

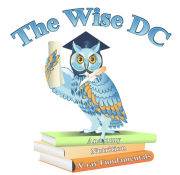


Part IV - Cultural Competency Introduction

In 1999, the U.S. Department of Health and Human Services' (DHHS) Office of Minority Health (OMH) first proposed national standards for culturally and linguistically appropriate services (CLAS) as a means to correct inequities that exist in the provision of health care (Federal Register 64(240), 70042–70044). The standards were developed on the basis of an analytical review of key laws, regulations, contracts, and standards used by federal and state agencies and other national organizations, with input from a national advisory committee of policymakers, health care providers, and researchers. Open public hearings also were held to obtain input from communities throughout the nation. The standards represent the first national standards for cultural competence in health care. The 14 standards are comprised of guidelines (standards 1–3, and 8–14) and mandates (standards 4–7) for all recipients of federal funds. They follow three general themes: Culturally Competent Care (standards 1–3), Language Access Services (standards 4–7), and Organizational Supports (standards 8–14) (Box 1). The final CLAS standards were issued in the Federal Register on December 22, 2000, (Federal Register 65(247), 80865–80879), and the final report, “National Standards for Culturally and Linguistically Appropriate Services in Health Care,” was published in March 2001 (See Box 1).

A second phase of the CLAS initiative, “Developing a Research Agenda for Cultural Competence in Health Care,” is currently being prepared for dissemination. The main goal of the Cultural Competence Research Agenda Project is to produce and disseminate a working research agenda on the relationship between CLAS interventions and health outcomes. The research agenda was developed after conducting a literature review on cultural competence interventions, convening a Research Advisory Committee, and soliciting public comments (Fortier & Bishop, forthcoming).

These national initiatives reflect a recognition that culture and language are central to the delivery of health services. It is essential for physicians to be sensitive to cultural and linguistic factors while providing health care to people from diverse backgrounds, particularly minority groups. One of the requirements for implementing culturally competent health care is teaching physicians how to practice it. There have been many efforts across the country to develop formal and informal curricula for teaching cultural competence in service delivery settings. These efforts have been largely isolated, with each institution or organization developing its own discrete curricula independently. Up to this point, no standardized curriculum for cultural competence has been developed. The development of the CLAS standards by the Office of Minority Health was the first attempt to unify efforts in defining and implementing culturally and linguistically appropriate services. The OMH has now contracted the



Box 1: National Standards for Culturally and Linguistically Appropriate Services (CLAS)

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 belief and practices and preferred language.
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.
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.
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.
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.
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).
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.
8. 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.
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.
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.
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.
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.
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.
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.

Source: Federal Register 65(247), 80865–80879.



American Institutes for Research (AIR) to carry out the first national effort to design and assess Cultural Competence Curriculum Modules to teach cultural competence to family physicians.

DEFINITION OF “CULTURAL COMPETENCE”

Early work that shaped today’s understanding of cultural competence in health care was largely in the field of medical anthropology (Harwood, 1981; Kleinman, 1980; Kleinman et al., 1978; Pfifferling, 1980). These anthropologists have applied the observational methods of anthropology to medicine, examining the dynamics of the physician-patient relationship within the context of medical culture and exploring the interactions between culture, health beliefs and health behavior. They have described the traditional culture of Western medicine as being disease-oriented, focusing on biological concepts and processes, and largely discounting the importance of cultural and psychosocial factors to health (Harwood, 1981; Pfifferling, 1980).

The concept of “cultural competence” has been applied to many fields of service delivery. For the purposes of this report, we adopt the definition of cultural and linguistic competence used in the CLAS standards, which was adapted from a definition developed in the mental health field (Federal Register 65(247)):

Cultural and linguistic competence is a set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among professionals that enables effective work in cross-cultural situations. “Culture” refers to integrated patterns of human behavior that include the language, thoughts, communications, actions, customs, beliefs, values, and institutions of racial, ethnic, religious, or social groups. “Competence” implies having the capacity to function effectively as an individual and an organization within the context of the cultural beliefs, behaviors, and needs presented by consumers and their communities. (Based on Cross, Bazron, Dennis, & Issacs, 1989)

It is important to point out that in our definition of cultural competence, the social groups influencing a person’s culture and self-identity include not only race, ethnicity, and religion but also gender, sexual orientation, age, disability, and socio-economic status. The culture of linguistic groups is also an important domain of culture to include. Linguistic minorities include not only people with limited English proficiency (LEP), but also people with low literacy skills and the hearing impaired. Although this report primarily focuses on issues of cultural competence that pertain specifically to ethnicity and race, it is our intention that the issues concerning culturally competent care addressed in this environmental scan and in the Cultural Competence Curriculum Modules that are subsequently developed will encompass a broad definition of culture and include these less often mentioned social groups.

Cultural competence can be viewed in relation to general competence in professional medical practice as an integrated aspect of overall competence. A recent article generated a definition of professional competence intended to be inclusive of all important domains of competence. According to



the definition, competence is “the habitual and judicious use of communication, knowledge, technical skills, clinical reasoning, emotions, values, and reflection in daily practice for the benefit of the individual and the community being served” (Epstein & Hundert, 2002, p. 226). This definition encompasses certain aspects of overall professional competence that were found to be underemphasized by Western medical culture, including interpersonal skills, lifelong learning, and integration of core knowledge into clinical practice (Epstein & Hundert, 2002). Many of these aspects are also central aspects of cultural competence. The implication is that cultural competence is part of a central set of professional competencies, rather than an isolated aspect of medical care with limited relevancy.

In addition to defining cultural competence as essential to professional competence in general, cultural competence can be defined in terms of the power dynamics in medicine as well as society at large. The need for cultural competence arises from the inherent power differential in the physician-patient relationship (Tervalon & Murray-Garcia, 1998). Ethnicity and social status are inextricably linked (Harwood, 1981), and social issues such as stereotyping, institutionalized racism, and dominant-group privilege are as real in the examining room as they are in society at large. Therefore, the goal of cultural competence training in health care should be to guide physicians in bringing these power imbalances into check. This process, consisting of ongoing self-reflection and self-critique, requires humility. In fact, the concept of “cultural competence” may be better described as “cultural humility” (Tervalon & Murray-Garcia, 1998).

It is important to make one other distinction regarding the definition of cultural competence. According to a comprehensive report, “Cultural competence is usually broken down conceptually into linguistic competence and cultural competence, even though true cultural competence recognizes language and culture as inseparable” (Fortier, 1999, para.1). However, in certain instances it is useful to conceive of them as separate competencies. In this scan, we consider linguistic competence as an integral aspect of cultural competence, but for practical reasons and better understanding, we discuss linguistic competence separately when appropriate.

PURPOSE

The purpose of this report is to synthesize the information from our environmental scan on the concepts, policies, and teaching practices regarding culturally competent health care and to inform the National Project Advisory Committee (NPAC) on this subject. The committee will convene to advise on the development of Cultural Competence Curriculum Modules (CCCMs) to teach culturally and linguistically appropriate health services to family physicians. The CLAS standards developed by OMH and summarized in Box 1 will serve as the starting point for this initiative. The 14 standards are directed primarily at health care organizations and represent a comprehensive set of recommendations and



mandates for implementing culturally and linguistically appropriate services at all levels of the organization. Individual providers are encouraged to use the standards to make their practices more culturally and linguistically accessible (Federal Register 65(247), 80865–80879). We first provide a context and rationale for cultural competence by discussing relevant health policy and research issues that support the need for culturally competent health care and training. After discussing the issues from this perspective, we discuss concepts of cultural competence and training practices as they pertain to the three major CLAS themes. Since the family physician is the subject of this project, we use the CLAS standards as the framework, but examine them as they apply specifically to the education of physicians on this subject. For our purposes, we discuss the three main themes of the CLAS standards as follows:

- 1) **Culturally Competent Care** refers mainly to the family physician-patient relationship and the delivery of culturally competent care by individual physicians.
- 2) **Language Access Services** focus on the family physician's role in ensuring appropriate language access services to every patient.
- 3) **Organizational Supports** focus on the family physician's functioning as part of a health care team within an organization. Although family physicians work in a variety of settings, the family physician is a central figure influencing the cultural competence of the staff and the organization as a whole. Given this role, knowledge of the issues concerning the implementation of culturally competent services at the organizational level increases the physician's capacity to enhance institutional change.

Even though we will discuss them separately, it is important to note that these three themes are interdependent. Naturally, culturally competent care is not authentic if it does not include language access services for people with limited English proficiency and if it is not supported by the organization at large. Similarly, language access services will not be effective if they are not delivered in a culturally appropriate manner, and culturally competent care will not be provided on an ongoing basis if organizational supports are not in place. The three themes are ultimately parts of the interrelated and overall construct of cultural competence.



CONTEXT AND RATIONALE FOR CULTURAL COMPETENCE CURRICULA IN HEALTH CARE

There are many reasons why it is important for family physicians to learn to practice culturally competent care. In this section, our purpose is to provide a context that illustrates the critical need for cultural competence curricula from the perspective of health-related research and the laws and policies that govern the delivery of health care services to an increasingly diverse U.S. population. This section is divided into two subsections; the first describes the importance of cultural competence in three major health research contexts, and the second offers an overview of the laws and policies that shape culturally competent practice and provides some examples of the ways they are implemented.

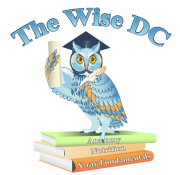
THE IMPORTANCE OF CULTURAL COMPETENCE IN THREE RESEARCH CONTEXTS

Research and writing on cultural competence are relatively new in the literature. In this section we relate the need for cultural competence to the context of three major areas of health services research and policy: health disparities, access to health care, and quality of care (specifically the aspects of patient safety and patient centeredness).

RACIAL AND ETHNIC HEALTH DISPARITIES

The long-standing problem of racial and ethnic health disparities is well documented and well known in health and policy arenas (DHHS, 2001; Geiger, 2001; Lillie-Blanton, Martinez, & Salganicoff, 2001; NIH, n.d.; Rutledge, 2001; Stapleton, 2001). Despite improvement in overall health for the majority of Americans, the burden of health disparities continues to disproportionately affect minority populations. Recent studies reveal that good health is connected with an individual's socio-economic status, environmental factors, ethnicity, and gender. In response to staggering disparities, a number of major initiatives to improve the health of minority populations have been implemented (DHHS, 2001). Healthy People 2010 establishes a public health agenda with the elimination of health disparities as one of its two overarching goals. Its other major goal is to improve health. The focus for disparity reduction is on six key areas shown to affect racial and ethnic groups differently at all life stages: infant mortality, diabetes, cardiovascular disease, cancer screening and management, HIV/AIDS, and child and adult immunizations (DHHS, 2001).

For example, according to the National Institutes for Health (NIH), infant mortality rates among Blacks, American Indians and Alaska Natives, and Hispanics in 1995 or 1996 were all above the national average of 7.2 deaths per 1,000 live births. The greatest disparity exists for Blacks, whose infant death



rate (14.2 per 1,000 in 1996) is nearly two and a half times that of White infants (6.0 per 1,000 in 1996). The overall Hispanic rate (7.6 per 1,000 live births in 1995) does not reflect the diversity among this group, which had a rate of 8.9 per 1,000 live births among Puerto Ricans in 1995. Paralleling the death rate, the incidence rate for lung cancer in Black men is about 50 percent higher than in White men (110.7 vs. 72.6 per 100,000). Native Hawaiian men also have elevated rates of lung cancer compared with White men. Alaska Native men and women suffer disproportionately higher rates of cancers of the colon and rectum than do Whites. Vietnamese women in the United States have a cervical cancer incidence rate more than five times greater than White women (47.3 vs. 8.7 per 100,000). Hispanic women also suffer elevated rates of cervical cancer (NIH, n.d.). An increasingly large, consistent body of research indicates that racial and ethnic minorities are less likely to receive even routine medical procedures and experience a lower quality of health services (Geiger, 2001; Lillie-Blanton et al., 2001; Rutledge, 2001).

The complexity of issues surrounding health disparities makes it hard to research causal factors. Causes have been attributed to a variety of factors including socio-economic status, lack of access to quality health services, environmental hazards in homes and neighborhoods, and the scarcity of effective prevention programs tailored to the needs of specific communities (Satcher, 2001); shortages of health professionals in urban areas where minority populations are high (American Medical Student Association, 2001); patients' mistrust of the health care system (Coleman-Miller, 2000); perceived discrimination (Krieger, 1999); poor communication between physician and patient (Vermeire et al., 2001; Woloshin et al., 1995); and lack of cultural sensitivity and cultural competence on the part of physicians and other health care workers (Rutledge et al., 2001; Geiger, 2001; Canto, Allison, & Kiefe, 2000).

