U.S. Department of Health and Human Services

HRSA

Health Resources and Services Administration

TRANSFORMING THE FACE OF HEALTH PROFESSIONS THROUGH CULTURAL AND LINGUISTIC COMPETENCE EDUCATION:
THE ROLE OF THE HRSA CENTERS OF EXCELLENCE

United States Department of
Health & Human Services

Transforming the Face of Health Professions Through Cultural and Linguistic Competence Education: The Role of the HRSA Centers of Excellence

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Preface

In 2002, the Institute of Medicine issued an important report, *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care,* which showed that racial and ethnic minorities in the United States are less likely to receive equal routine medical procedures and that they experience a lower quality of health services. A large body of research demonstrates significant variation in the rates of medical procedures by race, even when insurance status, income, age, and severity of conditions are comparable, the report said.

Furthermore, minorities of all kinds, including Black or African American, American Indian or Alaska Native, Native Hawaiian or other Pacific Islander, Hispanic or Latino, and many Asian Americans, are less likely to get certain medications or procedures, such as kidney dialysis or transplants. By contrast, the report added, they are more likely to receive certain less-desirable procedures, such as lower limb amputations for diabetes and other conditions. The committee recommended a number of ways to reduce racial and ethnic disparities in health care, including increasing awareness about disparities among the general public, health care providers, insurance companies, and policy-makers.

Recognizing the significant role that the Centers of Excellence can play in ensuring that cultural and linguistic competency is not an adjunct to health care, but is a core component of quality health care. The Health Resources and Services Administration (HRSA) of the United States Department of Health and Human Services is working with the Centers of Excellence (COE) program to reduce disparity in the health care system by increasing the number of underrepresented minorities working in the health field. HRSA and the COEs also are working together to foster the teaching of cultural and linguistic competency content in the educational curricula among HRSA grant recipients.

This curriculum guide, "Transforming the Face of Health Professions Through Cultural & Linguistic Competence Education: The Role of the HRSA Centers of Excellence," is one result of the efforts of HRSA and the COEs. The publication of this guide is a significant achievement brought about by the efforts of a large number of dedicated individuals who have worked over many months to develop a cohesive and valuable curriculum guide.

The staff of HRSA wish to commend the efforts of the Expert Team and Magna Systems Inc., which have worked for more than 18 months to pull together all of the many and disparate elements contained in this curriculum guide. We also wish to acknowledge the significant contribution of the COEs themselves and the steps they are taking in teaching cultural and linguistic competence and fostering an environment in which the health professions educational institutions learn from each other about the best ways to enhance culture and linguistic competency education.

As the demography of the United States changes, the issue of disparity in health care becomes more important each day. Our Nation's health profession schools—and particularly the COEs—have been working for many years to develop methods of serving our Nation's underserved and vulnerable populations. The COEs in particular have done so successfully and creatively.

But it is clear that we need to do more to raise awareness of the problem among all health care providers, to improve approaches to health care in all settings that demonstrate cultural and linguistic competence, and to improve diversity in the U.S. health care workforce.

HRSA has a long-standing commitment to cultural and linguistic competence, and has addressed the problem of disparity in health care by working in partnership with the COEs, as well as providing funding to grantees that serve the disadvantaged, underserved, and diverse populations of the United States. HRSA believes strongly that a key component to solving the problem of disparity in health care is to have a diverse workforce that is culturally and linguistically competent. We envision that this curriculum guide is but one step along the road to developing such a workforce.

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Rockville, Maryland
March 2005

Opening Commentaries

As a way of providing a general context for the materials in the Curriculum Guide, two Nationally recognized experts in the field of cultural and linguistic competence in health care were asked to comment on its format, content, and potential value to those who educate health care professionals. In the following commentaries, they not only accomplish this task, but also provide important food for thought and cautionary insights from both clinical and educational perspectives.

Commentary I: Transforming the Face of Health Professions through Cultural and Linguistic Competence Education

By Joseph Betancourt, M.D., M.P.H.

Joseph Betancourt, MD, MPH, is the Senior Scientist in the Institute for Health Policy, the Program Director for Multicultural Education in the Multicultural Affairs Office of the Massachusetts General Hospital-Harvard Medical School in Boston, and an Assistant Professor of Medicine in the Harvard Medical School.

Consider these situations:

> *A 54-year-old Hispanic woman with hypertension whose blood pressure has been difficult to control because, although she says she takes her medication every day, she believes she knows when her pressure is high and thus takes it at different times of the day, and occasionally not at all.*
>
> *A 64-year-old African-American man who has angina but is reluctant to go for a cardiac catheterization because of mistrust due to a poor experience a family member had in the health care system, and memories of the invasive procedures done as part of the Tuskegee Syphilis Study.*
>
> *A 42-year-old limited-English proficient Chinese man whose 8-year-old asthmatic daughter is being given herbal remedies (in addition to her prescribed inhalers) for her condition because this tradition has been passed down for generations.*
>
> *A 72-year-old Italian woman who has just had a CT scan consistent with metastatic colon cancer whose son asks the surgeon not tell her the diagnosis because it will "kill her".*

In almost every clinical setting across the Nation, health care professionals face scenarios like these each day. In fact, these are all real patients and real clinical cases. For each of these individuals, culture plays a large role in shaping their health values, beliefs, behaviors, and choices. Interestingly, though, the situations presented here are common *across* cultures for many patients. Currently, an educational movement referred to as "cultural and linguistic competence" has emerged, with the goal of providing health care professionals with the knowledge and skills to manage these "cross-cultural" challenges effectively in the clinical encounter. This field is in fact not new, yet has been re-energized over the last ten years with pronouncements by the Institute of Medicine, American

Medical Association, and the American Nursing Association, among others, that cultural and linguistic competence is necessary for the effective delivery of health care in the United States.

Many have considered cultural and linguistic competence to simply be the skills or strategies necessary for addressing language barriers in a clinical encounter, or learning as much as one can about specific patients from specific cultures. Whereas the former is extremely important and remains a key component of such competence, the latter is more problematic. Previous efforts in cultural and linguistic competence have aimed to teach about the attitudes, values, beliefs, and behaviors of certain cultural groups—such as the key practice "do's and don'ts" for caring for the "Hispanic" patient, for example. While in certain situations learning about a particular local community or cultural group can be helpful (following the principals of community-oriented primary care), a closer examination of the definition of culture highlights that these efforts—when broadly applied—are reductionist and can lead to stereotyping and oversimplification of culture.

The curriculum development project, *"Transforming the Face of Health Professions through Cultural and Linguistic Competence Education,"* aims to address this tension by providing a guide consisting of strategies, tools, and resources for implementing and integrating cultural and linguistic competency content and methods into existing academic programs under the leadership of the HRSA Centers of Excellence. Through the use of an expert consensus process, this curriculum guide provides a template and starting point for cultural and linguistic competence education ranging from guiding principles on the issue and implementation strategies to evaluation, dissemination, and a compendium of resources for teaching.

