



REVIEW ARTICLE

A Culturally Competent Patient Care: A Review of the CLAS Standards

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Abstract

Multiculturalism is rapidly growing. It affects all aspects of society, including healthcare. A culturally competent healthcare system has a critical impact on meeting the needs of the diverse population that it serves. The national Culturally and Linguistic Approach Services (CLAS) standards have been developed and implemented as a tool to improve the quality of care, potentially transforming how we address disparities in healthcare.

Abbreviations

CLAS: Culturally and Linguistically Appropriate Services;
UC: Urgent Care

Introduction

Motivated by a nationalized concern about societal impartiality and health disparities, the concept of cultural competency is being incorporated into both professional standards and government regulations. The ethnic composition of the United States population is changing dramatically and is challenging. As this country continues to evolve as a multi-ethnic, culturally diverse society, a standard of cultural competency in all human service is wholesome, desirable, and consistent with the democratic principles on which this nation was founded. Recommendations from healthcare regulatory agencies emphasize that cultural competency become a goal in providing care.

Culturally competent care approach

In order to attain a culturally competent healthcare, a framework must be within the context of a patient's cultural background, beliefs, and values related to

health and illness to attain optimal patient outcomes. An essential component of access to care for culturally diverse populations is the cultural competence of healthcare systems [1], which is fundamental to healthcare since the aim of competent care is to decrease the occurrence of medical errors as a result of misunderstanding caused by differences in culture, belief, practice, and language and to maintain the provision of appropriate healthcare services. Cultural competence is likely to improve the efficiency of services and care in the urgent care clinic by reducing unnecessary diagnostic testing or inappropriate use of services [1]. Cultural competence is not a simple matter of social pleasantries; instead, it has real-life consequences for health outcomes [2].

Issues and cultural vulnerability of populations served

The United States minority population is rising remarkably. As the population grows and becomes more diverse, the demand for healthcare services among these groups becomes significant. As part of the hospital institution, in the urgent care (UC) clinic, the vast majority of populations served are Latino/Hispanics, Native Americans, African Americans, and Asian Americans. Minority populations are notably escalating that the Asian Americans were the fastest-growing minority and Hispanics were the second between 2000 to 2019 [3,4].

Unfortunately, there continue to be disparities in the incidence of death and illness among the minority group compared with the total population in the U.S.



Citation: Mora AA (2022) A Culturally Competent Patient Care: A Review of the CLAS Standards. Int Arch Public Health Community Med 6:077. doi.org/10.23937/2643-4512/1710077

Accepted: May 14, 2022; **Published:** May 16, 2022

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Unfortunately, they are likely to believe that they are treated with disrespect when obtaining healthcare. These populations bear a disproportionate burden of several illnesses, but they also seem to have access to and receive needed services; they often receive poorer-quality services and remain underrepresented in the healthcare system. Health disparities exist for multiple health outcomes, and some common issues that have been are: socioeconomic status, social discrimination based on gender or race and ethnicity, distribution of health resources, and social policies. Additionally, 20% of the U.S. population speaks a language other than English [4,5], imposing more challenges to healthcare providers to respond efficiently to the psychosocial and language needs of the population served.

National standards of cultural competence

Although the CLAS was first developed in 2000, it was in 2007 when the Department of Health and Human Services' Office of the Minority Health [6] published national standards for culturally and linguistically appropriate services (CLAS) in healthcare to provide a familiar and consistent meaning of culturally and linguistically appropriate healthcare services and a universal understanding of cultural competence. It was enhanced in 2013 and intended to improve the quality and advance health equity. Thus, eliminating disparities in healthcare. Moreover, they were developed to create healthcare more receptive to the needs of patients and families, connect inequities of health services and aim to eliminate ethnic and racial disparities in health conditions and hence improve health outcomes of the population served. This paper reviewed the recommended CLAS standards [6]: *principal standard* ("provide effective, equitable, understandable and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs."), *governance, leadership, and workforce* (Standards 2-4), *communication and language assistance* (Standards 5-8), and *engagement, continuous improvement, and accountability* (Standards 9-15) to determine the degree to which these standards result in patient satisfaction, improved processes and patient outcomes within the UC, health organization, and community.

Principal standard

The framework aims the achievement the other 14 standards.

Governance, leadership, and workforce (Standards 2-4)

Standard 2: This standard appears to be met as evidenced by the organizational leaders, nurses, and other healthcare providers' awareness and acceptance of cultural differences with an open-minded attitude and approach to caring for the population served.

Healthcare providers are aware of their own biases and own's cultural values. Self-awareness of their own cultural identities is essential to practice as the informed assumptions about patient's cultural backgrounds and beliefs.

Standard 3: This standard is partially met. A diverse workforce is seen at all levels of the organization, but the turnover of diverse staff is high, which indicates that not much is being done to retain them. Diversity and talent go hand and hand [7]. The organization should consider seeing the benefits of a diverse workforce. A well-balanced and diverse distribution of the workforce is worth the investment, let alone impact the health of the population.

Standard 4: In response to this, an annual competency course online is conducted by the education department for all employees on cultural competence but seems not enough to meet the needs of each employee to develop the skills and knowledge to respond to the needs of the population served.

Language access services (standards 5-8)

Standard 5: This appears to be partially met. Online language assistance and telephonic systems are available in the UC clinic, and the portable machine can be wheeled from room to room. However, several problems exist in using the systems. One example, staff, and patients have to wait for several minutes before the language assistance personnel answers due to the high volume of callers. Trained interpreters are not available in the facility, making it more challenging to fill the language and communication barriers gaps.