Even though a direct link between racial and ethnic health disparities and the lack of culturally competent care has not been empirically demonstrated, the provision of culturally competent services can potentially improve health by increasing the understanding between physicians and patients and potentially increasing the adherence to treatment (Vermeire et al., 2001). Culturally competent services have the potential to increase the quality of health care so that it is delivered in the context of each patient's cultural beliefs and practices and those of his or her family and community.

ACCESS TO HEALTH CARE: CULTURAL BARRIERS TO ACCESS

Barriers in access to health care are economic, geographic, social, and cultural (Office on Women's Health, 2000). These types of barriers encompass a wide variety of specific impeding factors; however, much of the literature on access to health care focuses on access to health insurance. Data on health insurance coverage indicates that every major minority group has significantly less access to health care insurance than Whites do (Brown, Ojeda, Wyn, & Levan, 2000). A major reason for these disparities in access is that minorities have higher rates of poverty, but racial and ethnic disparities in insurance



coverage persist among people of the same income level. Even for people with similar health insurance coverage, disparities include differences in the source of primary care (Lillie-Blanton et al., 2001; Commonwealth Fund, n.d.) and patient-reported experiences with health providers (Commonwealth Fund, n.d.). These examples accentuate the fact that social, cultural, and language barriers to access outside of insurance coverage are numerous.

Barriers in access to health care also include cultural and linguistic differences. Cultural and linguistic differences can be present within groups of the same race and ethnicity and thus are significant because both language and culture affect health in many ways. These intraethnic variations include the individual's level of acculturation, which depends on citizenship and refugee status, the circumstances of immigration; and the length of time the family has lived in the United States. These differences affect individual health practices and the ability to navigate the American health system. Fear may be a powerful barrier for groups who are illegal immigrants. History can have a tremendous influence on creating barriers of mistrust toward physicians and hospitals for minority groups who have historically experienced racism, as the legacy of the Tuskegee University experiment demonstrates. The study, funded by the U.S. government, observed Black men with syphilis in order to study long-term complications of the disease while allowing the study participants to believe that they were being treated. Intergenerational transmission of health care experiences and attitudes based on stories of such extreme discrimination are very powerful influences (Coleman-Miller, 2000).

Even when language barriers are reduced through interpretation services, other cultural barriers can hinder effective communication and produce negative effects. Patients are less likely to comply with treatment if they do not understand it (Coleman-Miller, 2000; Woloshin et al., 1995) or have conflicting health beliefs (Coleman-Miller, 2000; Vermeire et al., 2001). Strategies to increase access to health insurance are important and necessary to decrease disparities in access owing to economic reasons, but the means to decreasing cultural and language barriers lies in the provision of culturally and linguistically appropriate services to increase understanding and improve quality of care.

QUALITY OF CARE RESEARCH: PATIENT SAFETY, PATIENT CENTEREDNESS, AND CULTURAL COMPETENCE

In today's changing health care environment, physicians and health care organizations are under increasing pressure to ensure quality of care for their patients. It is important for all practitioners and organizations to understand that providing culturally competent services is essential to quality care. Recently, the Institute of Medicine (IOM) convened a national committee of experts to develop a framework for a National Health Care Quality Report on the quality of health care in the United States (IOM, 2001). According to the framework, health care quality consists of four components: safety,



effectiveness, patient centeredness, and timeliness. Two of these components, safety and patient centeredness, can be used to illustrate the necessity of cultural competence to quality care. www.TheWiseDC.com

The IOM report refers to patient safety as “avoiding injuries to patients from care that is intended to help them” (IOM, 2001, p. 44). Lack of culturally competent care can result in a patient’s misunderstanding of the treatment plan and harm to the patient. For example, a patient may not take a medication correctly due to a miscommunication, compromising the patient’s safety. So, the physician must be able to communicate treatment plans effectively to patients with limited English proficiency or of diverse cultural backgrounds through culturally and linguistically appropriate services.

The relationship between the clinician and the patient is central to patient-centered care. Patient-centered care is based on a partnership of practitioners, patients, and their families and takes into account the patient’s needs and preferences (IOM, 2001, p. 50). Patient centeredness is “furthered when patients receive information in their own language, when the clinicians have greater awareness of potential communication difficulties, and most importantly, when care is provided taking into account the context of the patient’s cultural beliefs and practices” (Hurtado et al., 2001, p. 52). A competent physician must be aware of the role of cultural health beliefs and practices in a person’s health seeking behavior and be able to negotiate treatment options appropriately and in a culturally sensitive way. As the population becomes increasingly diverse, culturally competent health care practitioners, bilingual practitioners, and language access services are becoming a requirement for high quality care (Chin, 2000).

POLICIES AND LAWS PROMOTING CULTURALLY AND LINGUISTICALLY APPROPRIATE SERVICES

This subsection provides an overview of the laws and policies that influence culturally and linguistically appropriate services. We briefly discuss Title VI of the Civil Rights Act of 1964; Medicare and Medicaid policies; accreditation standards for health care organizations and medical schools; and policies, activities and resources of professional organizations and consumer advocate and minority interest groups

FEDERAL AND STATE LAWS

Title VI of the Civil Rights Act of 1964 states that “no person in the United States shall, on the grounds of race, color, or national origin be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination” under any federally supported program (Civil Rights Act of 1964). The U.S. Department of Health and Human Services’ Office for Civil Rights (OCR) extends this protection to language, viewing inadequate interpretation as a form of discrimination. DHHS-funded health programs are required to provide patients with limited English proficiency access to services equal



to that of English speakers. Programs that do not comply risk losing all federal funds. However, the regulation is vague and is difficult to comply with and enforce. On August 30, 2000, OCR issued a Policy Guidance to provide clarity and guidance to physicians and other recipients of federal funds on the regulation as it applies to LEP patients. According to the Policy Guidance (Federal Register 65(169), p. 52772):

The key to providing meaningful access for LEP persons is to ensure that the relevant circumstances of the LEP person's situation can be effectively communicated to the service provider and the LEP person is able to understand the services and benefits available and is able to receive [them] in a timely manner.

In the section on Language Access Services, we discuss this issue further.

The Minority Health and Health Disparities Research and Education Act became effective on October 1, 2000, establishing the National Center on Minority Health and Health Disparities to facilitate the work of the National Institutes of Health (NIH) to address and reduce health disparities.

In recognizing the importance of language access services, many states have also enacted laws that require providers to offer language assistance to LEP persons in many health care and other service settings. In fact, at least 26 states and the District of Columbia have enacted legislation requiring some form of language assistance (OCR, 2000). A few state laws, such as those passed in California, Massachusetts, and New York, give specific guidance to health care providers regarding what they must do to meet the regulation. Other states' legislation, such as that in Illinois, note the importance of translation services, but do not specify what services must be offered. Many states have tied language access laws to specific categories of health services, with some of the most stringent requirements being those for mental health and long-term-care services (Perkins et al., 1998).

At least 18 states have enacted laws that make English the official state language. Although many of these laws are purely symbolic, and even the strictest of these laws include exceptions for law enforcement and public health activities, state agencies may interpret public health exceptions broadly or narrowly (Perkins et al., 1998). Because of state English-only laws, agencies that receive federal funding may not realize that they are required to provide language access services to non-English speakers.

MEDICARE AND MEDICAID POLICIES

Medicare is the federal health insurance program that covers people over age 65, people with permanent kidney failure, and certain other disabled people of any age. Although Medicare policies consider bilingual services reimbursable costs for hospital overhead rates, no explicit billing for interpreter services is allowed. The provision to pay for any outpatient interpreter services virtually does not exist (Woloshin et al., 1995).



Medicaid is a cooperative federal and state medical assistance program, and policies vary among the states. Medicaid provides services to indigent aged, blind, and disabled people; poor families with children; and poor children and adolescents (Perkins et al., 1998). Typically, hospitals are reimbursed for patient care according to the diagnosis and are not reimbursed specifically for interpreter services. In fact, most states do not have legislation that deals explicitly with interpreter services, and states that do typically have problems of vagueness and a lack of funding (Woloshin et al., 1995).

In recognizing the need to improve the provision of health care services to minorities, a growing number of states have begun requiring that health plans meet the linguistic needs of non-English-speaking enrollees under their Medicaid managed care contracting provisions. Under these provisions, nearly three-quarters of all states require plans and providers to make written materials available in other languages; close to half require language interpreter services for clinical and administrative encounters; and nearly two-thirds of all Medicaid managed care contracts have some cultural competence requirements that are non-language specific (Coye & Alvarez, 1999).

States' approaches to ensuring culturally competent services to Medicaid beneficiaries vary widely, primarily as a result of differences among states' demographics and health care delivery systems. In California, all Medicaid (Medi-Cal) recipients are enrolled in managed care plans. All of these plans provide cultural competence training for member services personnel. The state and most health plans offer education to providers on the appropriate use of linguistic services (Coye & Alvarez, 1999). Several programs are also interested in providing more detailed educational programs for other staff and contracted health care providers.

Both California and Oregon have a concentration criterion as part of their Medicaid contracting requirements for providing linguistic services to certain language groups. In California, linguistic services must be provided in areas that either meet a threshold standard of 3,000 beneficiaries per language group or meet concentration standards. Concentration standards are defined as 1,000 beneficiaries of a specific language group in a single zip code or 1,500 in two contiguous zip codes. In Oregon, the criterion is defined at the provider level. A physician who is selected by at least 35 members of a single ethnic group must provide linguistic services. Few contractual requirements exist. Translation and interpreter costs are included as administrative costs in capitation rates (Coye & Alvarez, 1999).

In an increasingly complex political environment, physicians should be aware of the complicated issues and problems surrounding Medicare and Medicaid policies. They should be aware of the potential benefits of policies that support culturally competent care that certain states have implemented.



ACCREDITATION STANDARDS FOR HEALTH CARE ORGANIZATIONS AND MEDICAL SCHOOLS

In addition to federal and state laws, accrediting organizations influence standards regarding cultural competence for health care organizations and medical schools. New standards have been implemented by the Liaison Committee on Medical Education (LCME), which mandated higher standards for curricular material in cultural competence for medical schools than were in place before (LCME, 2001a).

The Joint Commission on Accreditation of Healthcare Organizations (JCAHO) accredits hospitals and other health care institutions such as behavioral health care facilities and home care agencies (JCAHO, n.d.). JCAHO standards require hospitals to employ policies that provide the means for effective communication for each client served. For example, on admission, patients must be informed of their rights in a manner that they can understand (Perkins et al., 1998).

The National Committee for Quality Assurance (NCQA) accredits managed care organizations in primary health and behavioral health (NCQA, 2001). NCQA's accreditation standards call for managed care organizations to be able to provide materials in languages of major non-English speaking populations that make up at least 10 percent of the membership.

The Accreditation Council for Graduate Medical Education's (ACGME) requirements for family practice ensure that residency programs teach residents to assess and understand the specific health needs of the community in which they work (ACGME, 1997). Clearly, in today's increasingly diverse communities, training programs must prepare physicians to care for people of diverse cultures.

The Liaison Committee on Medical Education's (LCME) new accreditation standards for 2001 include a specific requirement for cultural competence. The accreditation handbook states (LCME, 2001a, p. 19):

The faculty and students must demonstrate an understanding of the manner in which people of diverse cultures and belief systems perceive health and illness and respond to various symptoms, diseases, and treatments. Medical students should learn to recognize and appropriately address gender and cultural biases in health care delivery, while considering first the health of the patient.

This new requirement is evidence that the importance of patient-centered care, the influence of both culture and gender on health care needs, and the need to teach concepts of culturally competent care are becoming increasingly recognized. We discuss examples of curricula that address this requirement in the section on Curricula and Training.



PROFESSIONAL ORGANIZATIONS

Many professional organizations in different areas of health have instituted policies that promote culturally competent practices. The Society for Teachers of Family Medicine (Like, Steiner, & Rubel, 1996), the American Psychological Association (1990), the American Medical Association (1999), the National Association of Social Workers (2001), the American Academy of Pediatrics (Committee on Pediatric Workforce, 1999), the American Medical Women's Association, the Association of American Medical Colleges, the National Medical Association, the American Academy of Family Physicians, and the National Alliance for Hispanic Health are a few examples of organizations that have policies, research and initiatives or that provide training in cultural competence (American Medical Association, 1999; Horowitz, Davis, Palermo, & Vladeck, 2000). The American Medical Association's *Cultural Competence Compendium* (1999) provides comprehensive information on policies, publications, educational programs, and relevant activities of physician associations, medical specialty groups, and state medical societies.