Pedagogically, this project highlights that cultural and linguistic competence has evolved from gathering information and making assumptions about various cultural groups and their beliefs and behaviors to developing of a set of skills that are in essence an expansion of the concept of patient-centered care. It expands the repertoire of knowledge and skills classically defined as being "patient-centered" to include those that are *especially* useful in cross-cultural interactions, but remain vital to all clinical encounters. This guide includes frameworks for teaching health care professionals to be aware of certain cross-cutting social and cultural issues that affect all patients, while providing methods to deal with information clinically through negotiation once it is obtained. It also provides methods for eliciting patients' understanding of illness, strategies for identifying and bridging different styles of communication, skills for assessing decision-making preferences and the role of family, techniques to determine the patient's perception of biomedicine and use of complementary and alternative medicine, tools for recognizing sexual and gender issues, mechanisms for negotiation, and the importance of being aware of issues of mistrust, prejudice, and the effect of race and ethnicity on clinical decision-making. The project stresses that, while it is important to understand all patients' health beliefs, it may be particularly crucial to understand the health beliefs of those who come from a different culture or have a different health care experience. In sum, all of these skills would assist health care providers with the patients presented here.

The HRSA Centers of Excellence now have the opportunity to expand their role in cultural and linguistic competence education. This project forms the foundation for a broad portfolio of educational methods that can be considered in this process. It has a particularly high value as a guide and as a grounding set of principles in the field, which should be expanded upon by the COEs as local need dictates.

Cultural and linguistic competence can be taught and learned. Just as in many other areas of clinical education, case-based, interactive sessions that highlight the clinical applications of such competence are the gold standard. When utilized in an inductive manner, selectively when the clinical scenario dictates (just as one would use the review of systems), these skills provide a window into the individual patient's values, beliefs, and behaviors that are relevant to the process of health care delivery. In conclusion, these are skills that can be used by any health care professional, in any clinical setting, no matter where the practice, in an effective and time-efficient manner.

Boston, Mass.
March 2005

Commentary II: Gaining Insight into the Framework, Elements, Topics, Content, and Resources Relevant to Cross-Cultural Education

By Jerry Johnson, M.D.

Jerry Johnson, M.D., is a professor of medicine and project director and principal investigator for the Center of Excellence for Diversity in Health Education and Research at the University of Pennsylvania, School of Medicine, in Philadelphia.

Culture, the shared values, beliefs, and behaviors of members of a group, influences the presentation of symptoms by patients, the decisions of physicians, and the patient's receptivity to recommendations. Thus, culture profoundly influences diagnosis, treatment, and responsiveness. On the one hand, cultural differences lead to miscommunications and misunderstandings that lead to misdiagnoses. More commonly, practitioners miss opportunities for optimal illness management. Thus, practitioner understanding and recognition of the cultural context of the patients' illness is essential to a successful therapeutic relationship. Some have argued that physicians should not attempt to learn ethnic-specific cultural characteristics but should instead learn a generic approach to cross-cultural interactions. In support of this thinking there is ample evidence that belonging to a racial or ethnic group is not tantamount to adherence to the traditional cultural beliefs of that group. Other factors intermingled with ethnicity influence health beliefs: gender, social and economic class, age, the length of time in the United States, whether the patient lives in a rural or urban area, level of education, and language. Nevertheless, since many traditional health beliefs and practices originate in distinct ethnic groups, ethnicity is an important clue to common cultural beliefs. While a generic approach is helpful, the physician informed of cultural tendencies is better prepared to ask the right questions, understand the patient's response, avoid confusion and misunderstandings, and negotiate differences in thinking. The skillful practitioner uses knowledge of cultural beliefs and practices to enhance, rather than detract, from the ability to understand each individual as a unique person.

This curriculum guide presents insights into the conceptual framework, elements, topics, content within topics, and resources relevant to cross-cultural education and training in the health professions. Most important, the resources represent a wealth of information and experience that educators experienced in teaching in this field or newcomers can use. While directed to Centers of Excellence funded by the HRSA, the guide is applicable to any health care program or institution. The targeted trainees range from students to faculty, though at times the targeted population is unclear. Experienced educators will value the resources, the numerous examples of teaching methods used by their colleagues, and the insights to evaluation. Less experienced educators will find helpful hints in all aspects of cross cultural education from planning to delivery. They will still have to match the content and methods to the larger curricula in which it must fit.

In addition to focusing on current and future practitioners, the guide contains multiple references to organizational competence and assessment. Moreover, the organizations may be teaching institutions (health schools) or may be sources of care (such as hospitals and health systems). While practitioner performance (competence) can be modified by teaching, and schools may be susceptible to change by faculty (who are ostensibly teachable), I'm unconvinced that organizations that deliver care (meaning hospitals and health systems) can be influenced by teaching. Educators and investigators may still wish to assess the cultural competence of these delivery systems, but

changing the competence of delivery systems should not be an expected outcome of this or any educational guide.

The curriculum is not a substitute for leadership or commitment to cross-cultural education. Nor is it a substitute for intimate knowledge of the unique, but limited, opportunities for curricula change of each institution, and the need to adapt teaching methods to the overall curricula of the school. Undoubtedly, the content will overlap with materials taught in some institutions under the auspices of professionalism, humanism, ethics, introduction to history taking, or another title suggesting nothing about culture. This overlap is not a criticism, since the guide should enhance or complement those courses rather than compete with them. Its length may present some problems; it has some redundancies, and some sections may seem overly philosophical (interesting but difficult to know how to translate into teaching). Nevertheless, the information to be gleaned is worth the effort.

Chapters 3 through 10 offer the full range of perspectives of cross-cultural education. Some of the more interesting perspectives follow:

In Chapter 3 (Strategies for Success), the rationale for education programs on cross cultural care is discussed. Among these reasons, the reader should be cautious about expecting educational programs to solve the multifaceted tasks of eliminating health disparities. Indeed, one would not expect competence in taking an appropriate medical history of a person with heart failure to result in improved outcomes of persons with heart failure. Several models or standards of competence are discussed. The reader will want to distinguish those that focus on the practitioner (Bell and Evans, and Bennett) from those that focus on the organization (CLAS, Cross, and Lewin).

Chapter 4 (Establishing a Framework) is related to the previous chapter's focus on the organization, but offers a more formal conceptual and philosophical underpinning (Banks and Campinha-Bacote), a process of instructional systems development.

Chapter 5 (Content) focuses on content, as reflected in attitudes, knowledge, and skills. The reader will find the full range of the content areas of cross-cultural education, and models of some elements of curricula. Note that these examples represent only a fraction of what should be taught.

Chapter 6 (Delivery) overlaps with and elaborates on the framework and conceptual issues of Chapter 3 and, to a lesser extent, the content of chapter 5. The highlight of the chapter may be the multiple tools that are introduced (Chapter 10, Resources, contains still more such tools). Since the number of hours in a curriculum is fixed and limited, each institution will have to establish priorities, sequence the courses, modify the content and delivery method to match different levels of trainees, and match the courses to the larger curriculum.

