersectionality; T04_03 Hofstede Cultural Dimensions

What this framework is

The National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health and Health Care are a set of 15 action steps published by the U.S. Department of Health and Human Services (HHS) Office of Minority Health (OMH) and available through Think Cultural Health (thinkculturalhealth.hhs.gov) (<https://thinkculturalhealth.hhs.gov/clas>). The CLAS Standards were first published in 2000 and comprehensively updated in 2013 ("Enhanced CLAS Standards"). They were developed as a blueprint to help health and health care organizations — and by extension, human services organizations like DSD — provide services that are equitable, respectful, responsive to the cultural and linguistic diversity of the populations they serve.

As described by HHS OMH (<https://thinkculturalhealth.hhs.gov/clas>), "CLAS is a way to improve the quality of services provided to all individuals, which could ultimately help reduce health disparities. CLAS is about respect and responsiveness: Respect the whole individual and Respond to the individual's health needs and preferences."

The 15 CLAS Standards are organized around one Principal Standard and three thematic areas:

- Governance, Leadership, and Workforce (Standards 2–4)

- Communication and Language Assistance (Standards 5–8)
- Engagement, Continuous Improvement, and Accountability (Standards 9–15)

Why DSD uses this framework

DSD is a human services organization serving a population of remarkable linguistic and cultural diversity. Minnesota — and particularly the Twin Cities metropolitan area — is home to large Somali, Hmong, Karen, Latino, Oromo, and other language communities, as well as communities whose cultural relationship to disability, help-seeking, family, and government is substantially different from the dominant culture assumptions embedded in many service systems.

The CLAS Standards provide DSD with:

- A self-assessment framework for evaluating where DSD currently stands on culturally and linguistically appropriate service delivery.
- A roadmap for improvement organized across governance, communication, and continuous improvement dimensions.
- A legal and regulatory grounding for language access and cultural responsiveness — including the connection to Title VI of the Civil Rights Act and the Affordable Care Act's nondiscrimination provisions.
- A shared language for equity expectations that can be used consistently across DSD units, contracted providers, and community partners.

The CLAS Standards also reinforce DSD's own program goals, particularly Goal 1 (Eliminate Disparities), Goal 2 (Community Engagement), and Goal 6 (Communication and Accessibility).

The 15 CLAS Standards (plain language with DSD application)

Principal Standard

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.

This is the overarching commitment from which all other standards flow. As stated by HHS OMH (https://cccm.thinkculturalhealth.hhs.gov/PDF_Docs/CLASStandards.pdf), Standard 1 requires services that are effective (they work), equitable (they work for everyone), understandable (people can engage with them), and respectful (they honor the person's dignity and cultural identity).

For DSD: Every DSD service interaction is subject to Standard 1. The question is not whether DSD aspires to culturally responsive services — it is whether the actual service experience delivered to a Somali family, a Karen elder, a Native American person with a disability, and a monolingual Spanish speaker meets this standard as fully as it meets it for an English-speaking, acculturated, white family.

Theme 1 — Governance, Leadership, and Workforce (Standards 2–4)

Standard 2 — Advance and sustain organizational governance and leadership that promotes CLAS and health equity through policy, practices, and allocated resources.

CLAS implementation starts at the top. Governance and leadership that do not explicitly commit to, resource, and model cultural and linguistic responsiveness cannot produce it at the service delivery level. HHS OMH (https://cccm.thinkculturalhealth.hhs.gov/PDF_Docs/CLASStandards.pdf) requires that this commitment be expressed through policy, practice, and resource allocation — not just aspiration.

For DSD: DSD's six program goals — particularly Goal 1 and Goal 6 — are the governance-level expression of Standard 2. But governance commitment requires allocation: Are staff time and budget allocated for interpretation services? For cultural responsiveness training? For community partnership? If the commitment is not resourced, it is not real.

Standard 3 — Recruit, promote, and support a culturally and linguistically diverse governance, leadership, and workforce that are responsive to the population in the service area.

HHS OMH (https://cccm.thinkculturalhealth.hhs.gov/PDF_Docs/CLASStandards.pdf) requires that the workforce reflect the linguistic and cultural diversity of the service population — not just at the entry level, but in governance and leadership.