Several organizations have instituted guidelines or standards in cultural competence for their memberships. For example, the American Academy of Family Physicians (AAFP) issued cultural proficiency guidelines for preparing information or continuing medical education programs (AAFP, 2001). A policy statement issued by the American Academy of Pediatrics on culturally effective pediatric care, education, and training issues defines "culturally effective health care" and other terms related to cultural competence and describes the importance of training in cultural competence in medical school, residency, and continuing medical education (Committee on Pediatric Workforce, 1999). Other professional organizations have issued guidelines on providing culturally competent services for their membership. The APA's "Guidelines for Providers of Psychological Services to Ethnic, Linguistic, and Culturally Diverse Populations" provides general principles that give suggestions for psychologists working with diverse populations (APA, 1990). A publication of the National Association of Social Workers, "Standards for Cultural Competence in Social Work Practice," presents and interprets 10 standards that address the need for definition, support, and encouragement of a social work practice that prompts cultural competence among all social workers (NASW, 2001).

The Association of American Medical Colleges (AAMC) surveyed medical schools for information on established programs in cultural competence and identified needs (AAMC, 1998), and the organization's Task Force on Cultural Competence was instrumental in developing and supporting the new standard on cultural diversity that was recently implemented by the Liaison Committee on Medical Education (AMA, 1999; LCME, 2001a). Other professional organizations also support projects and initiatives that promote cultural competence. The American Public Health Association's "Alternative and



Complementary Health Practices” special primary interest group sponsors sessions at the annual meeting that focus on topics such as using cross-cultural communication and synthesizing alternative and complementary health practices into Western medical practice (AMA, 1999). The National Hispanic Medical Association has a Cultural Competence Project that includes a medical education curriculum survey, a speakers’ list, and policy reports and programs for medical schools (AMA, 1999).

Some professional organizations have developed their own curricular materials, such as the Society for Teachers of Family Medicine and the National Alliance for Hispanic Health. In 1996, the Society for Teachers of Family Medicine published curricular guidelines, developed over a decade, that are designed to introduce cultural competence into residency training and graduate medical education (Like et al., 1996). The National Alliance for Hispanic Health has developed resources for delivering culturally competent services to Latinos, such as “A Primer for Cultural Proficiency: Towards Quality Health Services for Hispanics” (National Alliance for Hispanic Health, 2000). The Administration on Aging has also produced an introductory guidebook that addresses culturally competent care for elderly minority population (DHHS Administration on Aging, 2001).

Professional organizations have developed and continue to develop policies, guidelines, and resources that encourage their memberships to learn and continue learning to provide effective culturally competent health care. They are important vehicles for promoting and training their members to be culturally competent health care providers.

SECTION IV: THREE THEMES OF THE CLAS STANDARDS

The contexts of health care research and policies and laws guiding health care practices, the rationale for a physician to enhance his or her cultural competence through training is evident. In the next three sections we discuss the three major themes of culturally and linguistically appropriate services (CLAS) as they apply to family physicians. For each of the three main themes of the CLAS standards—culturally competent care, language access services, and organizational supports—we present the main concepts drawn from the information we gathered and synthesized, and we include examples. More detailed examples of the materials we collected are included in appendices where indicated.

CULTURALLY COMPETENT CARE

The theme of culturally competent care is addressed by the first three CLAS standards (see Box 1), and for the purpose of this report refers to the culturally competent services delivered by individual physicians. Many of the materials reviewed for this section provide conceptual frameworks and key aspects of culturally competent care that can be used in developing curricula for training physicians and



other health care practitioners. The main themes of culturally competent care are discussed in this section. A review of curricular matters focusing on relevant aspects of pedagogy is provided in the last section of this paper.

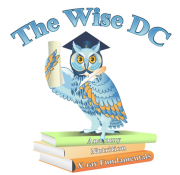
The resources gathered for this section represent the majority of the information we collected and were found mainly in journals and web sites. Summaries of some of these cultural competence frameworks or approaches are given in Appendix B. After reviewing the materials we gathered on culturally competent care, we saw five themes emerge: a patient-centered focus; effective physician-patient communication; balance fact-centered and attitude/skill-centered approaches to acquiring cultural competence; the acquisition of cultural competence as a developmental process; and understanding alternative sources of care.

PATIENT-CENTERED FOCUS

In the information we reviewed, most conceptual frameworks of cultural competence emphasized the patient (and family when appropriate) as the focus of attention, rather than the person's cultural group characteristics or the disease (Carrillo et al., 1999; Leininger, 1978; Shapiro & Lenahan, 1996). This idea marks a departure from the traditional medical model that focuses on treating a disease rather than the whole patient. These frameworks tend to take a holistic approach, emphasizing the cultural and social influences on a person's health and health beliefs. This scenario empowers the patient as the "expert" of his or her unique illness experience (Tervalon & Murray-Garcia, 1998). An important concept to patient centeredness is the distinction between disease and illness.

The difference between "disease" and "illness" is an important distinction. Disease refers to the malfunctioning of physiological and psychological processes, whereas illness refers to the psychosocial meaning and experience of the perceived disease for the individual, the family, and those associated with the individual (Kleinman, Eisenberg, & Good, 1978). Individuals seek health care because of their experience of illness, so it is important for physicians to recognize that a patient's experience with illness may vary from their professional interpretation of the disease and may be influenced by cultural and social factors (Blue, 2000). In response to a particular illness episode, an individual forms an explanatory model that encompasses his or her own beliefs about the course of the sickness, such as its origin, severity, treatment, and expected recovery (Kleinman, 1980). The goal of medical interviewing techniques is to "elicit" the patient's explanatory model of his or her sickness. This focus on the patient's perspective marks a shift from a disease perspective to a more holistic perspective that sees the patient as a whole person and not just as an organ system or a disease. A culturally competent physician must address both the disease and the illness. Examples of patient-centered approaches follow.

Carrillo, Green, and Betancourt (1999) warn against a categorical approach to teaching cultural competence that focuses on specific characteristics of certain groups of people. Instead, they emphasize a



patient-based approach to cross-cultural curricula that focuses on differences between individuals rather than between groups or cultures. One of the five major content areas focuses on determining the patient's social context. The curriculum they have developed combines medical interviewing techniques with the sociocultural and ethnographic tools of medical anthropology. A summary of the content areas of the five modules can be found in Appendix B, and a thorough description of this curriculum is given in the Curricula and Training section.

Leininger's Sunrise Model suggests that the patient's worldview and social structure are important areas of assessment and that the Western medical model fails to explore cultural patterns of illness. The Sunrise Model provides nine domains that practitioners can use to assess patients in order to provide comprehensive and culturally sensitive care. Leininger's nine domains are presented in Appendix B (Leininger, 1978).

As part of their solution-oriented approach to cross-cultural training for family practice residents, Shapiro and Lenahan use inductive models for learning about cultural differences as one of their basic strategies (Shapiro & Lenahan, 1996). An inductive model focuses on the patient and his or her family as the center of analysis rather than on some generalized theory.

Another patient focused approach to teaching cultural competence is to focus on the patient's family unit. Marvel and colleagues' (1993) approach to teaching concepts of culture focuses on the family system. The model uses the family as its basis for identifying and understanding cultural influences that affect health, and negotiating a treatment plan. The relationship between a patient centered approach and culturally competent care is intertwined. Culturally competent health interventions require a patient-centered focus, and conversely a patient-centered approach implies culturally competent interventions.

Box 2: Berlin & Fowkes'

LEARN Model

- ◆ **Listen** with sympathy and understanding to the patient's perception of the problem.
- ◆ **Explain** your perceptions of the problem.
- ◆ **Acknowledge** and discuss the differences and similarities.
- ◆ **Recommend** treatment.
- ◆ **Negotiate** agreement. *Source:*

Berlin & Fowkes, 1983

EFFECTIVE PHYSICIAN-PATIENT COMMUNICATION

Effective communication is essential for the physician-patient relationship to be successful. A majority of resources reviewed focus on enhancing the communication skills of the physician or the clinician. Important concepts related to communication include interviewing techniques, eliciting the explanatory model, and negotiation of treatment.

Many frameworks for cultural competence curricula emphasize the importance of learning communication skills as part of the core intercultural skills required for culturally competent care (Kristal et al., 1983; Bobo et al., 1991; Levin, Like & Gottlieb, 2000; Scott, 1997; Stuart & Lieberman, 1993). These frameworks stress the use of communication for eliciting the patient's understanding of his or her



culture and establishing rapport. Campinha-Bacote's construct of "cultural skill," www.TheWiseDC.com interdependent constructs that make up cultural competence in her model, depends on effective communication (Campinha-Bacote, 1999). Cultural skill is the ability to collect relevant cultural data regarding clients' health through a culturally sensitive approach to interviewing clients.

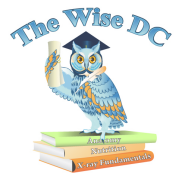
Several interviewing and communication strategies are cited in the literature as important techniques for culturally competent clinical practice. Kleinman and colleagues (1978) developed a set of patient-centered interviewing questions for eliciting a patient's explanatory model, such as "What do you think has caused your problem?" and "How does it affect your life?" Berlin and Fowkes' LEARN model consists of the five guidelines for cross-cultural encounters listed in Box 2. Stuart and Lieberman's (1993) BATHE model is a mnemonic that suggests useful questions for eliciting a patient's psychosocial context. ETHNIC is a framework that guides culturally competent clinicians to communicate effectively throughout the physician-patient encounter (Levin et al., 2000). Details of the BATHE and ETHNIC models are given in Appendix B.

Berlin and Fowkes and Carrillo and colleagues agree that negotiation is an essential component to treatment. Negotiation of explanatory models involves acknowledging and negotiating across belief systems (Carrillo et al., 1999). The treatment plan should be the result of a partnership in decision making between physician and patient (Berlin & Fowkes, 1983).

BALANCING FACT-CENTERED AND ATTITUDE/SKILL-CENTERED APPROACHES TO ACQUIRING CULTURAL COMPETENCE

Approaches to acquiring cultural competence can be categorized as fact-centered or attitude/skill-centered approaches. The fact-centered approach enhances cultural competence by teaching clinicians cultural information about specific ethnic groups. Although it has practical applications, a solely fact-centered approach risks presenting patients as racial stereotypes. An individual has far more cultural influences than any handbook or course can teach, and it may not be possible for physicians to learn about the particularities of all the various cultural and ethnic groups they serve. However, culture-specific knowledge, such as an ethnic group's historical context, cultural concepts of illness and disease, health-seeking behaviors, health-oriented data and disease patterns, etc., may be helpful in certain situations (Fisher, 1996; Harwood, 1981). Cultural competence resources that use a fact-centered approach usually emphasize the importance of recognizing intra-group variation, warn against ethnic stereotyping, and may be presented as a "first step" to learning culturally competent care (Fisher, 1996, p. xx).

The attitude/skill-centered approach represents a universal approach to cultural competence that enhances communication skills and emphasizes the particular sociocultural context of individuals. Although some cultural competence frameworks fall into one category or another, most emphasize the need for achieving a balance of the two approaches. Many frameworks of cultural competence have the



goal of balancing specific cultural facts and knowledge pertaining to health beliefs of specific cultures with acquiring sound skills and general knowledge of physician-patient interaction that applies to all patient encounters (Bobo et al., 1991; Kristal et al., 1983; Scott, 1997). An example of balancing fact- and attitude/skill-centered approaches to acquiring cultural competence is discussed in more depth in the Curricula and Training section.

ACQUISITION OF CULTURAL COMPETENCE AS A DEVELOPMENTAL PROCESS

Most of the conceptual frameworks we reviewed present cultural competence and sensitivity as an ongoing process of learning, reflecting and developing concepts, skills, attitudes, experiences, knowledge, or specific competencies (Culhane-Pera, Reif, Egli, Baker, & Kassekert, 1999; Cross et al., 1989; Borkan & Neher, 1991; Tervalon & Murray-Garcia, 1998). These developmental models describe cultural competence as consisting of levels or stages that build on each other as cultural competence develops, rather than as a competence that is achieved after attaining any one particular goal, such as passing a course or completing a training module. In other words, developing cultural competence requires more than just passive learning; it requires a deliberate process of thinking through, reflecting, and progressing on the part of the trainee. Campinha-Bacote (1999) encourages health care providers to focus on cultural competence as more of a journey than an ultimate goal. Her model of cultural competence is made up of five interdependent constructs: cultural awareness, cultural knowledge, cultural skill, cultural encounters, and cultural desire. See Appendix B for a more detailed description.

Examples of developmental models of cultural competence include Cross and colleagues' (1989) developmental continuum ranging from "cultural destructiveness" to "cultural proficiency." To articulate the continuum, the model characterizes six points along the range. Similarly, Culhane-Pera and colleagues' (1997) developmental model consists of five levels of cultural competence, ranging from level 1, "no insight about the influence of culture on medical care," to level 5, "integration of attention to culture into all areas of professional life." Borkan and Neher (1991) present a model with seven stages from "ethnocentric" to "ethnosensitive" that emphasizes the progression from stage to stage. For example, the stage of "superiority," which is characterized by negative stereotyping, is followed by "minimization," in which the trainee has learned to value similarities between cultural groups, accepts that no one group is superior, but tends to over-generalize this notion, minimizing the importance of cultural differences.