Chapter 7 (Assessment and Evaluation) begins with a framework and concludes with several useful examples, including questionnaires and standardized patient protocols. One of the proposed methods of evaluation was applied as part of a research project, a funding barrier that may prohibit others from using this approach.

Chapter 10 (Resources) is one of the most comprehensive resource guides the reader will find.

This guide is a wonderful resource for all persons interested in cross-cultural education and training in the health professions.

Philadelphia, PA
March 2005

Executive Summary

Ensuring cultural and linguistic competency among health care professionals is a critical issue that the U.S. health care system must address in order that all individuals residing in the United States, regardless of race, ethnicity, gender, age, language, country of origin, sexual orientation, religion/spirituality, socioeconomic class, political orientation, educational/intellectual levels, and physical/mental ability have access to and receive quality health care. Cultural and linguistic competency is not an adjunct to, but a core component of quality health care. The focus on cultural and linguistic competency in this curriculum guide is based on the understanding that all organizations and individuals operate within cultural frameworks, and that health care providers have an obligation to respectfully consider these cultural frameworks when they are designing and delivering health care services. The training of health care professionals should provide the skills and knowledge that will allow health care practitioners to incorporate cultural and linguistic competency into the standard practice of each particular discipline.

In 1991, the Health Resources Services Administration (HRSA) of the Federal Department of Health and Human Services created the Centers of Excellence (COE) Program. The program was designed to support excellence in health professional education for underrepresented minorities (URM) in health professional schools of medicine, dentistry, pharmacy, and mental health (Note: Nursing and allied health professional schools are not included in the HRSA COE Program but may still find this curriculum guide useful in developing cultural and linguistic competency in their institutions).

Definition: "Underrepresented minority," (abbreviated as URM in this report)

In this report, the term "underrepresented minority" is defined as racial and ethnic populations who are underrepresented in a designated health profession discipline relative to the percentage of that

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racial or ethnic group in the total population. This definition would include Black or African American, American Indian or Alaska Native, Native Hawaiian or other Pacific Islander, Hispanic or Latino, and any Asian other than Chinese, Filipino, Japanese, Korean, Asian Indian, Thai, or Vietnamese/Southeast Asian.

HRSA COEs differ from other Centers of Excellence programs (such as Women's COEs) in that they focus primarily on racially and ethnically underrepresented minorities in health professional programs. As a program intended to reduce disparity in the health care system by increasing the number of URMs in the health field, the HRSA COE program was one of the earliest programs to mandate the teaching of cultural and linguistic competency content in the educational curricula among HRSA grant recipients. Section 736 of the Health Professions Education Partnerships Act of 1998 encourages COEs "… to carry out activities to improve the information, resources, clinical education, curricula and cultural competence of the graduates of the schools as it relates to minority health issues." Although the COE Program encompasses many goals, the incorporation of cultural and linguistic competence training was visionary for its time.

This curriculum guide, *Transforming the Face of Health Professions through Cultural and Linguistic Competence: The Role of the Centers of Excellence*, was developed by a panel of experts, the Expert Team, brought together under a contract awarded by HRSA to Magna Systems, Inc. The extensive materials and recommendations contained in the document are intended to assist the COEs in designing and implementing the required cultural and linguistic competency educational components within their specific disciplinary curricula. The materials are appropriate for training health care professionals in medicine, dentistry, pharmacy, social work, psychology and counseling, and allied fields.

The Expert Team was drawn from the fields of medicine, nursing, pharmacy, psychology, anthropology, organizational development, and hospital administration. Collectively, the team members have significant and long-term knowledge and experience in the field of cultural and linguistic competency. Additionally, each Expert Team member has extensive experience in teaching cultural and linguistic competence subject matter to health care professionals.

Over 18 months, this team collaborated in collecting, reviewing, and organizing the resources in this curriculum guide under the supervision and direction of the HRSA's Division of Health Careers Diversity and Development, Bureau of Health Professions.

In developing the curriculum guide, the Expert Team drew considerably on feedback from COEs. Several opportunities were identified to initiate and maintain dialogue with them. The first opportunity occurred on March 19, 2004, at the annual COE grantees meeting in Washington, D.C. Two focus groups, led by Dr. Maria Soto-Greene and Mr. Beau Stubblefield-Tave, shared information regarding the project and gathered input from the COE grantees. The second opportunity to meet with COE grantees in a formal meeting was on October 6, 2004, in Washington, D.C., at the COE National technical assistance meeting. Electronic and paper copies of the draft curriculum guide were distributed to the COE grantees prior to this meeting. The input provided by the COE representatives was extremely useful and helped refine the curriculum guide. Magna Systems Inc., in collaboration with the Expert Team, also conducted a comprehensive assessment of the cultural competence activities of COE grantees and catalogued "best practices" for teaching cultural competency in health professions schools. The Assessment and Promising Practices Report documents these findings (see Appendix C).

When developing the material for this curricular guide, the expert team adopted the following premises:

- Health care providers have an obligation to respectfully consider cultural concerns as they design and deliver health care services. While it is not possible for any individual to become thoroughly familiar with the myriad cultures that exist within the United States, providers and the institutions that train them can and must incorporate the general principles of cultural and linguistic competency into the standard practice of care.

- The curriculum guide is being made available to COE grantees as a generic model for use in guiding the planning, development, implementation, and evaluation of cultural and linguistic competency education activities with faculty and students. The curricular materials can be used to supplement work already being done in many COEs, and are not mandatory or intended to replace existing or planned cultural and linguistic competency activities.

- The curricular materials focus on generic concepts and skills that the expert teams considered to be important. The materials are not designed to address the varying levels of cultural and linguistic competence education that may already be present in different COEs.

- The Expert Team identified certain approaches and models through collective consensus. However, these are by no means the only ones available. Readers will find alternative approaches in Chapter 10 (Resources) and in the appendices.

- Since COEs do not have a specific mandate to ensure the cultural and linguistic competency of the larger institutions of which they are a part, the primary users of this document will be COE faculty and other COE academicians; COE students are intended to be its primary beneficiaries. It is necessary and important, however, to acknowledge the significant link between an organization's cultural and linguistic competence and its implementation of successful cultural and linguistic competence education. Recognizing this link, the Expert Team strongly supports a leadership role for COEs in advocating cultural and linguistic competence in the larger university communities in which they reside. Wherever possible, COEs should encourage collaborative arrangements around cultural and linguistic competency subject matter with other university departments.

- Since HRSA COEs were among the earliest programs to require a cultural and linguistic competency mandate, many COE directors expressed the need for guidance on change processes and gathering support for the concept in a larger institution. Therefore, although it may not have a direct link to curriculum development, it may be beneficial for the COEs to receive information on organizational change and innovation from fields outside of health care (contained in Chapter 3).

Given these facts, the Expert Team encourages all users of this curriculum guide, *Transforming the Face of Health Professions Through Cultural and Linguistic Competence Education: The Role of HRSA Centers of Excellence,* to consider it an evolving document. The Expert Team invites all users to join with its developers in the practice of "cultural humility" (Tervalon and Murray-Garcia, 1998) as we assess the value of its content and seek to use it to promote the delivery of culturally

competent health care. Users of this curriculum guide are urged to engage in participatory and collaborative processes and to share the lessons they learn freely. While the information in this curriculum guide is designed primarily for use by COEs, it may also be a useful guide and resource for other institutions and organizations that provide education and training to health care providers. The members of the Expert Team hope that the strategies and resources provided here will be disseminated appropriately and used by relevant organizations.