For DSD: DSD's Goal 3 (Hiring and Retention) is the program-goal expression of Standard 3. A DSD workforce that does not reflect the communities it serves — in language, cultural background, and lived experience — will face persistent barriers to culturally responsive service delivery. Standard 3 also requires active recruitment, promotion, and retention — not just passive openness to diversity.

Standard 4 — Educate and train governance, leadership, and workforce in culturally and linguistically appropriate policies and practices on an ongoing basis.

Cultural and linguistic competence is not a one-time training event. HHS OMH (https://cccm.thinkculturalhealth.hhs.gov/PDF_Docs/CLASStandards.pdf) requires ongoing education and training — because communities evolve, staff change, and competence must be developed, not assumed.

For DSD: This standard is the regulatory grounding for DSD's Goal 4 (Learning and Development) as it applies to cultural and linguistic responsiveness. The One DSD learning ecosystem — including all T04 methodology assets — is an expression of Standard 4. Training must be ongoing, not a one-time checkbox.

Theme 2 — Communication and Language Assistance (Standards 5–8)

Standard 5 — Offer language assistance to individuals who have limited English proficiency and/or other communication needs, at no cost to them, to facilitate timely access to all health care and services.

Language assistance is a legal right under Title VI of the Civil Rights Act and Executive Order 13166 (Improving Access to Services for Persons with Limited English Proficiency). HHS OMH (<https://>

cccm.thinkculturalhealth.hhs.gov/PDF_Docs/CLASStandards.pdf) requires that this assistance be offered at no cost to the individual.

For DSD: Language access is not optional and is not a special accommodation. DSD is legally required to provide interpretation and translation services to people with limited English proficiency. This includes spoken language interpretation and, where relevant, communication assistance for people who use AAC, sign language, or other non-verbal communication modalities.

Standard 6 — Inform all individuals of the availability of language assistance services clearly and in their preferred language, verbally and in writing.

People cannot use language assistance services they do not know exist. HHS OMH (https://cccm.thinkculturalhealth.hhs.gov/PDF_Docs/CLASStandards.pdf) requires proactive communication of availability — not waiting for individuals to ask, which assumes they know the service exists and know how to request it.

For DSD: All DSD service entry points — intake processes, welcome materials, websites, first-contact communications — should clearly communicate that language assistance is available and how to access it. In the individual's preferred language.

Standard 7 — Ensure the competence of individuals providing language assistance, recognizing that the use of untrained individuals and/or minors as interpreters should be avoided.

Family members, friends, and children are not qualified interpreters. HHS OMH (https://cccm.thinkculturalhealth.hhs.gov/PDF_Docs/CLASStandards.pdf) requires that interpretation be provided by qualified, competent individuals — not by whoever happens to be present. Using a child to interpret for a parent in a disability services meeting is a confidentiality violation, a child protection concern, and an access failure.

For DSD: Qualified interpretation means interpreters who understand the relevant service context, are trained in professional interpretation ethics, and have demonstrated language competency. This is especially important in sensitive contexts (behavioral health, medical, legal) and for less commonly spoken languages where informal bilingualism may not be sufficient for accurate interpretation.

Standard 8 — Provide easy-to-understand print and multimedia materials and signage in the languages commonly used by the populations in the service area.

HHS OMH (https://cccm.thinkculturalhealth.hhs.gov/PDF_Docs/CLASStandards.pdf) requires that written and multimedia materials be both linguistically translated and easy to understand — plain language is part of this standard.

For DSD: DSD's priority languages per the One DSD Program Charter are Spanish, Hmong, Somali, Karen, and Oromo. Core service materials — eligibility information, rights and responsibilities, service descriptions, planning process explanations — should be available in these languages in plain-language,

culturally adapted form. Translation is not enough; culturally adapted communication is the standard.

Theme 3 — Engagement, Continuous Improvement, and Accountability (Standards 9–15)

Standard 9 — Establish culturally and linguistically appropriate goals, policies, and management accountability, and infuse them throughout the organization's planning and operations.

CLAS is not a silo; it must be integrated across DSD's planning and operations, not isolated in a diversity office or equity team. HHS OMH (https://cccm.thinkculturalhealth.hhs.gov/PDF_Docs/CLASStandards.pdf) requires that CLAS goals and accountability be embedded throughout.

