SECTION IV: THREE THEMES OF THE CLAS STANDARDS

In 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 individual patients 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.

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," which is one of five 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

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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

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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.

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, & Morphew, 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 the patient's own 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 up 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.

In relation to the CLAS standards, the main themes that emerged from this content analysis include concepts that pertain to both culturally competent care (first CLAS theme) and language access services (second CLAS theme). Most of the main themes pertain to the physician-patient relationship, and one theme (working with interpreters) has to do with linguistic access. Organizational supports (third CLAS theme) and the more programmatic aspects of language access services were not found to be main curricular themes. However, these findings may be a reflection of the limitations of our curricular sample and do not imply that themes related to organizational supports and programmatic aspects of language access services are not important topics for family physicians.

Very few of the curricula examined focus exclusively on studying specific elements that characterize various racial and ethnic groups. This approach is considered outdated by experts, since it can foster and reinforce biases and stereotypes that already exist about racial and ethnic groups. Most programs integrate content with the application of skills. Modern curricula explore the various types of situations and challenges that are likely to occur in cross-cultural medical encounters and teach students to identify and deal with such situations as they arise (Carrillo et al., 1999). Lectures, case studies and discussions, community speakers, guest lecturers, panels, use of videotapes, simulated experiences, role-plays with simulated patients, and critical incidents were all general pedagogical methods employed in the curricula reviewed. Although our curricular analysis was limited in sample, our analysis revealed that most curricula emphasize the application of skills through real, simulated, or demonstrated cases. In creating self-motivated learning modules for family physicians for our current project, it will be important to use effective methods of applied, experiential learning.

Assessment tools used in the sample of curricula included faculty and participant evaluation of the curriculum, participant self-evaluation of cultural competence, faculty evaluation of participant's cultural competence, and pre- and post-curriculum evaluation. There are multiple challenges to conducting reliable assessments of specific cultural competence curricula. Reliable assessments of program effectiveness, comparison studies of training programs, and reliable measures of physician or patient outcomes do not exist. While several tools exist for assessing cultural competence of both the individual physician and the institution, there are no agreed upon common measures for cultural competence (Fortier, 1999; HRSA 2001b). A recent study of professional competence found that few assessments are successful at measuring competencies other than core knowledge, problem solving skills, and basic clinical skills (Epstein & Hundert, 2002). This reflects the traditional Western model that values knowledge of facts and mastery of clinical skills over patient focused interactions, communication skills, and processes of self-reflection and self-critique (Tervalon & Murray-Garcia, 1998). Thus, the problems with measuring cultural competence are inherent to measuring professional competence in the context of Western medicine in general. Successful measurement of culturally and linguistically appropriate services

will first depend on the establishment of common measures. It will be important to use multiple assessment methods that evaluate applied skills in real settings and contribute to the learning process (Epstein & Hundert, 2002). Strategies may include participant observation, key informant interviews, trainees' journals, mechanisms for community, peer or patient feedback (Tervalon & Murray-Garcia, 1998), and measures that predict clinical outcomes (Epstein & Hundert, 2002).

Unfortunately, there is a lack of information in the literature on the most effective teaching and assessment strategies to inform the creation of new modules. We will look to the guidance of our National Project Advisory Committee, as well as the concept papers commissioned from experts in the field especially for this project, to design the curricular aspects of the modules.

SECTION VI: CONCLUSION

As is evident from this environmental scan, a growing body of information is available related to curricula in cultural competence. Information was gathered in five categories in order to obtain a broad perspective: published literature, medical and nursing schools, federal and state agencies, public and private health care, and consumer and advocacy groups. This report consists of information in three main sections pertaining to the teaching of cultural competence to family physicians. In this section, we review the implications resulting from the environmental scan for the creation of curricular modules that have the CLAS standards as a framework.

To provide a context and a rationale for this project, we presented an overview of the current health research and policy issues in several areas that shape health care. We illustrated cultural competence as an important tool for improving health care in three areas of health research—eliminating racial and ethnic health disparities, increasing access to health care, and improving quality of care. In today's health care climate, the potential of cultural competence to increase quality of care is a particularly important motivating factor for physicians to undergo training in cultural competence. Recent developments in grassroots activities, research, accreditation, and policies also reflect an increasing emphasis on culturally competent care and the importance of training in cultural competence. Accrediting organizations play a major role in the ongoing refinement of continuing medical education requirements for physicians. Partnering with professional organizations as well as accreditation organizations may be an important way to establish more stringent curricular standards in cultural competence. With limited time for additional training, significant motivating factors are necessary in order to engage family physicians in cultural competence training.

A large body of information is available pertaining to the three areas of CLAS and relevant to teaching core aspects of cultural competence to family physicians. Several themes emerged for each of the three major CLAS areas. In the first area, culturally competent care, the main themes for consideration as content for the development of the curricular modules are a patient-centered focus; effective physician-patient communication; fact-centered vs. attitude/skill-centered approach to acquiring cultural competence; the acquisition of cultural competence as a developmental model; and an understanding of alternative sources of care. In the area of language access services, the prominent themes are appropriate interpretation services; training physicians to work with interpreters; lack of resources for language access services; and language access strategies. The main themes related to organizational supports for cultural competence that may be important core knowledge for enhancing physicians' capacity for institutional change are a strong commitment to cultural competence at every level of the organization; community participation; the recruitment of minority and community health workers; training and professional

development; and organizational assessment. This project to create curriculum modules will represent the first effort to organize a curriculum around the framework of the CLAS standards, which will provide a comprehensive framework for learning cultural competence.

From our review of curricular issues, including an analysis of a small sample of curricula, we found that while many training materials in cultural competence have been developed, there is very little information available regarding the most effective teaching and assessment strategies (Fortier & Bishop, forthcoming; Fortier, 1999). Information about cultural competence training in continuing medical education and workplace settings is particularly scarce. However, an emphasis on the application of skills and knowledge to real situations was considered essential. All curricula in the sample used case studies, vignettes, or direct experience with simulated or real patients as teaching strategies. The assessment strategies in our sample of curricula were largely subjective and most focused on evaluating the curricula themselves. Two important goals of a cultural competence assessment tool are to evaluate participants in real, applied settings, and to facilitate further learning through feedback.

Despite the need for further research, this environmental scan shows that much information and many resources are available that address all three areas of the CLAS standards. The information available provides a sufficient basis to begin defining modules for cultural competence for family physicians. However, the recommendations of the National Project Advisory Committee, as well as insight from the five expert concept papers commissioned for this project, will be essential information for designing the curricular modules.

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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.

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♦ **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.

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- ♦ **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."

- ♦ **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 & LENAHAN, 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.

A: Affect	(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.
T: Trouble	"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.
H: Handling	"How are you handling that?" gives an assessment of functioning and provides direction for an intervention.
E: Empathy	"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.

- ♦ **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 or 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.

American Institutes for Research