Organization of the Curriculum Guide

This compendium provides practical guidance in the form of strategies, tools, and resources for COEs implementing and integrating cultural and linguistic competency content and methods into existing academic programs. It also provides guidance for evaluating cultural and linguistic competency efforts. The curriculum is organized into 10 chapters. An overview of the content of these chapters follows:

Chapter 1: Cultural and Linguistic Competence and the Centers of Excellence provides an overview of the COE legislative mandates, a brief history of COE cultural and linguistic competency initiatives, and the preliminary findings of an assessment of past and current COE cultural and linguistic competency activities.

Chapter 2: The Guiding Principles and Goals of Cultural and Linguistic Competence Education presents guiding principles and goals designed to help COEs maintain a clear and constructive focus on cultural and linguistic competency as they negotiate the complexities of planning, designing, implementing, and evaluating cultural and linguistic competence training and education programs into existing curricula.

Chapter 3: Strategies for Success in Implementing Cultural and Linguistic Competence Education outlines the rationale for educating for cultural and linguistic competence and provides an overview of the change management process. It also examines cultural and linguistic competence at the organizational level, including an overview of the National Standards for Culturally and Linguistically Appropriate Services in Health Care (the CLAS Standards).

Chapter 4: Creating a Framework for Cultural and Linguistic Competence Curriculum discusses some of the methods of teaching cultural and linguistic competency and of designing, modifying, and delivering cultural and linguistic competency curricula. Specifically, the topics covered in this chapter are the dimensions of multicultural education when designing and modifying curricula, incorporating the process of cultural competence in the delivery of health care services model, and adhering to standard principles of instructional systems development (ISD).

Chapter 5: Curriculum Content for Cultural and Linguistic Competence provides guidance and recommendations on content areas that could be included in a cultural and linguistic competency curriculum and discusses curricula models that are being used in various educational settings to teach cultural and linguistic competence. The topics covered in this chapter include learning objectives, recommended core competencies, recommended core curriculum topics, and examples of curriculum models. The last section includes three models used in curriculum development.

Chapter 6: Delivering a Cultural and Linguistic Competence Curriculum describes the processes and strategies that are used for delivering cultural and linguistic competence curricula and also provides examples of how several organizations have implemented components of culturally competent curricula. Included is a discussion about developing faculty commitment, providing a rationale for building cultural and linguistic professional competencies, creating a developmental learning path, integrating cultural and linguistic subject matter into basic and elective courses, and sample tools for delivering cultural and linguistic curricula.

Chapter 7: Assessment and Evaluation of a Culturally Competent Center of Excellence describes how COEs can make an initial assessment or benchmark of their cultural and linguistic competency training and education activities and then continuously assess organizational and educational programming. This chapter includes a discussion on educational assessments and evaluations, three examples of curriculum evaluation, organizational assessments and evaluations, the HRSA domains as a framework for organizational assessment, and integrated and stand alone evaluation processes.

Chapter 8: Dissemination outlines the process for developing a dissemination plan to share the lessons learned about the delivery of culturally competent health care in the community. It describes the importance of getting support from key stakeholders, such as university administrators and faculty, and strategies for achieving the adoption and integration of cultural and linguistic competency into established and new courses of study. It discusses the reasons a COE would disseminate, the mechanisms for dissemination, and offers examples of an effective dissemination plan.

Chapter 9: Summary/Next Steps discusses some caveats, potential issues, challenges, and barriers to the use of the curriculum guide. It also summarizes the important recommendations of the curriculum guide and provides suggestions for implementation.

Chapter 10: Resources is a list of cultural and linguistic competency guidelines, curricula, research reports, organizations, audio-visual tools, and web sites that may be helpful to COEs in their efforts to respond to their cultural and linguistic competency mandate.

Appendix A: The Toolbox, provides examples of tools and implementation strategies developed for teaching cultural and linguistic competency in health care.

Appendix B is a glossary of terms related to cultural and linguistic competency education.

Appendix C contains the *Centers of Excellence Assessment and Promising Practices Report* that describes cultural and linguistic competence activities of HRSA COE grantees.

Chapter 1: Cultural and Linguistic Competency and the Centers of Excellence

Interest in the subject of cultural and linguistic competency is beginning to reach the "tipping point" (Gladwell, 2002). Over the past twenty years there has been an explosion of interest in developing programs that meet the general health, mental health, oral health, and social service needs of our Nation's increasingly diverse population. Cultural and linguistic competence initiatives are underway at the systems, organizational, and clinical levels in a variety of institutions (The Commonwealth Fund. New York, NY, 2002). A growing number of Federal agencies, foundations, and private sector groups are supporting innovative educational, research, and service delivery activities.

This chapter covers the history of the COEs and their efforts to address health care disparities and cultural and linguistic competency, and also discusses a report on COE assessment and promising practices.

One such Federal agency is the Health Resources and Services Administration of the U.S. Department of Health and Human Services in Rockville, Maryland. HRSA's understanding of cultural and linguistic competence is based largely on the work of Terry Cross and that of the Georgetown University National Center for Cultural Competence (NCCC). According to Cross, cultural and linguistic competence is a developmental process that evolves over time. Both individuals and organizations begin this process with various levels of awareness, knowledge, and skills along the cultural and linguistic competence continuum (adapted from Cross et. al., 1989). Cross et al. defines cultural competence as "a set of congruent behaviors, attitudes, and policies that come together in a system, agency, or amongst professionals and enable that system, agency or those professionals to work effectively in cross-cultural situation."

By considering other definitions of cultural and linguistic competence, it is possible to draw a more complete picture of the state of cultural and linguistic competence in health care educational settings. For example, in 2002 the Commonwealth Fund in New York said cultural competence is "the ability of systems to provide care to patients with diverse values, beliefs, and behaviors, including tailoring delivery of care to meet patients' social, cultural, and linguistic needs. The ultimate goal is a health care system and workforce that can deliver the highest quality of care to every patient, regardless of race, ethnicity, cultural background, or English proficiency."

Similarly, the American Medical Association in Chicago said in a 1994 publication, *Culturally Competent Health Care for Adolescents,* that cultural competence is "the knowledge and interpersonal skills that allow providers to understand, appreciate, and work with individuals from cultures other than their own. It involves an awareness and acceptance of cultural differences; self-awareness; knowledge of the patient's culture; and adaptation of skills."

Linguistic competency, while linked to cultural competency, requires additional skills and understandings. Kaiser Permanente, the large non-profit managed care organization in Oakland, Calif., defines linguistic competence in its National Linguistic & Cultural Programs, National Diversity, (2003), saying:

"Linguistic competence recognizes that language and culture are interconnected. Language reflects culture while shaping it at the same time. Culture shapes our thinking, which in turn shapes our language. This powerful interrelationship affects all human interactions. Linguistic competence involves more than just the ability to speak and understand another language. It involves the knowledge of the cultural orientation that helps create meaning from language.