For DSD: Cultural and linguistic responsiveness goals should appear in DSD's strategic plan, unit plans, supervisor performance expectations, and contractor performance standards — not only in the equity team's workplan.

Standard 10 — Conduct ongoing assessments of the organization's CLAS-related activities and integrate CLAS-related measures into measurement and continuous quality improvement activities.

HHS OMH (https://cccm.thinkculturalhealth.hhs.gov/PDF_Docs/CLASStandards.pdf) requires ongoing assessment — not a one-time baseline survey, but a continuous cycle of measurement, learning, and improvement. This includes CLAS-specific measures in DSD's quality improvement processes.

For DSD: CLAS self-assessment at regular intervals — using the Think Cultural Health CLAS self-assessment tool or DSD-adapted equivalents — provides the data that drives improvement.

Standard 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.

HHS OMH (https://cccm.thinkculturalhealth.hhs.gov/PDF_Docs/CLASStandards.pdf) requires demographic data collection sufficient to track disparities and service equity — including race, ethnicity, and language data.

For DSD: Demographic data collection is a prerequisite for disparity identification (Goal 1). Data that is not collected cannot be analyzed. DSD should collect, maintain, and use race, ethnicity, primary language, and disability type data at a level of granularity sufficient to identify disparities by community.

Standard 12 — Conduct regular assessments of community health assets and needs and use the results to plan and implement services that respond to the cultural and linguistic diversity of populations in the service area.

Community assets and needs assessment — conducted regularly, not only at program inception — is the CLAS foundation for community-responsive service design. HHS OMH (https://cccm.thinkculturalhealth.hhs.gov/PDF_Docs/CLASStandards.pdf) requires that assessment results actually change what DSD does.

For DSD: Community needs assessment is part of DSD's community engagement practice. The assessment should identify community assets — not only needs — and should be conducted in partnership with communities, not just about them.

Standard 13 — Partner with the community to design, implement, and evaluate policies, practices, and services to ensure cultural and linguistic appropriateness.

HHS OMH (https://cccm.thinkculturalhealth.hhs.gov/PDF_Docs/CLASStandards.pdf) requires partnership — not consultation, not focus groups, but ongoing, genuine partnership in design, implementation, and evaluation.

For DSD: This is the CLAS expression of cultural humility's community partnership principle (T04_04). Genuine partnership means community organizations have real authority in shaping DSD services — not just advisory input that DSD may or may not use.

Standard 14 — Create culturally and linguistically appropriate processes to identify, prevent, and resolve conflicts, complaints, or grievances.

The grievance and conflict resolution process must itself be accessible. HHS OMH (https://cccm.thinkculturalhealth.hhs.gov/PDF_Docs/CLASStandards.pdf) requires processes that work across linguistic and cultural contexts.

For DSD: Can a Somali-speaking family who disagrees with their service plan navigate DSD's grievance process? In Somali? With interpretation? With cultural responsiveness? If not, Standard 14 is unmet.

Standard 15 — Communicate the organization's progress in implementing and sustaining CLAS to all stakeholders, constituents, and the general public.

HHS OMH (https://cccm.thinkculturalhealth.hhs.gov/PDF_Docs/CLASStandards.pdf) requires transparency — public reporting of progress, not internal-only reporting.

For DSD: DSD's annual reporting should include CLAS implementation progress, communicated in accessible language and in priority community languages where possible.

Using CLAS as a self-assessment framework

The CLAS Standards are most useful for DSD when applied as a structured self-assessment tool:

Step 1 — Baseline: For each of the 15 standards, where is DSD now? Use HHS's Think Cultural Health CLAS self-assessment (<https://thinkculturalhealth.hhs.gov/clas>) resources.

Step 2 — Gap identification: Which standards are partially or not met? For which populations, in which DSD programs or units?

Step 3 — Priority setting: Which gaps, if closed, would have the largest impact on equity? Prioritize Standards 5–8 (language assistance) as legally required floor; Standards 1, 9, 13 as organizational culture foundations.

Step 4 — Implementation planning: Assign clear responsibility, timeline, and resource allocation for closing each gap.

Step 5 — Continuous improvement: Repeat the assessment cycle annually; integrate CLAS measures into DSD's quality improvement system.