Standard 6: This appears to be met. Upon registration in the UC, patients are asked in written form and verbal by the front registration clerks if language assistance is needed.

Standard 7: A strict policy is imposed that family members are not used to providing interpretation services to patients unless otherwise requested by the patient and family. Family members are likely to filter information based on what they want the patient to hear. Moreover, it might be culturally inappropriate for the patient to discuss some health matters with certain family members.

Standard 8: Available pre-printed materials such as discharge instructions are available in different languages. Legal and administrative documents such as waivers, financial rights, and advance directives are in Spanish translation. Likewise, consent forms for special procedures are in Spanish but not in other languages of the commonly served population. The availability of written discharge materials is in partnerships with education providers.

Engagement, continuous improvement, and accountability (Standards 9-15): There is noticeable

diversity of culture and language at all levels of the organization that coordinates and complements each other. Organizational, written policies are available to outline the goals and operational plans to provide the system's cultural and linguistic appropriate services. The first significant factor in establishing the recommended processes for cultural and linguistic competence is the buy-in of upper management; their commitment to the imperative 'clear goals, policies, and mechanisms' is seemingly evident. A quality improvement department is dedicated to examining the effectiveness and performance of the delivery of standards and implemented successfully.

With the improvement of technology, tools produce a significant amount of data to analyze patients' demographics, such as race, sex, and ethnicity. These tools were beneficial especially during the wave of the Coronavirus pandemic. The data was collected as part of the continuous trends, monitoring, and evaluation of the changing patterns of those affected.

The healthcare institution has various partnerships within the community and is committed to actively engaging in health fairs, festivals, and town hall meetings. Such commitment evolves through functional relationships with the community and the public health agency and a general recognition by both the organization and the community that a commitment to improving the health of minority groups is part of the overall goal of achieving a healthy organization and community.

Potential impacts of delivery of care

Where standards are met: The standards were written to help the hospital organization and the UC clinic reduces barriers to adequate health. It ensures that patients and families receive the care in their preferred language; the care is respectful and compatible with patients' beliefs and practices. Several positive outcomes are believed to impact the delivery of care.

Improved patient care: In the urgent care clinic and institution, providing excellent care is the bottom line. Ethnic and racial minority patients are more likely to be compliant and comfortable with providers who can speak their language and understand their culture [7].

Greater patient satisfaction: Providing culturally competent service is more likely to improve health outcomes, add to the efficiency of clinical and support staff, and result in greater patient satisfaction [1].

Reduced health disparities: A diverse and culturally competent workforce could help reduce health disparities [7]. Diversity in leadership and all levels of the organization can improve outcomes by making care more effective and efficient.

Improve market share: A community that includes

a particular group that represents them tends to go to healthcare providers that represent, appreciate their differences, understand and accommodate, and welcome them.

Lower healthcare costs: Cultural competence and diversity and programs can cut costs through improved communication with clients regardless of their self-care and risks.

Prevent lawsuits: The likelihood and opportunity may add to actual incidence or perceptions that care is not provided equally.

Where standards are not met: Vega [8] pinpointed a core treatment problem in the 2004 report of the National Health Disparities that minorities receive worse healthcare and care systems, and individual providers are faulted for differential treatment that results in adverse health outcomes. Several negative outcomes can result if standards are not met: (a) Limited access to care, (b) Poor quality of care, (c) Poor health outcomes, (d) Increased health disparities, (e) Higher healthcare costs, (f) Cultural imperialism and ethnocentrism [7], and (g) Increase gap in health status across diverse populations.

Possible solutions

1. The creation of evidence-based programs to promote recruitment and retainment of diverse members, which mirror the cultural and ethnic diversity of the population served, thus improving workforce diversity and outcomes.
2. Active and ongoing staff education enhances awareness of cultural competency imperatives and establishes performance measures to evaluate cultural and linguistic competence.
3. Diversity training is an essential activity as meaningful guidance to standard 2. It must not be based merely on compliance or the achievement of racial or ethnic harmony but must also espouse the principles of racial or ethnic inclusion, social justice, and transformation. Diversity training must also seek to foster providers- physicians, nurses, and other allied health professionals.
4. Conduct and implement an institutional self-assessment and plan a committee to get a snapshot of the current level of compliance with CLAS standards and evaluate the overall organizational environment.
5. Employ trained interpreters, especially for the UC, given the critical nature of services delivered. Researchers have found that untrained interpreters are prone to errors that seriously impair healthcare delivery [9].
6. Network and collaborate with other healthcare organizations in the community to support and

develop initiatives such as primary prevention delivered culturally and linguistically.

Conclusion

Improving cultural competence in care is easy to put off for another day yet has severe implications for the care diverse populations are receiving today. By making a step towards self-awareness, education, and culturally appropriate care, healthcare providers, nurses, and other allied health professionals have an opportunity to serve their patients better and invalidate the trends in healthcare inequality. Successful programs and initiatives of culturally competent services are likely to define culture in a broad sense, value the patient and families' cultural beliefs, be aware of the complexity of linguistic interpretation and language, reciprocate the training and learning between providers, professionalize the process of recruiting and retaining staff, and institutionalized cultural competence. Thus, the standards propel extraordinary changes in the work environment, such as the urgent care that promote convenience, thoroughness, and accessibility of quality healthcare delivery to multiethnic and diverse people.

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