Void of the ability to communicate in a common language, people are forced to cope with limitations that are disorienting, frustrating, and stressful. Dealing with these limitations at a time of illness or duress has a direct impact on the quality of care a patient can receive, and the health system's ability to provide basic good medicine. A linguistically competent health care professional understands the intrinsic cultural meaning of a message and is able to elicit and send the right cultural response. This can be accomplished by sharing the same language and cultural understanding, or, by taking action to obtain appropriate assistance in facilitating intercultural communications. Thus, a health care professional's level of linguistic competence depends on personal knowledge, skills, and attitude. The appropriate action is optimized by a linguistically competent system of care or hindered by its absence."

The National Center for Cultural Competence at the Georgetown University Center for Child and Human Development defines linguistic competence as: "The capacity of an organization and its personnel to communicate effectively and convey information in a manner that is easily understood by diverse audiences including persons of limited English proficiency, those who have low literacy skills or are not literate, and individuals with disabilities. The organization must have a policy, structures, practices, procedures, and dedicated resources to support this capacity." (Goode & Jones, NCCC, August 2003)

Definitions of other key terms related to cultural and linguistic competence can be found in the glossary in Appendix B of this curriculum.

In summary, cultural and linguistic competence is a process that involves an ongoing commitment by individuals and organizations to develop the requisite knowledge, skills, and attitudes and to promote programs and systems that ensure that all individuals receive the highest quality health care. Aspiring to cultural and linguistic competence also involves a tremendous commitment of both people and resources. Among those organizations that have made such a commitment to cultural and linguistic competence is the HRSA's Centers of Excellence (COE).

I. The History of COEs: Efforts to Address Health care Disparities and Cultural and Linguistic Competency

HRSA Centers of Excellence (COEs) have a close and necessary involvement in cultural and linguistic competence. In 1991, HRSA instituted the Centers of Excellence (COE) Program, designed to support programs of excellence in health professional education for underrepresented minorities (URM) in health professional schools of medicine, dentistry, pharmacy, and mental health. Eligible applicants are accredited allopathic schools of medicine, osteopathic medicine, dentistry, pharmacy (PharmD programs only), graduate programs in behavioral or mental health, or other public and nonprofit health or educational entities including faith-based organizations and

community-based organizations that meet the requirements of section 736(c) of the Public Health Service Act, as amended.

Housed in HRSA's Bureau of Health Professions, Division of Health Careers Diversity and Development, the COE program was among the earliest Federal grantee projects that required recipients to address the cultural and linguistic competency training of individuals in their respective schools. The COE Program was established to be a catalyst for institutionalizing a commitment to URMs and to serve as a National resource and educational center for diversity and minority health issues.

The goals of the COEs are to demonstrate:

- Institutional commitment to underrepresented minority (URM) populations with a focus on minority health issues and eliminating health disparities

- Innovative methods to strengthen or expand educational programs to enhance academic performance of URM students of the school

- The presence of culturally competent health professions educators, students, and graduates of the school

- Models of URM faculty development and retention, multicultural curricula, and faculty and student research as it relates to minority health issues

Although the COE Program encompasses many goals, the incorporation of cultural and linguistic competence training in 1991 was visionary for its time. Since 1991, there have been many critiques of the Nation's health care delivery system, such as the Institute of Medicine's (IOM) report, *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care, National Academies Press, (2003), In the Nation's Compelling Interest: Ensuring Diversity in the Health-Care Workforce (2004), Crossing the Quality Chasm: A New Health System for the 21st Century (2001), and Missing Persons: Minorities in the Health Professions, A Report of the Sullivan Commission on Diversity in the Health care Workforce (2004).*

In its report, *Unequal Treatment,* the IOM included the following critical findings: Racial and ethnic disparities in health care occur within the context of broader historic and contemporary social and economic inequality and evidence of persistent racial and ethnic discrimination in many sectors of American life.

- Many factors—including health systems, health care providers, patients and utilization managers—may contribute to racial and ethnic disparities in health care

- Bias, stereotyping, prejudice, and clinical uncertainty on the part of health care providers may contribute to racial and ethnic disparities in health care

- Sociocultural differences between patient and provider influence communication and clinical decision-making

- A significant body of literature defines and supports the importance of cross-cultural education in the training of health professionals

- Cross-cultural education offers promise as a tool to improve the ability of health professionals to provide quality care to diverse patient populations, thereby reducing health care disparities

For COEs, cultural and linguistic competency training has become one of the foundations upon which to address the disparate care provided to some patients and to underrepresented minorities in particular. When the COEs opened, the directors and staff of the centers immediately understood the tremendous challenge of the cultural and linguistic competence mandate. Among the COEs, for example, there was a paucity of underrepresented minority faculty recruitment and development programs and a limited number of recognized programs related to cultural and linguistic competency knowledge, skills, and expertise. As a result, the faculty and administration of the COEs have taken modest incremental steps over the past 14 years to develop and teach cultural and linguistic competency.

For the majority of COEs, cultural and linguistic competency education began with an elective offering for those students who had an interest in this area. In other words, these programs were attempting to do little more than "preach to the choir." Over the first decade, however, as institutions began to understand the COE initiative and purpose, COEs became better positioned within their organizations. This improved positioning enabled the faculty of some COEs to implement cultural and linguistic competency programs and activities that positively affected individual students and, in some cases, faculty. However, the implementation of cultural and linguistic competency training was unevenly developed across COEs.

Today, health care professionals and educators in a prospective COE understand that developing a center of excellence requires making a strong commitment to addressing health disparities in a way that many institutions have not yet fully embraced. These professionals and educators must be willing to break down the barriers that exist in institutions, groups, and among individuals, and they must recognize the opportunities that exist in accepting that developing cultural and linguistic competency will result in delivering quality care for all. Additionally, they must also accept the challenge of promoting their cultural and linguistic competency efforts so that they can help others learn the lessons they have learned in the process of developing such competency.

Since all significant change initiatives encounter resistance, practitioners and educators employed at COEs must be prepared to meet and respond to such resistance with consistent and well-planned efforts to achieve culturally and linguistically competent health care delivery in the United States.

II. COE Assessment and Promising Practices Report Results

In the spring of 2004, Magna Systems, Inc., under contract with the HRSA Division of Health Careers Diversity and Development, conducted an assessment of the cultural and linguistic competence activities of HRSA Centers of Excellence (COE) grantees. This assessment used the 2001-2002 Uniform Progress reports, which the COE grantees complete annually. The assessment examined reports from twenty-nine COEs. The activities were coded and cataloged according to an assessment matrix, which was developed by the Expert Team of this contract. The matrix was

arranged by topic: content, teaching delivery/methods, non-teaching delivery/methods, and evaluation.

Some of the main findings include:

- The topic taught with the most frequency among the twenty-nine COEs was "Different Population Groups." This topic includes the general health-related and cultural beliefs of an ethnic group, as well as instruction on diversity and multiculturalism.

