

THE IMPORTANCE OF CULTURAL COMPETENCY IN THE DELIVERY OF LATINO HEALTH CARE IN THE 21ST CENTURY

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INTRODUCTION:

Do cultural factors characteristic of Latino populations affect their health status, their health choices and our ability to deliver their health care?

This question has been addressed professionally in both the research literature and in practice for more than thirty years and the answer is an emphatic, yes.

In spite of all that we have learned about the importance of culture and after more than thirty years of research on the issue, this critical and rapidly growing population continues to be one of the least understood in the American health care delivery system.

The importance of Latino cultural beliefs and our failure to incorporate them into modern health care delivery practice, and our general lack of attention to culture in general has greatly impaired our ability to deliver appropriate health care to Latinos and especially immigrant Latinos.

For the most part, allied health care education in the United States has failed to meaningfully and systematically incorporate material in the curricula intended to understand the unique cultural factors affecting Latino populations and their delivery of health care.

The rapid growth of the Latino population is due to a combination of natural increase through a high birth rate and an equally high rate of immigration from Latin American countries.

A decade ago *Texas Medicine*, the journal of the Texas Medical Association, featured a *Symposium on Immigrant Health* explaining the importance of awareness and understanding of Latino culture in the delivery of health and medical care in Texas.

The intended purpose of the special issue was to heighten Texas physician's and allied health professional's awareness of the tremendous need

to recognize this area of importance which often goes overlooked in both the private practices and public clinics of Texas. (Texas Medicine 1996)

The world continues each year to witness greater movement and re-location of peoples across borders.

Cultural beliefs and practices accompany immigrants and heighten the importance of an awareness of multi-culturalism in the delivery of health services.

As North America populations continue to diversify questions such as, “should health care professionals be concerned about mastering cultural competencies in their practices?” are ever more pressing.

Culture plays an important role in the every day lives of our patients. Simply stated, there is much to be done in improving health care delivery systems, and this is especially true where health care and cultural beliefs intersect creating unnecessary health disparities.

I believe this is even more critical in the delivery of mental health care.

The Kleinman physician-anthropologist model begs that we ask patients from other cultures the following questions.

- 1-What do you think has caused your problem?
- 2-Why do you think it started when it did?
- 3-What does your sickness do to you; how does it work?
- 4-How severe is your sickness?
- 5-Will it have a short or long duration?
- 6-What kind of treatment should you receive?
- 7-What are the most important results you hope to receive from treatment?

8-What are the chief problems your sickness has caused you?

9-What do you fear the most about your sickness?

LATINO CULTURAL DIVERSITY:

Importantly, and among the first concepts that health care providers must understand when treating Latinos is that there is a huge sub-cultural variation in the Latino population.

It is a mistake to lump Latinos together without regard to their sub-cultural variation.

In reality, the Latino population in the U.S. is incredibly diverse drawing their origin from numerous regions of Mexico, Central and South America and the Caribbean.

Each of these sub-areas has its own sub-cultural idiosyncratic beliefs.

The health care provider must always take into consideration a persons origin and the subtle cultural realities of their regional sub-culture.

Even more important for us on the border is the fact that the variation that exists between Mexican immigrant populations is every bit as dramatic as that between Latino sub-populations.

Simply stated, a person's sub-cultural origin, whether from Tamaulipas, on the northern border of Mexico, or Chiapas on Mexico's southern border with Guatemala, will determine, linguistic and dialectic variation as well as differences in beliefs, lifestyle, and customs.

Hence, sub-cultural variation defines a person's primary choice for health care and their health care behaviors.

Within the United States persons of Mexican descent demonstrate dramatic cultural differences.

Differences exist between urban and rural origins; between socio-economic levels; between educational levels and one's knowledge base; between generational status and intra-familial differences; between levels of acculturation and attitudes toward health care delivery modalities and between the various regions of the nation, to name a few.

LATINO HEALTH DETERMINISM:

Once again, the health care provider must be constantly cognizant that Latino populations are not alike. That is, they are not exactly like other populations and they are not always like other Latino populations.