In contrast, other approaches to cultural competence focus on methods and guidelines for practicing culturally competent care in certain multicultural situations (Carrillo et al., 1999; Pachter, 1994; Shapiro & Lenahan, 1996). These frameworks present a more methodological approach aimed at practical applications and may not emphasize the developmental nature of cultural competence acquisition. For example, Shapiro and Lenahan's (1996) solution-oriented approach identifies general strategies that can be applied in cross-cultural situations. However, such methodological guidelines for



addressing cultural competence may also be interpreted as important multicultural experiences that further the development of cultural competence. www.TheWiseDC.com

Two important aspects to learning cultural competence further articulate the idea that it is a personal process of developing one's own cultural sensitivity and proficiency. The literature emphasizes self-reflection of one's own cultural identity and cultural beliefs, and the importance of experiences with cross-cultural encounters, as important to developing cultural competence. Cultural competence frameworks that cite self-reflection as a key element explain the importance of exploring one's own cultural and family values and influences (Campinha-Bacote, 1999; Marvel, Grow, & Morpew, 1993) and exploring one's own biases or prejudices (Campinha-Bacote, 1999; Carrillo et al., 1999; Ohmans, 1996). Frameworks that emphasized the need for experience with cross-cultural clinical encounters noted that such experience is important for a variety of reasons. Through repeated interactions with diverse groups, providers have the opportunity to learn to deal adequately with and become comfortable with a variety of issues and scenarios (Campinha-Bacote, 1999; Lurie & Yergan, 1990); to prevent stereotyping through repeated interactions with diverse people from similar cultural groups (Campinha-Bacote 1999); or to achieve empathy or a sense of patients' essential values through cultural experiences (Carrillo et al., 1999; Lurie & Yergan, 1990). Tervalon and Murray-Garcia (1998) describe cultural competence as a commitment and active engagement in a lifelong process of self-reflection and self-critique, requiring humility.

For individuals who are beginning to learn to provide culturally competent care, presenting cultural competence as a developmental process that involves self-reflection and cross-cultural experience may be an important framework for learning.

UNDERSTANDING ALTERNATIVE SOURCES OF CARE

Many of the conceptual frameworks regarding culturally competent care explicitly emphasize the importance for physicians to recognize that patients may use alternative sources of health care and that their health care seeking behavior is influenced by culture (Pachter, 1994; Blue, 2000; Brach & Fraser, 2000; Cohen & Goode, 1999). That is, an important aspect of culturally competent care is an awareness that the Western health care system is only one among multiple sources of health information and resources from which people gain knowledge about health and receive health care. Traditional or folk models of health care differ from the Western biomedical model in that explanations for illness may include such factors as injuries, environmental factors, interpersonal conflicts, witchcraft, hexes, or spirits. In addition, traditional or folk health practices or remedies include herbal remedies, acupuncture, massage, prayer rituals, and the use of traditional healers or practitioners such as curanderos, shamans, and herbalists (Fortier & Bishop, forthcoming).

Spector (2000) points out that traditional health beliefs and practices should not be confused with



alternative medicine, which has been rapidly gaining in popularity. Traditional methods of health care differ from alternative medicine in that they are based on traditional beliefs and practices that are integral to a person's culture.

The foundation for today's understanding of traditional health care is anthropology. In 1980, Kleinman conceptualized multiple source health care sectors. According to Kleinman, the folk health care sector is a non-professional, specialist sector that may be based on secular or sacred beliefs and practices, or both. It also may overlap with the professional or popular health sectors. Kleinman's model emphasizes that culture plays a major role in influencing a patient's experience of and interaction with popular and folk health care sectors (Blue, 2000; Kleinman, 1980).

Most of the literature on traditional and folk health care describes traditional health models and practices and articulates that culturally competent care should attempt to coordinate alternative systems and practices with conventional approaches to care (Fortier & Bishop, forthcoming). For example, Spector's health traditions model uses a holistic concept of health, exploring traditional methods of maintaining, protecting, and restoring health. Traditional methods are based on the knowledge and understanding of health-related resources from within a given person's ethnoreligious cultural heritage (Spector, 2000). Similarly, Leininger's Sunrise model of nine domains that influence health status includes "health and life care rituals and rites of passage to maintain health" and "folk and professional health-illness systems used" (Leininger, 1978).

In terms of coordinating alternative care with conventional approaches, an example is Pachter's (1994) guidelines for addressing clinical issues surrounding folk beliefs in a culturally sensitive way, which include

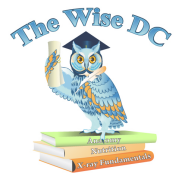
- ◆ becoming aware of the commonly held medical beliefs and behaviors in the patients' community;
- ◆ assessing the likelihood of a particular patient or family acting on these beliefs during a specific illness episode; and
- ◆ arriving at a way to successfully negotiate between the two belief systems.

An understanding of the clinical issues surrounding folk health provides the physician with a framework to develop a therapeutic plan within the context of the patient's cultural system, which may increase patient compliance.

Culturally competent care is dependent on the ability to understand and communicate. For many who do not speak English, communication can be a major barrier to health care. The next section focuses on the issues related to creating language access services for LEP patients.

LANGUAGE ACCESS SERVICES

A main tenet of anthropology is that language is the most important aspect of culture because it



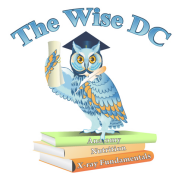
is the primary way that a culture is transmitted. This notion holds true in health care settings. The medical interview is the physician's most powerful tool (Woloshin et al., 1995). But millions of U.S. residents throughout the country do not have proficient English speaking and reading skills. Providing language access services in health care settings to people with limited English proficiency is the second theme of the CLAS standards. Standards 4 through 7 (see Box 1) represent the set of CLAS standards that are federal mandates, not just recommendations, for providing appropriate language access services for LEP patients so that they can have equal access to health care services. The standards support Title VI regulations mandating that every federally funded service provider ensures adequate language access services. Providing linguistically appropriate services entails overcoming difficult challenges with a shortage of qualified medical interpreters available and a lack of resources for interpretation and translation services.

In this section, we address issues related to the physician's role in ensuring appropriate linguistic services people with limited English proficiency. A large body of information on language access exists, and much of the information we found pertains to Title VI and related laws and policies. Even though we did not find information specific to services for the hearing impaired and people with limited literacy skills, we acknowledge that addressing the language access needs for all people is essential to providing culturally and linguistically appropriate services. Using information from the sources we reviewed on language access services, we discuss these prominent themes: appropriate interpretation services, the training of physicians to work with interpreters, the lack of resources for language access services, and language access strategies.

APPROPRIATE INTERPRETATION SERVICES

Appropriate interpretation services are essential to providing good health care. In the previous section, we discussed communication as a core aspect of the physician-patient relationship. Language barriers can hinder communication, often resulting in misdiagnoses, over-testing, poor compliance, patient dissatisfaction, and poor health outcomes, especially when complaints, questions, or psychosocial concerns cannot be effectively addressed (Woloshin et al., 1995; Jackson, 2001; Haffner, 1992; Fortier, 1999). In fact, according to two studies, 20 to 25% of patients who change physicians decide to switch because they are dissatisfied with physician-patient communication (Jackson, 2001). Inadequate interpretation can also raise ethical dilemmas because it puts client confidentiality at risk and can prevent truly informed consent (Woloshin et al., 1995; Haffner, 1992). Lack of informed consent or failure to convey treatment instructions because of language barriers may even result in liability and malpractice claims (Goode et al., 2000). The majority of information on interpreter services emphasizes the need for professional, qualified interpreters and warns of the risk of using inappropriate ones.

According to Woloshin and colleagues (1995), there are three suboptimal mechanisms for



communication between patients and clinicians where translation is involved: 1) using an interpreter with limited language skills; 2) relying on the English language skills of family or friends accompanying the patient; or 3) or using ad hoc interpreters, such as other patients in the waiting room or employees who are not professional interpreters. All of these mechanisms have the potential for errors in communication that could have negative health care effects. In caring for people with limited English proficiency, the preferred form of communication is using a bilingual physician who is fluent in the patient's preferred language. In fact, the literature shows a preference for language-concordant encounters, or encounters where the physician and patient speak the same language, because language concordance can eliminate many of the problems associated with language barriers (Fortier & Bishop, forthcoming). Of course, physicians who are not truly bilingual will likely lack the language skills necessary to effectively communicate with LEP patients. Family, friends, and ad hoc interpreters usually lack the health care knowledge, understanding of medical terminology, and interpretation skills to effectively carry out this function. Placing them in this role can jeopardize informed consent, that is, the ability of patients to make informed decisions about their own health care.

The development of clear standards for medical interpreter training and certification is an important step to ensuring appropriate use of interpreters. Most of the materials reviewed call for the implementation of standard training or certification for interpreters in cross-cultural medical interpretation (Woloshin et al., 1995; Fortier, 1999; Goode et al., 2000; Haffner, 1992). However, agreement about appropriate interpreter roles and a lack of interpreter standards have been ongoing problems. For this reason, it is especially important for organizations to have clear standards for interpreter roles that are understood and agreed on internally (Fortier, 1999).

In Minnesota and Massachusetts, statewide medical interpreter initiatives have developed standards and provide workshops to train interpreters to meet these standards. The Minnesota Interpreter Standards Advisory Committee developed recommendations for professional standards that include core competencies and professional ethics standards for health care interpretation. Core competencies include such skills as adequately introducing and explaining one's role to both the physician and patient at the first meeting; positioning oneself to best facilitate communication in the least disruptive, most respectful way; reflecting the style and vocabulary of the speaker; remaining neutral in times of conflict; and addressing culturally based miscommunication by providing relevant cultural information when necessary (Minnesota Interpreter Standards Advisory Committee, 1998).

Minnesota's standards were adapted from standards developed by the Massachusetts Medical Interpreter Association (MMIA) and the Education Development Center in 1995. In 1998, the National Council on Interpretation in Health Care endorsed the standards. The MMIA's standards of practice were based on the premise that an interpreter must go beyond proficiency in interpretation to an understanding of the nuances and hidden sociocultural issues involved with interpreting across cultures. Harvard Pilgrim



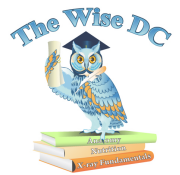
Health Care has an interpreter training program that provides both clinical and non-clinical interpreters at several health center sites. It has policies that encourage pre-scheduling of appointment with interpreters and recommend that providers allot an extra 15 minutes for initial appointments with LEP patients (Fortier, 1999).

TRAINING PHYSICIANS TO WORK WITH INTERPRETERS

Interactions between non-English speaking patients seeking care and physicians who do not speak their language are not just *bilingual*, but *bicultural* as well (Scott, 1997). The nature of the interaction is complicated and has many implications. To be effective, the physician must understand the interpreter's role and how to interact with both the interpreter and the patient when communicating through an interpreter (Fortier, 1999; Ohmans, 1996). Physicians should understand what constitutes an appropriate interpreter. As mentioned above, if an interpreter is necessary, a professional one is preferred, or at minimum, a person with a biomedical background. Also, the physician should not assume that a bilingual person wants to speak in his or her native language. Finally, debriefing with the translator after a session is also crucial to understanding potential intercultural misinterpretations (Scott, 1997).

One example of a program that trains physicians to work with interpreters is at the Asian Health Services of Oakland. The program has developed and distributes provider training for working with interpreters that includes understanding provider responsibilities for communication, interpreter role and skills, ethics, liability, and negotiation of basic cultural issues (Fortier, 1999). The Cross Cultural Health Care Program provides training programs for physicians who are concerned about working with interpreters. The Program's "Guidelines for Providing Health Care Services through an Interpreter" answers general questions about working with interpreters such as "how do you decide if you need an interpreter?" "how do you choose an interpreter?" and "how do you work effectively through an interpreter?" (The Cross Cultural Health Care Program [CCHCP], n.d.). Examples of guidelines for working through an interpreter include (CCHCP, n.d.):

- ◆ During the medical interview, speak directly to the patient, not to the interpreter.
- ◆ Assume that, and insist that, everything you say, everything the patient says and everything that family members say is interpreted.
- ◆ Be aware that many concepts you express have no linguistic, or often even conceptual, equivalent in other languages. The interpreter may have to paint word pictures of many terms you use; this may take longer than your original speech.
- ◆ Encourage the interpreter to ask questions and alert you about potential cultural misunderstandings that may come up. Respect an interpreter's judgment that a particular question is culturally inappropriate and either rephrase the question or ask the interpreter's help in eliciting the information in a more appropriate way.