- The teaching method the COEs employed most frequently was "Classroom-Directed Learning." This includes classroom-directed learning that has been incorporated into the curriculum either as a required course, elective, or unit in an established course.

- The non-teaching method used most frequently was "Research Pertaining to People of Color." This category is meant to determine the COEs' activities around academic or community-based research pertaining to people of color.

- A few COEs conducted evaluations of their programs. Three COEs conducted an evaluation of their cultural and linguistic competence curricula.

These findings demonstrate important achievements among the efforts of COEs to achieve and promote cultural and linguistic competence. The complete COE Assessment and Promising Practices Report is provided in Appendix C of this curriculum guide.

Chapter 2: The Guiding Principles and Goals of Cultural and Linguistic Competence Education

The implementation and integration of cultural and linguistic competence training, education programs, and activities are complex tasks. While the focus of these processes is on learning activities, educators and practitioners in COEs must also carefully consider policy and systems issues within their institutions. The need to consider that community norms and expectations, as well as those of students and patients, add further complexity to these tasks. This chapter provides guiding principles and goals and is adapted from *Principles and Recommended Standards for Cultural and Linguistic Competence Education of Health care Professionals* (2003), which was published by the California Endowment, a private health foundation in Woodland Hills, Calif., at www.calendow.org. This guidance is designed to help health care professionals and educators in COEs maintain a clear and constructive focus on the overall goals of cultural and linguistic competency as they negotiate the complexities of curriculum design and structure.

- The overall goals of cultural and linguistic competence training for health care professionals are: 1) increased self-awareness and understanding of the centrality of culture in providing good health care to all patient populations; 2) clinical excellence and strong therapeutic alliances with patients and 3) reduction of health care disparities through improved quality and cost-effective care for all populations.

- In all educational offerings devoted to cultural and linguistic competency there should be a broad and inclusive definition of cultural and population diversity, including considerations of race, ethnicity, class, age, gender, sexual orientation, gender identity, disability, language, religion, and other indices of difference.

- Training efforts should be incremental. Institutions may start simply by including cultural and linguistic competency training as a specific area of study, but should advance to complex, integrated, and in-depth attention to cultural issues in later stages of professional education. Trainees should be expected to become progressively more sophisticated in understanding the complexities of diversity and culture as they relate to the care of patients and to the delivery of health care services.

- Cultural and linguistic competence training is best organized around enhancing providers' attitudes, knowledge, and skills, and attention to the interaction of these three factors is important at every level of training.

- While factual information is important, educators should focus on process-oriented tools and concepts that will serve the practitioner well in communicating and developing therapeutic alliances with all types of patients.

- Cultural and linguistic competence training is best *integrated* into numerous courses, symposia, and into experiential, clinical, evaluation, and practicum activities as they occur throughout an educational curriculum. Initial attention will likely need to be directed to faculty, staff, and administrators when developing cultural and linguistic competence.

- Cultural and linguistic competence education should be institutionalized within an educational program so that when curriculum or training is planned or changed, appropriate cultural and linguistic competence issues can be included.

- Cultural and linguistic competency education is best achieved within an interdisciplinary framework that draws upon a variety of skills and knowledge in the field, such as medical anthropology, medical sociology, epidemiology, ethnopharmacology, and human genetics.

- Since health care is practiced within institutional and bureaucratic settings, students should have an opportunity to analyze and assess how the structure of the health care system and the organization of health care services affect the care of diverse populations.

- Both instructional programs and student learning should be regularly evaluated in order to provide feedback to the ongoing development of educational programs. Students should be involved in their own evaluation as well as the evaluation of the curricula. Students should also be given many supervised opportunities to practice, and be evaluated on their knowledge and skills.

- Education and training should be respectful of the needs, practice contexts, backgrounds, and levels of receptivity of the learners.

- Education in cultural and linguistic competence should be congruent with, and, where possible, framed in the context of existing policy and educational guidelines of professional accreditation and practice organizations, such as the Accreditation Council on Graduate Medical Education, the Liaison Committee on Medical Education, the American Academy of Nursing, the National Association of Social Workers, the Society for Public Health Education, and the Academies and Colleges of Family Practice, pediatrics, emergency medicine, obstetrics and gynecology, general dentistry, and clinical pharmacology.

- Wherever possible, diverse patients, community representatives, consumers, and advocates should participate as resources in planning, designing, implementing, and evaluating cultural and linguistic competence curricula.

- Cultural and linguistic competence education should take place in a safe, non-judgmental, supportive environment. The schools and organizations in which health care professionals study and work should be settings that visibly support the goals of culturally competent care. They must encourage and be conducive to health care delivered in a culturally and linguistically competent manner.

Chapter 3: Strategies for Success in Implementing Cultural and Linguistic Competence Education

Responding to resistance to change or innovation requires providing a strong rationale. Those who will be affected by a curriculum for cultural and linguistic competence must be provided with good reasons for changing how they have been doing things or for adopting new behaviors. Some of those who resist change may ask why there is a need for cultural and linguistic competence within the health professions. This chapter outlines the following: 1.) the rationale for educating for cultural and linguistic competence, 2.) an overview of the change management process, and 3.) an examination of cultural and linguistic competence at the organizational level.

I. The Rationale for Educating for Cultural and Linguistic Competence

There are a number of significant reasons COEs have undertaken the effort to develop cultural and linguistic competence. Some of the best reasons have been collected by the National Center for Cultural Competence and are reported on the NCCC website (at http://gucchd.georgetown.edu/nccc/). They are used here with permission.

The reports by the IOM and other organizations cited earlier provide a compelling moral argument and social-justice rationale for cultural and linguistic competence within the health professions. In addition, the NCCC says there are other practical considerations, including the following:

A. To respond to current and projected demographic changes in the United States
B. To eliminate long-standing disparities in the health status of people of diverse racial, ethnic, and cultural backgrounds
C. To eliminate disparities in the mental health status of people of diverse racial, ethnic, and cultural groups
D. To improve the quality of services and primary care outcomes
E. To meet legislative and regulatory mandates
F. To meet accreditation mandates
G. To gain a competitive edge in the marketplace
H. To decrease the likelihood of malpractice claims

A. Responding to current and projected demographic changes

The make-up of the American population continues to change as a result of immigration patterns and significant increases among racially, ethnically, culturally, and linguistically diverse populations already residing in the United States. Primary care organizations and Federal, state, and local governments must implement systemic change in order to meet the health and mental health needs of this diverse population. Census 2000 data show that more than 47 million persons speak a language other than English at home, an increase of nearly 48 percent since 1990. Since 1990, the foreign-born population has grown by 64 percent to 32.5 million persons, accounting for 11.5 percent of the U.S. population (Schmidley, 2003).