Historically we have tended to stereotype Latino beliefs and cultural characteristics. While culturally driven behaviors are real, it is important not to confuse culturally defined behaviors with behaviors that are determined by economic marginality.

That is to say, it is simply too easy to assume that a patient's behavior is determined by a person's cultural beliefs when in fact lack of economic resources almost always plays a role in determining their health choice.

It is important to note that in general, Latino populations in the United States and elsewhere have limited resources and this only one reason that has forced them to opt for "alternative" health care delivery systems what we call professionally complementary and alternative or CAM systems.

A more powerful reason is cultural loyalty.

Research has shown that given the opportunity, Latino populations will maximize the use of modern medical health care delivery systems and combine the use alternative and complimentary systems simultaneously.

Health care modality choice is complicated; especially when culture is a variable, therefore, no single model can explain a person's choice.

There is a significant emergent Latino middle class and research has also shown that like other North Americans populations, the Latino middle class is a growing consumer of alternative and complimentary medicinal modalities.

This seems counter-intuitive but the same pattern is common in the general population as well.

Economic marginalization remains the major determining and characterizing factor responsible for Latino health care selection in the United States.

It is critical that health care professionals in the 21st century, construct new and effective health care models for treating Latino populations.

New health care delivery models must incorporate modern medicine and culturally appropriate alternatives into a new single functioning paradigm.

THE CULTURAL CONTEXT OF THE LATINO FAMILY

Throughout the literature on Latino health care, the resilience and cohesiveness of the “Latino Family” has always been singled out as a primary determinant of what is “best” in the culture.

The Latino family is believed by most to remain the single most important cultural unifier in spite of a powerful argument that the stereotypic Latino family no longer exists as the cultural gold standard it once was.

There are however, very real characteristics which embody the values found in any prototypic “traditional” family, and in the best sense, many Latino families continue to demonstrate these characteristics.

For example, the family is the focal point for the enculturation of one's beliefs, values, norms,

and customs and as such, the origin of the social context of the family determines one's cultural reality.

Therefore, whether there is, or is not, a cultural construct for the “Latino family,” the fact still remains that, like other traditional families found in industrializing settings, Latino families impart cultural beliefs and serve as a critical safety net for its members.

The socialization and enculturation of children, adolescents and adults in the Latino family takes place within the larger framework of the extended family including the family’s ritual kinship networks.

The existence and integrity of the culturally defined family-based safety net will directly impact, both positively and negatively, upon a person's health status.

For example, perceived Latino fear or mistrust of “official” bio-medical health care delivery systems, such as hospitals and social service agencies, is often an unfounded urban myth held in the family.

Simply stated, in treating Latino families it is important to involve the multi-generational

extended family at every stage in the health care delivery process. The social network of family and family involvement with the individual is critical to the emotional and physical well being of the individual, the family and the community at large.

For example, family members often accompany one another to a provider's office, especially when treatment is invasive or out of the ordinary.

The multi-generational family support system should be understood and utilized to maximize patient compliance instead of being seen as an unnecessary nuisance in the provider office.

Understanding this fact, the provider is able to maximize patient compliance by incorporating family in decision making.

As the focal point for the enculturation of beliefs and the socio-economic context, the family determines one's cultural reality and hence, the interpretation of health and illness.

Family members accompany one another to the provider's office because decision making takes place as a family consultation. This is especially true for children's issues.

For many people, the cultural mind places sickness in a context which is much more than the invasion of the body by an antigen. The way in which a person reacts to the symptoms of illness are often culturally derived and played out by the family according to an accepted illness scenario in which each person's role is pre-determined and sanctioned by the cultural appropriateness of a script validated by the family.

Patients are active agents in a “quest for wellness” choosing between different practitioners and or therapies rather than between traditional and modern medical systems.

Additionally, the family-patient considers all therapies fair game in their ultimate quest for health and wellness including the incorporation of religious beliefs.

Depression, for example, is a disease that affects the entire family.