What it looks like in DSD practice

Standards 5–6 in action: A Hmong family contacts DSD about services for their adult child with a developmental disability. The first contact — phone call, website, or in-person — clearly communicates in Hmong that interpretation is available at no cost. The intake appointment includes a qualified Hmong-speaking interpreter as standard, not arranged in response to a request. This is Standards 5 and 6 met.

Standard 7 in action: A case manager is scheduling a planning meeting and learns that the family's teenage daughter is bilingual. The case manager arranges a qualified Somali-community interpreter through DHS language services rather than relying on the daughter — protecting the daughter from an inappropriate role and ensuring accuracy.

Standard 13 in action: DSD's community advisory structure for its waiver program includes compensated positions for representatives from Somali, Hmong, Karen, and Black disability advocacy organizations. These representatives co-design the waiver program's outreach strategy and provide ongoing feedback on cultural responsiveness. Their input results in actual program changes.

How to apply this in your role

As a DSP: Ensure that the people you support can communicate with their service system in their preferred language and format. If they cannot, escalate as an access barrier.

As a case manager: Use the 15 standards as a checklist for your caseload. Which families have language assistance? Which have never been told it is available?

As a supervisor: Include CLAS compliance in your team's quality review. Are language assistance services being offered proactively and consistently?

As a leader or program designer: Commission a CLAS self-assessment for your unit or program. Use the results to drive improvement planning.

Common misconceptions

"CLAS is a health care framework — not relevant to disability services." CLAS was developed in health and health care, but HHS explicitly applies it to all health and human services organizations. DSD is a human services organization subject to CLAS's principles and to the underlying legal frameworks (Title VI, Executive Order 13166) that CLAS implements.

"If we have interpretation services available, we're CLAS-compliant." Language assistance (Standards 5–8) is one of three themes. Governance, workforce, community engagement, continuous improvement, and accountability (Standards 2–4, 9–15) are equally required.

"CLAS is aspirational, not mandatory." Language access under Title VI and Executive Order 13166 is legally required for federally funded organizations. DSD is a federally funded state agency. Some CLAS standards are regulatory floors, not aspirational goals.

Connection to other frameworks

- Cultural Humility (T04_04): CLAS Standards 1, 3, 13 are institutional expressions of cultural humility's community partnership and institutional accountability principles.
- Universal Design (T04_15): Standards 8 and the communication theme broadly reflect universal design's mandate for accessible communication across diverse populations.
- Intersectionality (T04_11): CLAS implementation that attends to language but not disability, or to race but not language, is intersectionally incomplete. All 15 standards should be applied with an intersectional lens.
- Hofstede Cultural Dimensions (T04_03): Understanding cultural dimensions helps DSD implement Standards 1, 4, and 13 with substantive cultural knowledge, not just procedural compliance.

Connection to DSD's six program goals

DSD Goal — CLAS Connection

Goal 1 — Eliminate Disparities — CLAS is explicitly a health disparities reduction framework. All 15 standards, implemented with fidelity, are disparity-reduction strategies.

Goal 2 — Community Engagement — Standard 13 (partner with community to design, implement, and evaluate) is the CLAS articulation of genuine community engagement.

Goal 3 — Hiring and Retention — Standard 3 (recruit and retain diverse workforce) directly maps to Goal 3.

Goal 4 — Learning and Development — Standard 4 (ongoing education and training) maps directly to Goal 4 and is the regulatory grounding for DSD's learning ecosystem.

Goal 5 — Contracts and Procurement — CLAS standards can and should be embedded in DSD's contractor performance requirements — particularly language assistance and cultural responsiveness standards.

Goal 6 — Communication and Accessibility — Standards 5–8 are the CLAS framework's direct expression of communication and accessibility requirements.

When to escalate / where to refer

- For language access compliance questions: Contact DHS language services and DSD's legal and policy team. Language access under Title VI is a legal obligation.
- For CLAS self-assessment tools: HHS Think Cultural Health provides free resources at <https://thinkculturalhealth.hhs.gov/clas>
- For community partnership development: Contact the Equity and Inclusion Operations Consultant for existing community partnership frameworks and contacts.
- For language access complaints: Individuals who believe DSD has not provided required language assistance may file complaints with HHS Office of Civil Rights.