B. Eliminating disparities in health status

Nowhere are the divisions of race, ethnicity, and culture more sharply drawn than in the health of the people in the United States. Despite recent progress in overall national health, disparities continue in the incidence of illness and death among African Americans, Latino/Hispanic Americans, Native Americans, Alaskan Natives, Pacific Islanders, and some Asian Americans as compared with that of the U.S. population as a whole (more information is available in the *National Health care Disparities Reports* for 2003 and 2004; http://www.qualitytools.ahrq.gov/disparitiesreport/browse/browse.aspx). The U.S. Department of Health and Human Services (DHHS), through its 2010 Objectives, established goals for the elimination of racial and ethnic disparities in health. Six major areas of health status have been targeted for elimination, including cancer, cardiovascular disease, infant mortality, diabetes, HIV/AIDS, and child and adult immunizations. Regrettably, there has been little change in these indicators of illness and death since these goals were established in 2000.

C. Eliminating disparities in mental health status

The first Surgeon General's report on mental health, *Mental Health: A Report of the Surgeon General,* 1999, emphasized the importance of culture for both patients and providers. "The cultures that patients come from shape their mental health and affect the types of mental health services they use," the report said. "Likewise, the cultures of the clinician and the service system affect diagnosis, treatment, and the organization and financing of services." (Executive Summary). This report, as well as a later supplement, *2001 Surgeon General's Report on Mental Health: Culture, Race, and Ethnicity*, documents the pervasive disparities in mental health care. Specifically, the report revealed evidence that racially and ethnically diverse groups are less likely to receive needed mental health services and are more likely to receive poorer quality of care. Furthermore, the report goes on to say that these groups:

- Are over-represented among the vulnerable populations who have higher rates of mental disorders and more barriers to care and

- Face a social and economic environment of inequality that includes greater exposure to racism and discrimination, violence, and poverty, all of which take a toll on mental health.

D. Improving the quality of services and primary care outcomes

Despite similarities, fundamental health-related differences among people also arise from such cultural factors as Nationality, ethnicity, acculturation, language, religion, gender, and age, as well as factors attributed to family of origin and individual experiences. These differences affect the health beliefs and behaviors of both patients and providers. They also influence the expectations that patients and providers have of each other. The delivery of high-quality primary care that is accessible, effective, and cost-efficient requires providers to have a deeper understanding of the sociocultural background of patients, their families and the environments in which they live. Recent studies have shown that culturally and linguistically competent primary care increases patient satisfaction and health outcomes, and provides higher levels of preventive care (Lasater et al, 2001; Saha et al, 1999).

E. Meeting legislative and regulatory mandates

The requirement for care to be delivered in a culturally and linguistically competent manner is increasingly emphasized by legislative and regulatory bodies. As both an enforcer of civil rights law and a major purchaser of health care services, the Federal government has a pivotal role in ensuring culturally competent health care services. Title VI of the Civil Rights Act of 1964 mandates that "no person in the United States shall, on ground of race, color, or National origin, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving Federal financial assistance." In August 2003, the DHHS Office for Civil Rights issued a revised Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons (http://www.hhs.gov/ocr/lep). In December 2000, the DHHS Office of Minority Health published in the Federal Register the National Standards on Culturally and Linguistically Appropriate Services (CLAS) in Health Care, a document which provides guidance on the provision of health care to diverse populations.
(http://www.omhrc.gov/omh/programs/2pgprograms/finalreport.pdf)

F. Meeting accreditation mandates

State and Federal agencies rely on private accreditation entities to set standards and monitor compliance. The Joint Commission on the Accreditation of Health care Organizations, which accredits hospitals and other health care institutions; the Liaison Committee on Medical Education, the accrediting organization for medical education; and the National Committee for Quality Assurance, which accredits managed care organizations and behavioral health managed care organizations, support standards that require cultural and linguistic competence in health care. (P. 4, National Center for Cultural Competence, Bureau of Primary Health Care Project.)

See Chapter 10, Resources, Section I for additional references.

G. Gain a competitive edge

A significant portion of publicly financed primary care services continues to be delegated to the private sector. The issues that are of the most concern to health care consumers, purchasers, and providers in the current social and political environment are rising health care costs, quality of care, and the effectiveness of service delivery. Therefore, while the research in this area is relatively new, it stands to reason that as the U.S. population continues to diversify, organizations that embrace the values of cultural and linguistic competence when providing primary care may be well positioned in the current market and in the future. For example, health care organizations such as Aetna, Blue Cross, and Kaiser Permanente have focused efforts on marketing to discrete ethnic and racial groups with the promise of taking into consideration the specific health needs of those populations.

H. Decreasing the likelihood of malpractice claims

Lack of awareness about cultural differences and failure to provide interpretation and translation services can result in liability under tort principles in several ways. Practitioners may discover, for example, that they are liable for damages as a result of treatment in the absence of informed consent. Also, health care organizations and programs face potential claims that their failure to understand beliefs, practices, and behaviors on the part of providers or patients breaches professional standards

of care. In some states, patients' failure to follow instructions because they conflict with values and beliefs may raise a presumption of negligence on the part of the provider.

II. An Overview of the Change Management Process

As organizations evolve along a developmental continuum that moves from ignoring cultural and linguistic differences in patients to one that carefully considers the effect of cultural variation on patient care, the changes required for such a complex process must be managed carefully. In this role of managing change, COEs have a unique mandate and opportunity. The mandate concerns the requirement to integrate and institutionalize cultural and linguistic competency within their academic organizations and to disseminate their cultural and linguistic competency knowledge and skills to the broader community. There is an opportunity to become early adopters of cultural and linguistic competency principles and practices, and thereby contribute to the improvement in the health status of Americans, particularly among underserved populations. Yet when COEs take on the task of becoming culturally and linguistically competent, they must expect some resistance to the concept of cultural and linguistic competence. Therefore, it may be useful to understand the change-management process.

A. The Change Process and Resistance to Change

Creating institutions and organizations in which cultural and linguistic competency is the norm involves change. For COEs, the change process around cultural and linguistic competency begins in the academic environment. As progress is achieved within academic institutions, it will be important for those employed by COEs to expand their efforts to affiliated health delivery organizations, such as hospitals and clinics. It will also be important for at least one, and preferably a number of forward-looking individuals, to assume a leadership role in an effort to lead the change process of developing cultural and linguistic competency. These leaders will need to champion the cause against those who will resist the call for change.

As mentioned in Chapter 1, COEs have neither the mandate nor the authority to require adherence to cultural and linguistic competency principles within their parent universities. It is also clear that the promotion of cultural and linguistic competency is only one of several mandates for which COEs are accountable. The fact remains, however, that clinicians and educators in the COEs have a unique opportunity to serve as leaders and advocates for cultural and linguistic competency and the processes of cultural change that will support this initiative.

The text for the following has been adapted from *Promoting a Positive Prison Culture* (2003), developed by Carol Flaherty-Zonis and published by the National Institute of Corrections, with permission.

Faculty members within COEs will no doubt react in many different ways to the idea of changes and additions to the curriculum necessitated by a new focus on cultural and linguistic competency, Flaherty-Zonis says. On the positive side, some people may see change as a challenge, an opportunity for personal and professional development, a way to enhance morale and increase

productivity, or a way to renew their energy and passion for their work. On the other hand, some people may see change as a threat to their power and influence, a loss of familiarity and comfort, a statement that the way they have done things is wrong, or as a loss of control. Many people fear change for all these reasons and many more.