That is, all members are concerned about how it affects all other family members.

Additionally, depression is one of those diseases for which there are literally hundreds of

culturally-based remedies which are often recommended to family and friends who are only too glad to try them. But one does not know what the unintended consequences could be to the depressive physiology.

**The Latino Education Crisis,
By Gándara and Contreras, 2009, Harvard Press**

p. 77 Mental Health

In their recent book, *The Latino Education Crisis*, Gandara and Contreras 2009, found that...

Depression is a serious mental health problem that leads to lower motivation, loss of focus, and often underachievement, and Latinos appear to be particularly prone to it.

Latino youth and adults both, have exceptionally high rates of depression.

Depression develops over time as a realistic response to harsh conditions and stress, in part due to racism, that Latinos faces in the US.

Additionally, research shows that Latino youth depression goes largely untreated leading to social and academic problems, leading to school dropout and encounters with the criminal justice system.

How well students do in school and how others view them influences the developing identities of most adolescents.

For many Latino students, the struggle to reconcile the perceptions that others have of them results in their rejecting either their ethnicity or the role of the good student, neither of which argues well for healthy personal or psychological development.

Could a well intentioned remedy also be adversely affecting the patient's behavior?

This is an area in which it is clear that the provider has the responsibility to query the patient and the family about what if any alternative remedies they may be taking.

Often, culturally-based beliefs are hard to compartmentalize with the practice of modern medicine and are difficult to reconcile with our own beliefs, and ethical standards.

One intangible that is often encountered by clinicians and counselors is how people's cultural belief systems affect decision-making regarding their health choices.

Exhaustive research and experience in practice in recent decades has shown conclusively that there are very real differences in cultural interpretation of illness and disease.

In her extensive anthropological work in Mexico, Finkler, demonstrated the clear impact that culture has on both illness and wellness in Mexico.

We can be confident that sickness is much more than a simple fact of biology or the invasion of the body by an antigen.

Ataque de nervios

Bilis and colera or muina

Locura

Mal de Ojo

Nervios

Spell or trabajo

Susto
Zar or spirit possession

Are all found in the DSM-IV Outline for Cultural Formulation and Culture-Bound Syndromes.

Clearly, the way in which a person reacts to the symptoms of illness are culturally derived and culturally manifested.

That is, the illness scenario is played out by each family member via a pre-determined and culturally appropriate script. (Kaja Finkler, 1994)

The Cultural script does not stay behind at the border.

Gender ranks second as the largest differential in rate of illness. During their life time women experience more illness than men and women's wellness and illness experience is accumulated and passed on from generation to generation.

The conclusion is simple, when treating the Latino population; both family and matriarchy must be foremost on the minds of the health care delivery team.

That is, what does Grandmother think? What does mother know?

Many researchers concluded that, “women's lives are filled with more health problems, higher incidence of acute conditions, higher prevalence of most nonfatal chronic ones, more frequent health problems, than men's.” (Lois Verbugge, 1990)

The study of Mexican women, accurately concludes that psychosocial factors affect the perceptions of symptoms, the evaluation of their cause and severity, choice and continuation of therapeutic actions, and short- and long-term disability.

However, psychosocial factors affect all people of every culture all the time.

If we know this then why do we continue to ignore the cultural realities of the fastest growing population in the United States?

Anyone who has treated or been involved with the treatment of Latino populations will immediately recognize the importance of this conclusion.

Avoiding the obvious stereotype, it is clear that in the majority of Latino families, if not all families, the female head of household and especially the extended family matriarch, grand or great-grand mother is responsible for the interpretation of family issues concerning wellness and illness.

This critical observation must be brought into play in the health care delivery picture for Latinos in the clinical setting.

ISSUES CONCERNING FOLK-RELIGION AND FOLK-MEDICINE

Folk-medicine and folk-religion are major factors in Latino culture and hence their cultural construct of health and illness.

In the early 1980's, children of migrant and seasonal agricultural families were brought to the clinic with symptoms that were eventually identified as severe lead poisoning.