- ◆ Be patient. Providing care across a language barrier takes time. However, the time spent in front will be paid back by good rapport and clear communication that will avoid wasted time and dangerous misunderstandings down the line.

Although our review of materials for this section did not uncover many resources for training physicians and other staff to work with interpreters; however, the importance of such training was mentioned frequently.

LACK OF RESOURCES FOR LANGUAGE ACCESS SERVICES REQUIREMENTS

Even though language access services are currently the only culturally competent services required by law, the enforcement of Title VI faces significant barriers owing to a lack of federal and state reimbursement policies that support interpretation. Even though they recognize language access services as necessary, many doctors are frustrated by the expense required to implement them. Some policy analysts are worried that owing to these requirements, private practice physicians enrolled in Medicaid and Medicare will decrease in numbers, making it harder for many minority patients to obtain quality care (Landers, 2000).

Only two states, Washington and Oregon, have created a separate billing code for interpretation. In Oregon, translation and interpreter costs are included as administrative costs in capitation rates (Woloshin et al., 1995). Many states have also enacted provisions that encourage or require both state agencies and their contractors to provide language appropriate services to LEP patients. In California, the Dymally-Alatorre Bilingual Services Act imposes direct obligations on state and local agencies to provide appropriate translation services, such as translated materials and sufficient numbers of bilingual persons on staff (Perkins et al., 1998). Examples of these types of services that states have developed are discussed in the Language Access section below.

Physicians must be aware of the particular state laws and other policies that determine whether and how interpreter services can be billed. Physicians and health care organizations should promote direct reimbursement or capitation differentials for interpreter services by health plans and government agencies, as well as support research on interpreter services cost and the appropriate calculation of reimbursement/capitation levels (Fortier, 1999).

Besides cost, another reason some physicians may resist providing language access services for their patients is a lack of awareness of the range of services that are available or of potential alternatives.

LANGUAGE ACCESS STRATEGIES

Health care organizations may employ a wide variety of language access strategies, some of which highly effective. However, the majority of health care practice settings (community health centers, hospitals, clinics, managed care organizations, and individual practitioners) do not employ such model strategies, relying on inefficient, ad hoc approaches (Fortier, 1999). Model language access services are often created in isolation to serve a particular need of a particular community. The result is a lack of



shared knowledge about more cost-effective options than hiring full-time, professional interpreters. There is clearly a need for disseminating information on models and best practices for providing language access services. This section explores some innovative and successful strategies.

In August 2000, the Office for Civil Rights (OCR) acknowledged the need for clarification and issued a Policy Guidance in response to widespread confusion about how to meet Title VI requirements (*Federal Register* 65 (169), 52762–774). The Guidance includes examples of promising practices, which are given in Box 2.

We found several examples of the use of the language access strategies. Many communities, especially ones with large cultural and linguistic populations, can use local resources. Some communities have programs that recruit, train, and certify medical interpreters from the bilingual community at large (Woloshin et al., 1995). For example, the University of Minnesota's Department of Linguistics runs a community interpreter program that recruits bilingual individuals for 150 hours of technical training, and Hunter College in New York City recruits and trains local college students as medical interpreters in exchange for scholarships or academic credit (Woloshin et al., 1995).

A similar strategy is to recruit bilingual hospital staff internally to serve as interpreters after they undergo training and certification. At facilities where demand is greatest, Kaiser Permanente of Southern California offers a pay incentive for bilingual staff who pass a proficiency exam to serve as interpreters (Fortier, 1999).

Community interpreter banks hold promise for many areas as a way to offer a wide variety of languages to many providers at competitive rates. It is a shared resource that allows many providers to access interpreters, especially from small language groups. As a response to language discrimination complaints, Seattle area hospitals initiated the Hospital Interpreter Program in the late 1980s. University-based programs, immigrant services agencies, health departments, and community clinics have initiated similar community interpreter banks. Although setting up these complex programs may take considerable resources and effort, community interpreter banks could offer the most cost-effective solution in certain areas (Fortier, 1999).

Some physicians and hospitals have filled the need for interpreters in less frequently heard languages by using telephone services as an alternative to full-time or contracted interpreters. These telephone services can be considerably less expensive (Jacob, 2001). For example, Logansport Memorial Hospital in Logansport, Indiana, treats many patients who speak Vietnamese, Bosnian, or Spanish and uses telephone interpreter services every day. Kaiser Permanente's medical center in Panorama City, California, has used both on-site interpreters and telephone language interpretation services for 20 years. Phones are installed in examining rooms, and doctors are trained to use phone interpreter services (Jacob, 2001).

A number of simpler interventions can also improve access to health services for LEP patients.



For example, using multilingual materials in the facility to inform patients about interpreter services is a way to reach LEP patients. In Hennepin County, Minnesota, the Metropolitan Health Plan is a public HMO with the Hennepin County Medical Center as its flagship facility. The plan added translated patient forms, patient education material, and audiovisual programs to the hospital's interpreter program (Fortier, 1999).

Another simple intervention is to provide staff and patients with bilingual phrase sheets for common expressions, words, and questions to help patients reach the appropriate service areas and to create a more welcome environment for LEP persons (Woloshin et al., 1995).

A final idea for a simple intervention is to give patients access to bilingual telephone operators for asking questions or making appointments (Woloshin et al., 1995). Blue Cross of California has established community resource centers to provide specialized member services in communities where service populations do not meet the state criteria for required services. The centers' staff is representative of the ethnic and linguistic demographics of the communities they serve and deal with member services, appointment scheduling, intake needs assessments. They also emphasize preventive services and prenatal care (Coye & Alvarez, 1999).

To improve overall linguistic access through language access strategies, it is important to promote awareness of and dissemination of technical information, case studies, and summaries of model programs and strategies of bilingual/interpreter services programs. It is also important to promote information sharing on best practices and lessons learned.

Language access services that serve particular language groups and meet a particular need in the community or service area are likely to be a challenge to develop and implement. Organizations that serve multi-linguistic populations have the challenge of implementing even more extensive linguistic services. However, ideally these language services are just one part of a health care organization's overall plan to increase cultural competence. In the next section, we discuss the main themes associated with implementing cultural competence, including language access services, at the organizational level.

**Box 3: Office for Civil Rights' Promising Practices for Language Access Strategies**

- ◆ —
which the provider and the patient communicate using wireless remote headsets while a trained competent interpreter, located in a separate site, provides simultaneous interpreting services to the provider and the patient. The interpreter can be miles away. This reduces delays in the delivery of language assistance, since the interpreter does not have to travel to the medical facility.
- ◆
providers have created community language banks that train, hire, and dispatch competent interpreters to participating organizations, reducing the need to have on-staff interpreters for low-demand languages. These language banks are frequently non-profit and charge reasonable rates.
- ◆
Interpreter Services and Translation.” This office tests and certifies all in-house and contract interpreters; provides agency-wide support for form translation, client mailing, publications, and other written materials into non-English languages; and monitors the policies of the agency and its vendors that affect LEP persons.
- ◆
interpreters to help immigrants and other LEP persons navigate the county health and social service systems. The project uses community outreach workers to work with LEP clients and can be used by employees in solving cultural and language issues. A multicultural advisory committee helps keep the county in touch with community needs.
- ◆
Interpreter.” They are intended to facilitate basic communication between patients and staff to increase the comfort level of LEP persons as they wait for services.
- ◆
documents online. The documents can be retrieved as needed.
- ◆
requirements, and the availability of free language assistance in appropriate languages by a) posting signs and placards with this information in public places such as grocery stores, bus shelters and subway stations; b) putting notices in newspapers and on radio and television stations that serve LEP groups; c) placing flyers and signs in the offices of community-based organizations that serve large populations of LEP persons; and d) establishing information lines in appropriate languages.

Source: OCR Policy Guidance (Federal Register, 65 (169), 52762–774) (Summarized.)



ORGANIZATIONAL SUPPORTS

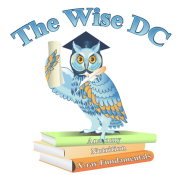
The third theme of the CLAS standards is organizational supports for cultural and linguistic competence. This aspect is addressed in standards 8 through 14. The recommendations in these standards are extensive. They cover many issues related to developing and implementing cultural and linguistic competence at the organizational level, including strategic planning, self-assessment and evaluation, management information systems, community partnering, complaint/grievance structures, and notification of the public. This section focuses on the core concepts of organizational supports that are necessary to foster the physician's capacity to facilitate change and enhance cultural competence in his or her clinic or health care organization.

In the social structure of the health care organization, the physician is hierarchically in a position to exert a lot of influence on the "institution's patient care, processes, and outcomes" (Rutledge 2001, p. 317). Even though the physician's role within an organization varies greatly depending on the setting, learning about the role of organizational policies and procedures in supporting culturally competent care is an important aspect of any physician's training. The family physician is largely responsible for whether or not an atmosphere of cultural competence is established among the staff, and he or she may be solely responsible for the cultural competence of the whole health care organization.

For health care organizations, implementing culturally competent policies and procedures is very complex—practically, politically, and programmatically (Rutledge, 2001). Like cultural competence training approaches, cross cultural health programs and initiatives at the organizational level often fall into one of two categories: programs that focus on specific population groups and/or health conditions and programs that address overall organizational cultural competence. Generally, it is easier to develop organizational programs targeted at specific groups than to achieve multiethnic cultural competence (Fortier, 1999). In this section, we primarily address issues related to developing and implementing overall organizational cultural competence.

Although there is a great deal of overlap, we have attempted to focus this report on information regarding cultural competence that is targeted toward physicians rather than administrators. For example, organizational assessment tools and handbooks on organizational cultural competence undoubtedly contain information that is useful for physicians but are not targeted at physicians.

The materials we reviewed on organizational supports were largely drawn from journal articles, web sites, and other online resources. They were often in the form of guidelines or recommendations for implementing cultural competence. Some material was from federal agencies. Several of the comprehensive sets of guidelines, key elements, or recommendations we refer to in this section are summarized in Appendix B. The main topics relevant to organizational support that emerged from the



materials reviewed are: the need for a strong commitment to cultural competence at every level of the organization; the importance of community involvement; the recruitment of minority and community health workers; training and professional development; and organizational assessment.

STRONG COMMITMENT TO CULTURAL COMPETENCE AT EVERY LEVEL OF THE ORGANIZATION

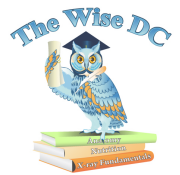
One of the major aspects stressed in the materials reviewed is that a strong commitment to cultural competence at every level of the organization is essential to successfully supporting culturally competent care (Fortier, 1999; Rutledge, 2001; Siegel, 1998; Goode, 1999). In fact, some have stated that a true commitment and dedication to cultural competence at every level is the most important factor to successful implementation. According to Rutledge and colleagues, “The key ingredient in this effort is ensuring that the governing bodies and executive management are absolutely committed to the journey and the destination” (2001, p. 323). Some have noted that it is important for the commitment to cultural competence to penetrate every aspect of the organization, including its policies and plans.

An organization’s commitment to cultural competence in all its departments and activities should be stated in its mission statement (Goode, 1999). It is also important for all stakeholders of an organization to understand and be committed to a vision that articulates culturally competent values. The organization’s policies and everyday operating procedures should reflect the principle of cultural competence (Rutledge, 2001). An effective diversity or culturally competent plan infuses cultural competence into every aspect of the organization so that it becomes part of the operating culture of the system.

However, the reality is that health care policy is generally lacking in the area of cultural competence. The National Center for Cultural Competence (NCCC) has documented policy as the most underdeveloped area at the programmatic level after observing cultural competence initiatives that serve children with special health care needs and their families. They determined that many health care initiatives lack the policies, structures, and planning procedures that support culturally competent practices (Cohen & Goode, 1999). Implementing cultural competence is an incredible challenge, and the commitment must begin at the top in order to be a serious and authentic goal for staff and clients throughout the organization (Siegel, 1998). Thus, a committed leadership is a first key to achieving a culturally competent organization.

THE IMPORTANCE OF COMMUNITY INVOLVEMENT

A main theme emphasized in the literature on organizational supports is the importance of community involvement. Community involvement can refer to involving community members or family members in clinical encounters or in the planning and implementation of programs. A main assumption of



either paradigm is that through community involvement, families or communities can identify cultural issues essential to health care, which can then be more effectively addressed (Fortier & Bishop, forthcoming). Although individual physicians may find that some organizational aspects are not relevant to them; they should have a general understanding of the importance of community involvement in terms of both culturally competent clinical encounters and health care programming in order to thoroughly understand culturally competent care. For example, on the level of the clinical encounter, physicians should be aware that some minority groups believe that family and/or community members should be involved in health care decisions; therefore involving them may be crucial to care (Brach & Fraser, 2000).