Reflective questions for your practice

1. Walk through the 15 CLAS Standards. For which of the three themes (Governance/Leadership/Workforce; Communication/Language Assistance; Engagement/Accountability) is your unit strongest? Where are the gaps?
2. The last time a person with limited English proficiency contacted your service area, what happened? Was language assistance offered proactively and at no cost?
3. Which communities in your service area are most underserved by DSD's current CLAS implementation? What would it take to close that gap?
4. How does "partnership" in Standard 13 differ from "consultation"? Is DSD's current community engagement structure partnership or consultation?
5. If DSD published its CLAS progress report publicly tomorrow, what would it show — and what would you want to be different about it?

Sources

- HHS Office of Minority Health. National CLAS Standards. <https://thinkculturalhealth.hhs.gov/clas/standards>
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- Betancourt, J. R., Green, A. R., Carrillo, J. E., & Ananeh-Firempong, O. (2003). Defining cultural competence: A practical framework for addressing racial/ethnic disparities in health and health care. *Public Health Reports*, 118(4), 293–302.
- U.S. Department of Justice. Executive Order 13166: Improving Access to Services for Persons with Limited English Proficiency. (2000).
- Title VI of the Civil Rights Act of 1964. 42 U.S.C. §2000d.
- Office of Civil Rights, HHS. Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons. (2003).

Always defer to the person in front of you. Frameworks describe patterns; people are individuals.

Ask: How does "partnership" in Standard 13 differ from "consultation"? Is DSD's current community engagement structure partnership or consultation?

Connect the guidance to the person's goals, program rules, access needs, and follow-up using CLAS Standards — Culturally and Linguistically Appropriate Services Walk-Through.

Verify current authority, preserve rights and exceptions, and route interpretation questions using CLAS Standards — Culturally and Linguistically Appropriate Services Walk-Through.

Confirm the current purpose, audience, and decision authority before using CLAS Standards — Culturally and Linguistically Appropriate Services Walk-Through to connect the guidance to the person's goals, program rules, access needs, and follow-up.

Choose the sections of CLAS Standards — Culturally and Linguistically Appropriate Services Walk-Through that match the situation; do not apply unrelated guidance as a blanket rule.

Document the action taken from CLAS Standards — Culturally and Linguistically Appropriate Services Walk-Through, the people affected, unresolved questions, and the responsible follow-up owner.

Check the stated limitations and evidence status for CLAS Standards — Culturally and Linguistically Appropriate Services Walk-Through; escalate when current authority or individual context is missing.

For policy regulatory analysts, use CLAS Standards — Culturally and Linguistically Appropriate Services Walk-Through to connect the guidance to the person's goals, program rules, access needs, and follow-up; trace each recommendation to current authority, preserve exceptions, and document the decision record. Start by ask: How does "partnership" in Standard 13 differ from "consultation"? Is DSD's current community engagement structure partnership or consultation?

For program service staff, use CLAS Standards — Culturally and Linguistically Appropriate Services Walk-Through to verify current authority, preserve rights and exceptions, and route interpretation questions; apply the guidance in the person-specific workflow, explain options accessibly, and document the next step. Start by connect the guidance to the person's goals, program rules, access needs, and follow-up using CLAS Standards — Culturally and Linguistically Appropriate Services Walk-Through.

For community engagement staff, use CLAS Standards — Culturally and Linguistically Appropriate Services Walk-Through to connect the guidance to the person's goals, program rules, access needs, and follow-up; plan accessible participation, make influence visible, and close the feedback loop with community partners. Start by verify current authority, preserve rights and exceptions, and route interpretation questions using CLAS Standards — Culturally and Linguistically Appropriate Services Walk-Through.

For facilitators learning leads, use CLAS Standards — Culturally and Linguistically Appropriate Services Walk-Through to verify current authority, preserve rights and exceptions, and route interpretation questions; build the guidance into preparation, practice, debrief, access checks, and follow-up. Start by confirm the current purpose, audience, and decision authority before using CLAS Standards — Culturally and Linguistically Appropriate Services Walk-Through to connect the guidance to the person's goals, program rules, access needs, and follow-up.

Use cultural and community context to ask better questions, never to predict an individual or treat a group as monolithic.

Do not replace official legal, policy, clinical, supervisory, program, or Tribal authority.

Do not infer an individual's identity, preferences, needs, or experience from group-level information.

State uncertainty, use current authoritative sources, and escalate when the decision exceeds the user's role.

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