Ultimately it was determined that their mothers were giving them a popular folk remedy called *greta* or *azarcon* for upset stomach or *empacho*.

This substance was readily available at neighborhood stores on both sides of the Texas-Mexico border. Most folk-remedies have a distribution network that extends to the neighborhood stores, *yerberias* and *botanicas* throughout the nation and its Latino cultural-communities.

Migrant children were seen by doctors in clinics in the Midwest. Chemical analysis determined that this substance was 99% lead oxide which caused severe mental retardation and death, in otherwise healthy children.

This realization triggered a massive nation-wide public health action to remove it from shelves and homes, and the development of health education materials for both parents and providers. As a result of this intervention, providers in the nation's migrant health clinics learned to identify sets of symptoms and to pro-actively ask mothers about the cultural remedies they give their children.

Through the work of health educators and networks of community workers called, "*promotoras de salud*," the message was delivered and the problem has been contained, yet never completely solved.

The same problem surfaced once again in Houston last year, 20 years after the initial public health problem and one generation later. The point is that culture is never erased. Culture is always in the picture.

We must train mental and emotional health community workers. Some may say we already do. If so do we have research demonstrating their efficacy?

Situations, where knowledge of cultural-competency is critical, find their way into the health care delivery system on a daily basis.

Many positive and supportive culturally-based alternative therapies are proven effective, and their use is encouraged.

Visits to community-based cultural providers, sometimes called *curanderos/as*, is a proven effective first-line intervention as long as the *curanderos* are connected to the second line of intervention, professional medical and mental health care.

Long ago we recognized that 85 percent of all human ailments, mental and physical can be

effectively treated by what was called a bare-foot doctor. Only minimal training followed by support at the community level was necessary for them to be effective. Sound familiar?

The family remains the single most important determining factor in culturally-based alternative health care and the family is connected to the neighborhood *curandera*.

Culturally-based health care beliefs and practices have existed from antiquity and the recognition of their widespread use has given new emphasis to the need to better understand their effects and their role in treatments from the perspective of community public health.

Beliefs common to both mainstream religion and folk-religion in Latino populations include many concepts, which characterize and define one's perception of the origin, nature, and treatment of illness.

It is a commonly held belief in contemporary Latino populations that “spiritual and supernatural” forces are directly involved in the promotion of health and illness.

Religious faith is a crucial aspect of Latino culture and hence it is commonly believed that

entities like Catholic Saints, folk-saints, and the supernatural in general, are physically capable of affecting the lives of the living.

That means, active in both the causation of illness and facilitating a pathway to wellness.

In Latino cultures today, traditional religion and folk-religion co-exist as a single interacting system involved in the health care delivery system.

The majority of Latinos are spread out across the United States, living in large metropolitan cities, and in small towns, many are recent arrivals. They are connected by extended kinship groups and by the dynamic influence that religion has on their perceptions of illness and health care choices.

Latino populations have an active and long-time tradition of alternative health care beliefs and delivery systems. These systems and practices are highly complex, diverse and are generally lumped together into what anthropologists commonly call the cultural system of “*Curanderismo*.”

It is through this system called *curanderismo* that health care and religion come together and directly influence a person's health care choices.

The category of folk-healers known as *Curanderos/as* is comprised of both men and women who have diverse traditions and who serve the cultural folk-community.

They serve as a first-line of sub-primary health care, including both mental and physical and are sustained in local neighborhoods throughout the country.

That is, they are locally-based persons of one's own culture who have a culturally received gift of healing and imperative to assist the underserved population in the treatment of illness, physical, emotional, and spiritual.

Many decades of research has shown that first time visits to a folk-healer or *curandero/a* almost always are prompted by a serious or catastrophic physical, emotional, personal, or economic problem in the visitor's life.

Contrary to popular belief, people who seek mental or physical care from a spiritual folk-healer do not do so as a first choice.

Almost without exception, physicians and other providers have been consulted first.

If medical therapy has not been successful, alternative therapies, especially miraculous treatment, is sought.