On the level of program planning and implementation, a majority of the literature states that organizations should solicit input from consumers and the community representatives for planning policies and programs and for gaining information about their needs (BPHC, n.d.; Coye & Alvarez, 1999; Goode, 1999; Siegel, 1998). Two ways to ensure community participation are to convene committees or advisory boards that include representatives from the community and to partner with community-based providers and traditional healers. Building networks of community informants can be a useful resource for developing a knowledge of diverse groups in the community (Goode, 1999).

The purpose of convening an advisory committee is to elicit community participation from diverse segments of the community and enlarge the pool of expertise available for program design and activities (Rankin & Kappy, 1993). The role of a committee is to exchange ideas and knowledge about achieving cultural competence in the community (Siegel, 1998). Federally funded community health centers are required to have consumer representatives from the community as 51% of their board representation. Community involvement on such entities is essential to cultural competence. Another mode of community participation is to convene focus groups or special ad hoc committees for specific input on topics such as professional development needs (Goode, 1999). A health center in Arizona drew from the expertise of native peoples and representatives from the community in humanities, education, and arts organizations to contribute to an educational program to heighten the cultural sensitivity of its health care professionals (Rankin & Kappy, 1993).

In some situations, it may be beneficial for physicians to collaborate with traditional healers from the community to negotiate a treatment that best fits with the patient's health beliefs (Pachter, 1994). Similarly, managed care organizations may contract with community-based health centers that provide services to minorities (Coye & Alvarez, 1999). A final important reason for maintaining ties with representatives from the community or with community-based providers is that it can be helpful in assessing the needs of cultural and linguistic minorities in the area. This information can be useful for outreach efforts and for tailoring health services to specific needs (Siegel, 1998; HRSA, 2001a).



THE RECRUITMENT OF MINORITY STAFF AND COMMUNITY HEALTH WORKERS

Hiring minority staff to match community demographics is a goal that many health care organizations strive for and struggle with. Minority providers tend to proportionately serve more minority patients than white health care providers (Murray-Garcia, Garcia, Schembri, & Guerra, 2001). Minority physicians have also been shown to communicate better with minority patients. Racial concordance between patient and physician can enhance satisfaction and adherence to treatment (Cooper-Patrick et al., 1999; Saha, Komaromy, Koespsell & Bindman, 1999). For these reasons, the recruitment of bilingual minority physicians and other staff is the primary way linguistic competence and should be a primary goal of health care organizations. Because minority (and especially bilingual) staff are often difficult to find, organizations may try implementing creative recruiting strategies. Some health care organizations have also implemented programs to recruit and train community health workers to support the health care needs of patients (Brach & Fraser, 2000; Coye & Alvarez, 1999).

Some strategies for recruiting and retaining minority group members in health care follow (Brach & Fraser, 2000):

- 1) creating minority residency or fellowship programs,
- 2) hiring minority search firms,
- 3) adapting personnel policy to create a comfortable and welcoming workplace for minority group members,
- 4) mentoring minority employees by senior executives,
- 5) tying executive compensation to steps taken to match hiring to community needs,
- 6) establishing a set of principles for respectful treatment of all people,
- 7) reviewing fairness of human resource practices and compensation of all staff, and
- 8) tracking staff satisfaction by racial and ethnic groups.

The increased need for minority and bilingual health care staff has led to increasing programs to recruit community health workers. Community health workers are bicultural and/or bilingual residents of the community and train them as community health workers. Asian Counseling and Referral Services of Seattle, Washington, is a community-based provider that recruits staff from different Asian ethnic groups and trains them in interpretation and basic mental health beliefs and practices of both Asian and American cultures. The trainees then work as co-providers with a licensed mental health professional (Fortier, 1999).

Another program in Seattle, Washington, has developed a model that uses community health workers. The Harborview Medical Center's Community House Calls project, created initially as a demonstration program, developed the interpreter cultural mediator (ICM) model, which uses two kinds



of LEP patient liaisons. Interpreter Cultural Mediators are bicultural, bilingual staff whose responsibilities include medical interpretation, cultural mediation and advocacy, case management, and community outreach. Community Advisors are selected representative of each cultural group served who educate staff about the specific social needs of their communities (Jackson-Carroll et al., 1998). Community health workers can be an important way to create and maintain ties with the community, and to inform health care staff of the health needs of the community.

Although the pool of minority health care workers does not meet the need, and recruitment is difficult, the increased presence of minorities in health care is an important goal.

TRAINING AND PROFESSIONAL DEVELOPMENT

The following section on Curricula and Training focuses on the core components of curricula in cultural competence. This subsection is concerned with the organizational aspect of providing training and opportunities for professional development in cultural competence. Such training for physicians and their staff is essential to providing culturally competent services, and it is important for organizations to support it (OMH, 2000; Brach & Fraser, 2000; Coye & Alvarez, 1999; Goode, 1999). However, organizations are often reluctant to provide organization-wide training because of the cost, the time lost, or the reluctance to face the real problems their organizations may not be addressing (Fortier, 1999). A report from the OMH found that in a study of eight states, most training was spearheaded by minority health entities, rather than the health care organization (OMH, 2000).

Some organizations have recognized the need for staff education and have implemented different modes of training. Organizations may implement cultural competence training as part of new staff orientation, as part of in-service training, or as a separate activity. They can also integrate a multicultural perspective throughout a curriculum or multiple training activities (Brach & Fraser, 2000).

Health care organizations should also set aside a budget each year for professional development through conferences, workshops, colloquia, and seminars on cultural and linguistic topics (Goode, 1999). Other examples of training and resources provided are a medical course in Spanish and an informational clearinghouse (OMH, 2000).

Further information regarding the curricular content for training physicians in cultural competence is given in the next section.



APPENDIX A: MINORITY CONSUMER AND COMMUNITY ADVOCACY GROUPS

Association of Asian Pacific Community Health organization

<http://www.aapcho.org>

The Black Health Network

<http://www.blackhealthnetwork.com/>

California's Pan-Ethnic Health Network

<http://www.cpehn.org/>

The Center for multicultural and multilingual Mental Health Services

<http://www.mc-mlmhs.org/>

Families USA: The Voice For Health Care Consumers

<http://www.familiesusa.org/html/color/color.htm>

Hispanic Health Council, Inc.

<http://www.hispanichealth.com/hhchome.htm> Accessed January 4, 2002.

The National Council for La Raza's Institute For Hispanic Health (IHH)

<http://www.nclr.org/policy/health.html>

National Multicultural Institute

<http://www.nmci.org/>

The Native Elder Health Care Resource Center

<http://www.uchsc.edu/ai/nehcrc/>

OTHER SITES RESEARCHED

Asian and Pacific Islander American Health Forum

<http://www.apiahf.org>

Association for Multicultural Counseling and Development

<http://www.counseling.org>

California Rural Indian Health Board

<http://www.crihb.org>

Center for American Indian Health

<http://ih.jhsph.edu/cnah>

Centros Para el Control y la Prevencion de Enfermedades

<http://www.cdc.gov/spanish>



Circles of Care Evaluation Technical Assistance Center

<http://www.hsc.colorado.edu/sm/coc>

Hispanic Federation

<http://www.hispanicfederation.org>

National Alliance for Hispanic Health

<http://www.hispanichealth.org>

National Asian Women's Health Organization

<http://www.nawho.org>

National Center for American Indian and Alaska Native Mental Health Research

<http://www.uchsc.edu/sm/ncaianmhr>

National Hispanic Medical Association

<http://home.earthlink.net/~nhma>

National Indian Health Board (national office)

<http://www.nihb.org>

National Latina Health Network

NLHN@erols.com

National Minority AIDS Council

<http://www.nmac.org>

National Native American AIDS Prevention Center

<http://www.nnaapc.org>

Search Institute

<http://www.search-institute.org>



APPENDIX B: FRAMEWORKS AND KEY ASPECTS OF CULTURALLY COMPETENT CARE

(BERLIN & FOWKES, 1983)

Berlin and Fowkes' LEARN model is a well-established approach for communication that consists of a set of guidelines for health care providers who serve multicultural populations. The model is intended as a supplement to the history-taking component of a normal structured medical interview.

LEARN consists of five guidelines:

- ◆ **Listen** with sympathy and understanding to the patient's perception of the problem.
- ◆ **Explain** your perceptions of the problem.
- ◆ **Acknowledge** and discuss the differences and similarities.
- ◆ **Recommend** treatment.
- ◆ **Negotiate** agreement.

(BOBO, WOMEODU, & KNOX, 1991)

Learning objectives for cross-cultural training of family medicine residents:

INTERCULTURAL CONCEPTS

- ◆ Culture is important in every patient's identity.
- ◆ Communication of cultural understanding and respect is essential for establishing rapport and confidence.
- ◆ Culture-related stresses and tensions can induce illness.
- ◆ Culture-related behaviors (e.g., religion, diet) affect patient's acceptance of and compliance with prescribed therapy.
- ◆ Nonverbal and verbal communication may differ from culture to culture.

INTERCULTURAL KNOWLEDGE

Should be specific for each culture represented and includes the following:

- ◆ Common dietary habits, foods, and their nutritional components
- ◆ Predominant cultural values, health practices, traditional health beliefs



- ◆ Family structure—patriarchal vs. matriarchal; nuclear vs. extended; role of individual members
- ◆ Effect of religion on health beliefs and practices
- ◆ Customs and attitudes surrounding death
- ◆ Significance of common verbal and nonverbal communication
- ◆ Awareness of the “culture shock” experienced by the very poor and immigrants upon entering modern health centers
- ◆ Awareness of prevailing cross-cultural tensions and psychosocial issues

INTERCULTURAL SKILLS

Should be specific for each culture represented and includes the following:

- ◆ Communicate an understanding of patient’s culture.
- ◆ Elicit patient’s understanding of patient’s culture.
- ◆ Recognize culture-related health problems.
- ◆ Negotiate a culturally relevant care plan with patient as partner.
- ◆ Interpret verbal and nonverbal behaviors in culturally relevant manner.
- ◆ Have basic or essential language proficiency.
- ◆ Apply principles of clinical epidemiology to common illnesses.

INTERCULTURAL ATTITUDES

- ◆ Recognize importance of patient’s cultural background and environment when constructing an approach to an illness.
- ◆ Acknowledge patient’s role as an active participant in his or her own care.
- ◆ Accept responsibility for the patient who has few support systems; avoid the “what can I do?” attitude when facing a patient in abject poverty or with language barriers.

(BORKAN & NEHER, 1991)

Seven stages of a developmental model of ethnosensitivity for family practice training from “ethnocentric” to “ethnosensitive”:

- ◆ **Fear.** Family physicians may fear a specific group and idea or have a general mistrust of differences. Fear is an incredibly problematic response because it is a powerful motivator. The goal is to decrease or eradicate fear by using basic approaches and understandings.



- ◆ **Denial.** In this stage, “culture blindness” or “over-generalization” are displayed. Trainees have little understanding of cultural variation and behave as if cultural differences do not exist. The goal at this stage is to “promote recognition of ethnicities” through fostering the simple awareness of cultural differences. The medical trainee must learn that “everyone has an ethnicity.”
- ◆ **Superiority.** This stage is characterized by negative stereotyping, which results from “ranking” cultural differences according to one’s own culture, or “reversal,” which results in denigrating of one’s culture as a result of identifying with another group’s attitudes, beliefs, and practices to the point of seeing it as superior. The goal at this stage is to promote the recognition of similarities between cultural groups.
- ◆ **Minimization.** The trainee acknowledges that cultural differences exist but views them as unimportant compared with similarities. The characteristics of this stage are “reductionism” and “universalism.” Reductionism, which most medical training promotes, stresses “biochemistry and pathophysiology models while de-emphasizing the medical effects of personality, family structure, and socio-cultural factors.” Universalism is the idea that universal laws and principles of human behavior exist that transcend human differences. At this stage, it is important to stress individual and group differences by stressing bio-psychosocial awareness and by debunking the belief that “common sense” is all that is needed to establish good therapeutic relationships.
- ◆ **Relativism.** This stage is characterized by the acceptance of ethnic and cultural differences, but a naiveté regarding actual knowledge of specific differences and their implications on providing care. The goals for this stage are to gain experience through cultural exploration and education and to foster empathy.
- ◆ **Empathy.** This stage involves a framework shift to be able to experience events as a patient might. Trainees exhibit “pluralism” when they are able to come outside their own worldview to come to an understanding of the patient’s value system and worldview. However, ethical decision making requires more than empathy; it requires an enrichment of cultural experiences.
- ◆ **Integration.** The culturally integrated practitioner “stands both inside and outside a culture, having both deep understanding and a critical viewpoint.” The integrated physician is able to make ethical decisions through a contextual evaluation of critical cultural and individual factors. The refinement of cultural integration can continue through fostering integrative skills and multiculturalism.