Additionally, every *curandero/a* has a regular group of persons who give impassioned and convincing testimony concerning the impossible and miraculous cures they have received through the intercession of the healer. These claims are often documented.

Chronic ailments commonly go untreated in Latino communities. Therefore, mental illness, diabetes, hypertension, arthritis, and similar chronic ailments are common in the folk-healer's client-patient load and it is essential that the folk-healers be networked with medical professionals-not rejected and alienated, or as has been seen in some notable cases, prosecuted.

There is no systematic process for becoming a Latino folk-healer or singular body of knowledge or cultural certification of a person as trained in folk-healing.

Therefore, not all folk-healers in the Latino population in the U.S. are reputable. Some cause

great harm while others are revered as living folk-saints. Physical ailments are treated by Latino folk-healers in a variety of ways.

Because of these high growth rates and the fact that the Latino population is disproportionately marginalized relative to the general population, we can expect alternate healing systems like Latino folk-healing to continue to thrive.

Curanderos/as generally dedicate their lives to serving the physical and mental health needs of their local population.

Additionally, an important dimension of folk-healing and folk-religion is the emergence of social movements surrounding wellness and illness.

Throughout Latin America, native belief systems have commingled with folk-Catholicism and folk-healing systems.

The syncretic hybrids that are produced are thriving alternatives to modern health care delivery systems, which operate side by side, that is, religion and health care.

The rejection by the bio-medical model of these large grassroots movements serves to

further alienate huge segments of the Latino population rather than to provide them with health care.

THE IMPORTANCE OF CULTURAL COMPETENCIES IN THE 21ST CENTURY CLINIC

Public health problems in the Latino populations in the United States and along the Texas-Mexico border continue to be unique and present very real challenges to the health care delivery team.

The 21st century provides an important opportunity to assess and address these border challenges within the context of both science and a culture which is real, and arrives anew in this country every day.

Movement toward culturally informed health care delivery systems must therefore, take into consideration the reality that cultural factors play a role in our attempt to produce a healthier Latino population.

Additionally, increased knowledge and understanding of complementary and alternative health care delivery systems will assist us in addressing the continued problem of lack of

resources as well as to deal effectively with continued in-migration from Latin America and especially from Mexico.

Today's health care delivery system in the U.S. is faced with heretofore unknown health challenges which must be addressed as public health concerns and treated effectively by incorporating what we have learned about culture and science.

Untreated chronic illnesses in Latino populations continue to rank high as an unmet health need, affecting the entire population and the economic viability of the nation.

Lack of support and treatment networks for health care providers continues to be a problem in the nation, especially along the border.

Lack of provider understanding of the cultural realities of Latino populations must be addressed if we are to be successful in improving their health care.

The development of networking and community-based coalitions, continued cooperation with Mexico through cross-border programs, and more health education will only be effective if culture is taken seriously.

It is important to understand both the patient language as well as their culture. It is important to include the family in health care deliberation as well as community in health care delivery systems.

It is critical to listen to what the people are saying about their health care needs as well as for health care providers to avoid making stereotypic value judgments about peoples beliefs.

More than a third of American adults report using some form of alternative therapy, and the total number of visits to alternative providers each year now exceeds visits to primary-care providers.

In most other parts of the world the magnitude of alternative therapies is even greater. The way in which alternative treatments are learned is also culturally based.

One of the realities that we face today is that alternative therapies are usually not documented in writing.

Word of mouth was the favored method of transmission of culturally-based information but now it is the radio and the television followed closely by the computer.

Stories about alternative therapies are one of the most popular in Latin America media markets.

As clinically accepted information becomes available, many private and public providers, hospitals, managed care plans and federally funded clinics, have incorporated alternative therapies into their practices.

They understand how the alternative therapy can serve a complementary role and sometimes their patients demand it.

In the American Southwest some years ago, federally funded clinics began to provide clinical space to certain cultural-providers, who served effectively as part of the health care delivery team in that situation.