(CAMPINHA-BACOTE, 1999)

This model presents five interdependent constructs that make up cultural competence.

- ◆ **Cultural Awareness**—”The deliberate, cognitive process in which health care providers become appreciative and sensitive to the values, beliefs, lifeways, practices, and problem solving strategies of clients’ cultures.” The process includes examining one’s own prejudices and biases toward other cultures and exploring ones’ own cultural values.
- ◆ **Cultural Knowledge**—”The process of seeking and obtaining a sound educational foundation concerning the various world views of different cultures.” In addition to knowledge concerning worldviews of different cultures, knowledge regarding specific physical, biological, and physiological variations among ethnic groups is important to the process.
- ◆ **Cultural Skill**—”The ability to collect relevant cultural data regarding the clients’ health histories and presenting problems as well as accurately performing a culturally specific physical assessment.” This process involves using a culturally sensitive approach to interviewing clients about their perceptions of the health problem and treatment options.
- ◆ **Cultural Encounters**—”The process which encourages health care providers to engage directly in cross-cultural interactions with clients from culturally diverse backgrounds.” It is important to prevent stereotyping through repeated direct interactions with clients from diverse cultural groups to “refine or modify one’s existing beliefs regarding a cultural group.”
- ◆ **Cultural Desire**—”The motivation of health care providers to ‘want to’ engage in the process of cultural competence.” Only a genuine desire to work effectively with culturally diverse clients will make a successful culturally competent health care provider. Caring is central to the construct of cultural desire. The goal of the health care provider should be to reflect true caring to the client

(CARRILLO, GREEN, & BETANCOURT, 1999)

A patient-based approach to cross-cultural curricula, consisting of five content areas:

- ◆ **Basic Concepts**—Includes the meaning of “culture” and “disease,” the subjective concept of “illness,” and the attitudes that are fundamental to a successful cross-cultural encounter—empathy, curiosity, and respect.
- ◆ **Core Cultural Issues**—Includes “situations, interactions, and behaviors that have potential for cross-cultural misunderstanding,” such as issues of authority, physical contact, communication styles, gender, sexuality, family dynamics issues, among others.



- ◆ **Understanding the meaning of the illness**—Encompasses the patient’s explanatory model, which is “the patient’s understanding of the cause, severity, and prognosis of an illness; the expected treatment; and how the illness affects his or her life.” In addition to cultural factors, social factors may shape a person’s explanatory model, such as socioeconomic status and education. Another important related aspect is eliciting a patient’s explanatory model through specific methods for interviewing.
- ◆ **Determining the patient’s social context**—Includes socioeconomic status, migration history, social networks, and other factors. Social context is explored through four avenues: “1) control over one’s environment (such as financial resources and education), 2) changes in environment (such as migration), 3) literacy and language, and 4) social stressors and support systems.”
- ◆ **Negotiating across cultures**—Describes cross-cultural negotiation as a skill that is enhanced by the skills and knowledge learned in the previous four modules. Reaching a mutually acceptable agreement consists of six phases: relationship building, agenda setting, assessment, problem clarification, management, and closure. Negotiation skills can be used in addressing both explanatory models and treatment management options.

(CROSS ET AL., 1989)

Developmental continuum ranging from “cultural destructiveness” to “cultural proficiency.” The six possible points on the continuum follow:

- ◆ **Cultural Destructiveness**—Attitudes, policies, and practices that are destructive to cultures and consequently to the individuals within the culture. “A system which adheres to this extreme assumes that one race is superior and should eradicate ‘lesser’ cultures because of their perceived subhuman position.”
- ◆ **Cultural Incapacity**—Lack of capacity to help minority clients or communities, remaining extremely biased. Characteristics include “discriminatory hiring practices, subtle messages to people of color that they are not valued or welcome, and generally lower expectations of minority clients.”
- ◆ **Cultural Blindness**—Provision of services with the express philosophy of being unbiased, functioning with the belief that all people are equal and the same. Characterized by the erroneous belief that approaches used by the dominant culture are universally applicable, resulting in ethnocentric services that “ignore cultural strengths, encourage assimilation, and blame the victim.”



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- ◆ **Cultural Pre-Competence**—Recognition of weakness in serving minorities and attempt to improve services to a specific population. Characterized by the desire to deliver quality services and a commitment to civil rights, but with a lack of information on the function of culture and its impact on client populations and how to proceed.
 - ◆ **Cultural Competence**—“Characterized by acceptance and respect for difference, continuing self-assessment regarding culture, careful attention to the dynamics of difference, continuous expansion of cultural knowledge and resources, and a variety of adaptations to service models in order to better meet the needs of minority populations.”
 - ◆ **Cultural Proficiency**—The most advanced point on the continuum is characterized by holding culture in high esteem, always seeking to increase knowledge of culturally competent practice.

(CULHANE-PERA, REIF, EGLI, BAKER, & KASSEKERT, 1997)

Five levels of cultural competence:

- ◆ Level 1—No insight about the influence of culture on medical care
 - ◆ Level 2—Minimal emphasis on culture in medical setting
 - ◆ Level 3—Acceptance of the role of cultural beliefs, values, and behaviors on health, disease, and treatments
 - ◆ Level 4—Incorporation of cultural awareness into daily medical practice
 - ◆ Level 5—Integration of attention to culture into all areas of professional life
- Each of the levels has specific objectives for knowledge, skills, and attitudes.

(LEININGER, 1978)

The holistic “sunrise model” presents nine main domains that influence the care and health status of individuals, families, groups, and sociocultural institutions:

- ◆ Patterns of lifestyle
- ◆ Specific cultural values and norms
- ◆ Cultural taboos and myths
- ◆ World view and ethnocentric tendencies
- ◆ General features that the client perceives as different or similar to other cultures
- ◆ Caring behaviors
- ◆ Health and life care rituals and rites of passage to maintain health
- ◆ Folk and professional health-illness systems used
- ◆ Degree of cultural change



(LEVIN, LIKE, & GOTTLIEB, 2000)

ETHNIC: A framework for culturally competent clinical practice.

- E: Explanation** What do you think may be the reason you have these symptoms?
- What do friends, family, others say about these symptoms? Do you know anyone else who has had this kind of problem?
- Have you heard about/read/seen it on TV/radio/newspaper? (If patient cannot offer explanation, ask what most concerns them about their problems).
- T: Treatment** What kinds of medicines, home remedies or other treatments have you tried for this illness?
- Is there anything you eat, drink, or do (or avoid) on a regular basis to stay healthy? Tell me about it.
- What kind of treatment are you seeking from me?
- H: Healers** Have you sought any advice from alternative/folk healers, friends or other people (non-doctors) for help with your problems? Tell me about it.
- I: Intervention** Determine an intervention with your patient. May include incorporation of alternative treatments, spirituality, and healers as well as other cultural practices (e.g. foods eaten or avoided in general, and when sick).
- C: Collaboration** Collaborate with the patient, family members, other health care team members, healers and community resources.

(LURIE & YERGAN, 1990)

Seven key objectives for learning to deliver care to vulnerable populations:

- ◆ **Have direct experience serving as the primary physician for patients from several vulnerable population groups.** Medical residents should be given enough time with patients to adequately deal with different issues and should have the opportunity to serve patients from as many different backgrounds and with as diverse conditions as possible.
- ◆ **Become familiar with and sensitive to socio-cultural issues affecting various population groups, particularly those in geographical areas where they are likely to practice.** It is important for residents to learn how to be sensitive to patients' view of medical problems and their treatment, including information about "concepts of illness in different cultures, the

historical relationship between the population under study and the health care system, the nature of the sick role, the roles of the family, society, and religion on illness and health, the



use of lay and traditional beliefs and healing methods, and patterns of interaction with the health care community.”

- ◆ **Explore their own responses to patients who differ from themselves socially and culturally or who have lifestyles or value systems incongruent with their own.** Physicians should be given self-examinations to reflect on their own biases and should learn about the possible implications of these biases.
- ◆ **Acquire the skills needed to care most effectively for patients in vulnerable population groups.** These skills include good communication skills, understanding important tenets of communicating through interpreters, and strategies for related health issues such as managing mental illness, chemical dependency, illiteracy, violence, and sexual abuse. Such skills will help them derive satisfaction from caring for such patients.
- ◆ **Learn about the unique epidemiologies and presentations of diseases in major population groups in the United States and groups specific to their geographical areas.** Certain diseases have patterns in vulnerable populations. These patterns, as well as the role of poverty in the epidemiology of disease, should be part of the curriculum.
- ◆ **Become familiar with major health care financing programs and their effects on access to care and the practice of medicine.** Basic curriculum should cover eligibility criteria and benefits of the Medicare and Medicaid programs as well as information on other major state and local programs.
- ◆ **Develop a sense of themselves in relation to society at large.** Medical residents feel dissatisfied when they do not have success with patients. They should learn to set realistic goals for situations dealing with patients with multiple problems.

(MARVEL, GROW, & MORPHEW, 1993)

The core objectives for teaching concepts of culture in a family block rotation follow:

- ◆ Conducting a family conference (including conference structure, family dynamics, and negotiating a treatment plan)
- ◆ Identifying developmental tasks in the family life cycle (including cultural variations)
- ◆ Understanding how one's own cultural and family background influences the doctor-patient relationship
- ◆ Understanding basic family systems concepts
- ◆ Identifying cultural factors that affect health care
- ◆ Recognizing the family role in chemical dependency



(PACHTER, 1994)

Three requirements for a culturally sensitive clinician:

- ◆ **Become aware of the commonly held medical beliefs and behaviors in his or her patients' community.** Sources of ethnomedical information can be the patients themselves, office staff who reside in the community, and social science and clinical literature.
- ◆ **Assess the likelihood of a particular patient or family acting on these beliefs during a specific illness episode.** The individual's level of acculturation is likely in part responsible for his or her level of adherence to folk beliefs and behaviors. The clinician should be prepared to ask about the patient's thoughts and expectations concerning the course of illness.
- ◆ **Arrive at a way to successfully negotiate between the two belief systems.** The type of approach to treatment depends on the potential effects of the patient's belief system on the treatment outcome, as well as the ongoing physician-patient interaction. If possible, the clinician should work with the patient to combine the folk and medical therapies and not attempt to dissuade the patient from the folk beliefs and practices. The collaboration between folk healers and medical practitioners can also be effective in negotiating belief systems.

(SCOTT, 1997)

Practical guidelines for a culturally appropriate approach to health care that can be individualized for each patient:

- ◆ Recognize intraethnic variation.
- ◆ Recognize ethnic- and culture-bound gender role norms.
- ◆ Elicit and understand the patient's concept of the sick episode.
- ◆ Identify sources of discrepancy between physician and patient's concept of disease and illness.
- ◆ Validate the patient's perspective.
- ◆ Provide education and work within the patient's conceptual system.
- ◆ Negotiate a "clinical reality" on which patient and physician can base an approach to treatment.
- ◆ Validate resolution of the patient's concerns about illness and disease at the end of the encounter.

- ◆ When the assistance of a translator is required, encourage the use of the patient's own words.
- ◆ Ensure that employees who will serve regularly as translators, but who are not trained in biomedicine, should complete a brief program in cultural sensitivity/competence.



- ◆ Provide patients with cards printed with routine requests in English and their native language.
- ◆ Consider ethnically and culturally acceptable diets, food preferences, and religious beliefs.

(SHAPIRO & LENAHA, 1996)

A solution-oriented approach to cross-cultural training for family practice residents, identifying four general strategies:

- ◆ **Evidence-based evaluation of cultural information**—Evidence-based research attempts to specify particular cultural constructs that have clear linkages to social behavior, rather than making broad generalizations about cultural differences. Understanding evidence-based research is important for residents to evaluate the quality and integrity of cross-cultural information.
- ◆ **Inductive models for learning about cultural differences**—An inductive model focuses on the patient and family, rather than on a theory, as the center of analysis. Information obtained directly from the patient through ethnographic techniques has the greatest importance, whereas general information about the patient's culture is considered, but requires further validation.
- ◆ **Narrative approaches**—This refers to building a life-history review of the patient, perhaps over a long period of time, to establish a sense of the patient's essential values, assumptions, and expectations and to communicate respect for the individual.
- ◆ **Cultural flexibility**—Residents must develop a flexible patient interaction style in which they learn to adapt between traditional and modern orientations. This involves acknowledging potential differences; for example, patients with a traditional orientation may value a strong family identity and loyalty, whereas a modern orientation may value individual autonomy.

(STUART & LIEBERMAN, 1993)

BATHE: A useful mnemonic for eliciting the psychosocial context.

B: Background A simple question. "What is going on in your life?" elicits the context of the patient's visit.