In many places native healers are encouraged to visit their clients in hospital, treating both the physical and emotional aspect of recovery as

integrated members of the health care delivery team.

It is commonplace for people to utilize multiple therapies simultaneously, mixing their health metaphors and perceptions of medical and alternative care.

To provide a rational, effective, and personally satisfactory health care system, it is critical that the primary care provider know who is using an alternative therapy and why, as well as something about the therapy.

It is critical that the provider know how their patient's are obtaining information about the alternative therapy they are using and how credible that information is.

The typical patient does not inform their provider about their use of an alternative therapy.

Without this knowledge the provider is not fully empowered to evaluate the alternative therapy vis a vis the prescribed therapy and whether the two are compatible, safe and effective if used together.

Only in recent decades has there been a serious interest, world-wide, in scientifically investigating and evaluating alternative therapies.

The Office of Alternative Medicine within the National Institutes of Health was only established in 1992.

The development of baseline information on many complementary and alternative therapies began at that time.

But for many important and widespread therapies, investigation has not yet begun and this is particularly true in the Latino population.

There remains a lot to be done in this area. There is a tremendous shortage of skilled practitioners who are knowledgeable about the alternative therapies used in the populations they serve.

And there are even fewer providers who are able or willing to participate in the scientific inquiry necessary to establish credible information on those therapies.

Outside of the university there is a shortage of receptive and integrated research environments and this fact serves as a barrier to our ability to develop multi-disciplinary teams that include both alternative and conventional medical practitioners.

These factors contribute to the lack of standardization which must be understood in practice.

The decision-making model needed to determine whether or not a complementary therapy should be addressed in practice is also severely limited or lacking altogether.

There are virtually thousands of Complementary and Alternative medical therapies but the majority still require scientific validation and we are years away from understanding them.

Modern health care professionals now have an opportunity to play a role in our understanding of alternative therapies in the next generation. And it is important that they do so.

We know less about the etiology of mental health issues than we know about physical health issues.

The fact that science has not gotten around to validating a particular alternative therapy does not make it any less valid in the minds of the people who employ it.

In spite of all that we have learned and after more than thirty years of research, economically marginal and culturally-based populations like the American Latino continue to be the least understood in health care delivery.

The importance of cultural beliefs in health care treatment and the general lack of attention paid to them is a critical problem in the delivery of health care in today's world. The health care delivery team encounters this fact daily.

In the future, what position will modern health care delivery take?

Will it be one of intolerance or one of scientific inquiry or tolerance?

This huge area of importance is overlooked in both private and public settings.

Health care professionals for the 21st century must construct new and effective health care models for treating populations where culture is an essential variable.

New models must incorporate modern medicine and culturally appropriate alternatives into a single functioning paradigm.

Movement toward culturally informed health care delivery systems must, take into consideration the reality that cultural factors play a role in our attempts to produce a healthier population and reduce health disparities.

Increased knowledge and understanding of alternative health care delivery systems assists us in addressing the continued problem of lack of resources in most parts of the world.

Modern medicine must be continuously vigilant of patient beliefs, values and behaviors and seek knowledge on cultural issues which shape health behaviors, disease epidemiology including mental health, ethno-pharmacology, and their complementary health practices.

Health care professionals must develop the communication skills necessary to elicit

information from patients and their families and to understand their health beliefs.

This will ultimately empower the patient-provider in participatory decision-making regarding health care.

Only then will we be providing the health care needed for Latino and other culturally and economically marginalized populations of North America.

Culturally and Linguistically Appropriate Federal Standards (CLAS)

Standard 1 Recommended

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.

Standard 2 Recommended

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

Standard 3 Recommended

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

Standard 4 Mandated

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.

Standard 5 Mandated

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

Standard 6 Mandated

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).

Standard 7 Mandated

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

Standard 8 Recommended

Health care organizations should develop,

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

Standard 9 Recommended

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.

Standard 10 Recommended

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.

Standard 11 Recommended

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.

Standard 12 Recommended

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.

Standard 13 Recommended

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.

Standard 14 Voluntary Adoption

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.