<i>A: Affect</i>	(The feeling state) Asking “How do you feel about what is going on?” or “What is your mood?” allows the patient to report and label the current feeling state.
<i>T: Trouble</i>	“What about the situation troubles you the most?” helps the physician and patient focus, and may bring out the symbolic significance of the illness or event.
<i>H: Handling</i>	“How are you handling that?” gives an assessment of functioning and provides direction for an intervention.
<i>E: Empathy</i>	“That must be very difficult for you” legitimizes the patient’s feelings and provides psychological support.

APPENDIX C: GUIDELINES AND KEY ASPECTS OF ORGANIZATIONAL SUPPORTS FOR CULTURALLY COMPETENT CARE

(BRACH & FRASER, 2000)

Nine techniques for cultural competence in health systems most frequently described in cultural competency literature (the authors' explanations are summarized):

- ◆ **Interpreter services.** Approaches to interpretation include on-site professional interpreters, ad hoc interpreters (staff members, friends and family members, strangers in the waiting room), and simultaneous remote interpretation with off-site professional interpreters.
- ◆ **Recruitment and retention.** Techniques for recruiting and retaining minority group members in health systems include 1) creating minority residency or fellowship programs, 2) hiring minority search firms, 3) adapting personnel policy to create a comfortable and welcoming workplace for minority group members, 4) mentoring minority employees by senior executives, 5) subcontracting with minority health providers, 6) tying executive compensation to steps taken to match hiring to community needs, 7) expanding on traditional affirmative action programs aimed at attracting employees who match the race and ethnicity of the patient populations, 8) establishing a set of principles for the respectful treatment of all people, 9) reviewing the fairness of human resource practices and compensation of all staff, and 10) tracking staff satisfaction by racial and ethnic groups.
- ◆ **Training.** Cultural competence training programs aim to increase cultural awareness, knowledge, and skills, leading to changes in staff behavior and patient-staff interactions. Training may be part of undergraduate or graduate medical education, an orientation process for new staff, or in-service training. It can also be a separate activity, either a regularly occurring activity, or a one-time occurrence, or by infusion, which integrates a multicultural perspective throughout a curriculum or training activities.
- ◆ **Coordinating with traditional healers.** Many minority Americans use traditional healers while they are seeking biomedical care. Clinicians need to coordinate with these healers as they would with any other care provider to ensure continuity of care and avoid complications owing to incompatible therapies. In addition, coordinating therapies with traditional ones may increase patient compliance.
- ◆ **Use of community health workers.** Members of minority communities can be used to reach out to other community members as well as to provide direct services such as health education



and primary care. They act as liaisons that bring in individuals in need of care, provide cultural linkages, overcome distrust, and contribute to clinician-patient communication, thereby increasing access to care.

- ◆ **Culturally competent health promotion.** In an attempt to make health-promotion efforts more culturally competent, culture-specific attitudes and values have been incorporated into messages and materials such as screening tools and public information campaigns.
- ◆ **Including family and/or community members.** Some minority groups believe that family members should be involved in health care decision making. Involving families and community members may be crucial in obtaining consent for and adherence to treatment.
- ◆ **Immersion into another culture.** Members of one cultural group may develop sensitivity and skills working with another culture by immersing themselves in that culture. It is reported that immersion enables participants to overcome their ethnocentrism, increase their cultural awareness, and integrate cultural beliefs into health care practices.
- ◆ **Administrative and organizational accommodations.** A variety of decisions related to clinic locations, hours of operation, network membership, physical environments, and written materials also can affect access to and use of health care. Health systems can make themselves more welcoming and accessible to minority patients.

(BUREAU OF PRIMARY HEALTH CARE, N.D.)

Guidelines for Assessing a Program's Cultural Competence (summarized)

- ◆ **Experience or track record of involvement with the target audience.** The organization should have a documented history of positive programmatic involvement with the population or community to be served.
 - ◆ **Training and staffing.** The staff of the organization should have training in cultural sensitivity and in specific cultural patterns of the community proposed for services. Staff should be identified who are prepared to train and translate the community cultural patterns to other staff members. There should be clear, cultural objectives for staff and for staff development. Emphasis should be placed on staffing the initiative with people who are familiar with, or who are members of, the community to be served.
 - ◆ **Community representation.** The community should be a planned participant in all phases of program design. A community advisory council or board of directors of the organization with decision-making authority should be established with members of the targeted cultural group represented.
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- ◆ **Language.** If an organization is providing services to a multi-linguistic population, there should be multi-linguistic resources, including skilled bilingual and bicultural translators. Translated printed and audiovisual materials should be provided, and individuals who know the nuances of the language as well as the formal structure should do the translation.
- ◆ **Materials.** Audio-visual materials, public service announcements (PSAs), training guides, print materials, and other materials should be culturally appropriate for the community to be served. Pretesting with the target audience should provide feedback from community representatives about the cultural appropriateness of the materials under development.
- ◆ **Evaluation.** Evaluation methods and instruments should be consistent with cultural norms of the groups being served. The evaluation instruments chosen should be valid in terms of the culture of specific groups targeted for interventions. The evaluators should be sensitized to and familiar with the culture whenever possible.
- ◆ **Implementation.** There should be objective indicators that the organization understands the cultural aspects of the community that will contribute to the program's success and avoid pitfalls.

(COYE & ALVAREZ, 1999)

California's Medicaid managed care organization, Medi-Cal, instituted contract requirements for cultural competence that have had a substantial impact on health plan services and operations. The requirements have led to training programs and services designed to make health care access easier and health care services more effective for multiethnic populations. The following are key components from an early review of contract requirements and implementation:

- ◆ **Defining criteria for threshold populations.** Because of the great diversity of racial, ethnic, and linguistic groups served by Medi-Cal, plans and providers need a clear definition of the populations and service areas for which specialized services are required. Medi-Cal's threshold and concentration criteria appear to be useful toward this end.
- ◆ **Translation of plan materials.** Although the process of state approval is apparently cumbersome, it has spurred health plans to make their member services and health education materials uniformly available in languages appropriate to the needs of their members.
- ◆ **Complete access to interpreter services.** By requiring plans to provide 24-hour telephone access and establish protocols for scheduling interpreters when necessary, Medi-Cal has ensured a baseline availability of language services for beneficiaries.



- ◆ **Community participation in plan services development.** The establishment of community advisory committees has provided plan members with an organized framework for representing their needs and reviewing plan services. In addition, health plan staff gain insights from their direct interactions with members.
- ◆ **Development of training programs.** As plan services directors and provider organizations focus on meeting the needs of specific linguistic and cultural groups, administrators have recognized the need for more staff education, and all plans and provider organizations now have training programs.
- ◆ **Use of community health workers.** The implementation of contract requirements has led to increasing experimentation with the use of community health workers. Because of the limited time available between patients and clinical providers in most health care settings today, community health worker programs may offer an effective means of support for the health care management needs of all patients.
- ◆ **Use of plan surpluses.** Several Medi-Cal local initiatives reported plan surpluses at the end of their first year, which they allocated in part to community education, risk prevention, and disease management initiatives aimed at non-English speaking populations.
- ◆ **Minority physicians and traditional providers.** Medi-Cal policy calls for local initiatives to include traditional providers in their managed care networks. Mainstream plans reported that this process led them to expand their provider networks substantially.
- ◆ **Public hospitals and clinics.** The Medi-Cal managed care expansion plan proposed the development of local initiatives largely to ensure public and community hospital participation in managed care at levels adequate for these institutions to continue to receive Medicaid disproportionate share payments. The actual effect of this requirement, however, has been to maintain the availability of multicultural services at these hospitals.

(GOODE, 1999)

The National Center for Cultural Competence of the Georgetown University Child Development Center's checklist for organizations to help them to get started with planning, implementing and evaluating culturally competent service delivery systems in primary health care settings (summarized)

- ◆ Convene a cultural competence committee, work group, or task force within your program or organization that includes representation from policy making, administration, practice/services delivery, and consumer levels.



- ◆ Ensure that your organization's mission statement commits to cultural competence as an integral component of all its activities.
- ◆ Determine the racially, ethnically, culturally, and linguistically diverse groups within the organization's geographic locale. Assess the degree to which these groups are accessing services and their level of satisfaction.
- ◆ Determine the percentage of the population that resides in the geographic locale served by your organization affected by the six health disparities identified by HRSA (cancer, cardiovascular disease, infant mortality, diabetes, HIV/AIDS, and child and adult immunizations). Collaborate with consumers, community-based organizations, and informal networks of support to develop approaches for delivering preventive health messages in a culturally and linguistically competent manner.
- ◆ Conduct a comprehensive program or organizational cultural competence self-assessment. Determine which instrument(s) and or consultant(s) best match the needs of your organization. Use the self-assessment results to develop a long-term plan incorporating cultural and linguistic competence into all aspects of your organization.
- ◆ Conduct an assessment of what organizational personnel perceive as their staff development needs related to the provision of services to racially, ethnically, culturally, and linguistically diverse groups.
- ◆ Convene focus groups or use other approaches to solicit consumer input on professional or staff development needs related to the provision of culturally and linguistically competent health care.
- ◆ Network and dialogue with other organizations that have begun the journey toward developing, implementing, and evaluating culturally competent service delivery systems. Adapt processes, policies, and procedures consistent with your organization's needs and encourage mechanisms to share training resources.
- ◆ Aggressively pursue and use available resources from federally and privately funded technical assistance centers that catalog information on cultural and linguistic competence, primary health care, and related issues (e.g., treatment, interventions, how to work with natural healers, outreach approaches, consumer education programs).
- ◆ Convene informal forums to engage organization personnel in discussions and activities to explore attitudes, beliefs, and values related to cultural diversity and cultural and linguistic competence.



- ◆ Identify and include budgetary expenditures each fiscal year to develop resources and to facilitate professional development through conferences, workshops, colloquia, and seminars on cultural and linguistic competence and other related issues.
- ◆ Gather and categorize resource materials related to primary health care and culturally diverse groups for use as references by organization personnel.
- ◆ Build and use a network of natural helpers, community informants, and other “experts” who have knowledge of the diverse groups served by your organization.
- ◆ Network with advocacy organizations concerned with specific health care, social and economic issues affecting racially, ethnically, culturally, and linguistically diverse communities. Solicit their involvement and input in the design, implementation, and evaluation of primary and community-based health care service delivery initiatives.

(LURIE & YERGAN, 1990)

Organizational goals for supporting training of medical residents to care for “vulnerable populations,” whom the authors define as “those patients whom a substantial number of physicians regard as undesirable because they lack a means to pay for medical services, because they have medical problems that are difficult to manage, or because they have characteristics that give them low social status” (p. S27). Included in this definition are minority patients and non-English speakers. Goals for preparing residents to care for vulnerable populations include the presence of the following:

- ◆ A commitment to provide ambulatory as well as inpatient care for indigent patients and patients from other vulnerable groups.
- ◆ Adequate physician and non-physician staff to ensure that a satisfactory educational experience is provided for residents learning to care for these populations.
- ◆ Ongoing discussion of the ways (financial and other) in which departments and hospitals limit access to care.
- ◆ Individuals and institutions that model socially responsible provider behavior and recognition and support of faculty who do advocacy-oriented research on vulnerable population groups.
- ◆ A commitment to recruit and support faculty and house staff from racial and ethnic minority groups.
- ◆ Explicit learning objectives for teaching about the care of vulnerable populations in the ambulatory setting, and assurances that they are met.



(RUTLEDGE, 2001)

Major elements of an effective diversity or culturally competent plan:

- ◆ Acknowledge and accept the importance of delivering culturally competent care by including this principle in the institution's governing documents and adopting it in everyday operations.
- ◆ Ensure that all stakeholders—medical staff, employees, and volunteers—understand the institution's mission, vision, and values and how diversity and cultural competency are melded into those beliefs.
- ◆ Ensure that executives at the organization buy in and commit to this mission, vision, and values by including them in their individual goals and objectives and relating them to their compensation incentives.
- ◆ Address the issue of diversity at the departmental level, which is a precursor to promulgation of policies and value statements throughout the organization.
- ◆ Develop or revise policies, procedures, and/or operating principles.
- ◆ Carry out a comprehensive orientation of the workforce.
- ◆ Appoint an internal steering committee charged with developing a measurable diversity plan, which the board of directors is responsible for adopting. Members of this committee should represent both the clinical support and administrative functions of the institution. The committee's function can include but is not limited to (summarized):
 - conducting environmental assessment in cultural competence;
 - establishing a framework for integrating dimensions of cultural competence into all aspects of the organization;
 - developing an implementation strategy with timeline;
 - developing the orientation/educational process;
 - ensuring that policies and operating plan are carried out;
 - ensuring that each functional operating unit has an implementation plan; and
 - developing accountability measurements.

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¹ American Institutes for Research. (2002). Teaching cultural competence in health care: A review of current concepts, policies and practices. Report prepared for the Office of Minority Health. Washington, DC: Author.