Most important for people involved in a process of change, especially culture change, is acknowledging and respecting all of these reactions, even those that may seem to stand in the way of change, Flaherty-Zonis continues. Some people will be ready, willing, and enthusiastic about the change process and others will be unwilling and reluctant. One strategy for diffusing resistance among those who fear change is to continually emphasize the positive. As with diversity programs, some people will resist a cultural and linguistic competency initiative because they will perceive it as an indictment of their historic practices. Challenging individuals directly about practices that are deemed to be insufficient or not up to date will likely result in their becoming defensive or defiant. A better strategy would be to acknowledge their expertise and provide clear guidance and simple steps that can be taken to begin the process of adding to it by implementing cultural and linguistic competency, and then recognizing and complimenting each small success.

> If the institutionalization and integration of cultural and linguistic competency within an academic institution is to be successful, it must be well planned, Flaherty-Zonis adds. Those involved in planning the change should have well rationalized and clear goals. Additionally, individuals are more likely to be committed to the success of the cultural and linguistic competency program if they are given the opportunity to participate in its conceptualization and design. Each organizational unit within the institution should be encouraged to have goals for cultural and linguistic competency and a plan for achieving them that is well within the framework of the overall institutional goals for change. The goals and the plan set the direction for the change process.

B. Faculty and Staff Development

While students in COE programs are identified as the ultimate audience for cultural and linguistic competency training, faculty and other staff are the transmitters of this new mode of thinking and operating. The means of transmitting knowledge, skills, and attitudes are not only classroom activities, but also examples of cultural and linguistic competency that are demonstrated at all levels within the academic institution. Transmitting this knowledge and offering these examples will require training all faculty and staff in core competencies of cultural and linguistic competency. If cultural and linguistic competency is to become integrated into the organizational culture of the institution, all staff must be involved in understanding and practicing the principles of cultural and linguistic competency. Integrating cultural and linguistic competency into an organization's culture is likely a long-term goal, and one that will require cognitive restructuring and skill training programs for staff, launching a planning process that includes all levels of staff, training to develop organizational cultural and linguistic competence, and a meaningful examination of the institution's culture.

It is important to understand that beginning and sustaining culture change are not the same. They call for different skills. New ideas, even good ones, often fail to take hold because not enough attention is paid to specific ways of implementing and sustaining them. Implementing and sustaining ideas involves planning and identifying people who can help sell the ideas. Implementing and sustaining ideas also involves determining how to monitor the work and measure progress, how

to modify the plan as needed, how to help people build commitment to the idea, and how to assess the culture change.

C. Managing Conflict

Since culture change usually involves conflict, it is important to identify and resolve conflicts in a skillful and timely manner. Conflicts can sometimes lead to exciting new ideas and important changes in the culture. Conflicts may help open people's eyes to issues that need to be addressed and to new ways of operating. If people, especially those in leadership positions, see conflict in a negative way and as something to be avoided, the culture change process is less likely to be successful. On the other hand, if people can embrace conflict as a way to show respect for and clarify points of view, and to challenge old ideas and bring new ones into the open, then the culture change process is more likely to accomplish its goals.

Conflict in a change process often comes because some people view and label other people as "resistant." While resistant is a legitimate word, it may not be useful to label people in a culture change process because such labeling ignores the causes of the resistance, and it is vitally important to understand the causes of resistance if they are to be overcome. People may react negatively to change because of fear; a sense of loss and grieving over what is gone; loss of control, influence and power; concern about the skill and the knowledge level necessary to make a change; skepticism; distrust of leadership; and a negative experience in the institution with other innovative ideas.

D. The Importance of Leadership

Some people are great innovators. They are creative, intuitive, insightful problem-solvers. But these innovators sometimes forget that they need to lead others through the processes involved in innovation. They may not realize that if they fail to lead, others may not follow readily or enthusiastically. For this reason, institutionalizing cultural and linguistic competency within a COE and its host academic institution requires a firm commitment from all levels of an organization and particularly from its leaders. Thus, the university president, COE director, academic dean, curriculum dean, and other key decision-makers in the academic setting, regardless of title, will need to actively promote the cultural and linguistic competency initiative. While one person may have a vision of how cultural and linguistic competency might be integrated into the COE and host institution, he or she cannot change it alone. It is critical to have a group of people others trust, who support both the need for change and the direction of the change. It is necessary to have dedicated and skilled leadership and commitment throughout the organization if the changes are to have a positive effect on the cultural and linguistic competence of the students to be trained and, ultimately, the health status of the people they serve.

Any discussion about leadership clearly means those people who have authority because of their title and position. But within all organizations there are many informal leaders, particularly if there are significant sub-cultures. Cultural and linguistic competence programs will not be fully implemented if these informal leaders are not made champions in the cause and process of change. They should be involved from at the beginning of the process. If they are not included in the process, they may sabotage the work. Moreover, it is likely that they represent important perspectives that those leading the cultural change may otherwise miss. In addition, some people view change as a loss of power and influence, meaning it may be necessary to involve people who have power and influence at the start, so that they are part of the process.

Effective communication will be essential to the success of the COE's cultural and linguistic initiatives, and communicating effectively and often is an important role of leadership. There is no substitute for effective communication. Within any organization, people will communicate regardless of whether or not they have accurate information. Therefore the best way to prevent rumors, misunderstandings, and unnecessary conflict is to provide accurate information in a timely fashion, and to address issues as they arise. Leaders should promote ongoing, honest, formal, and informal communication about what is happening before and during the change process. Doing so requires communicating in all directions, and listening often may be more important than speaking.

Ultimately, the success of the change process may be determined by the leadership's commitment to change. The leader cannot and should not do the work alone. He or she has to lead the way, providing encouragement, support, ideas, passion, and commitment to the process as well as the outcomes. If the leader stops or turns away from the work, it will be difficult for the staff to keep it moving, or to see its value, and success is unlikely. More importantly, future attempts to bring about change may be met with staff skepticism, reluctance, and a refusal to participate. Staff may become immune to change.

To prevent such problems, leaders throughout the institution should remember that the change process is about meeting mandates and standards, while providing a hope-based environment and having the intention of improving the quality of life for staff, faculty, students, and health care consumers.

III. An Examination of Cultural and Linguistic Competence at the Organizational Level

A number of organizations have developed models and developmental frameworks for organizational change. COEs can use them to support the design and assessment of cultural and linguistic competence activities within their organizations. While all of the following models and development frameworks are not designed specifically for educating health care professionals, they would be useful to COEs nonetheless because they can be adapted for use in an educational setting for health care professionals.

Perhaps the most useful models for health care professionals are the National Standards for Culturally and Linguistically Appropriate Services in Health Care (known as the CLAS standards), from the U.S. Department of Health and Human Services, Office of Minority Health, and the Lewin Model of Cultural and Linguistic Competence. A third, the Cross Model, is useful in identifying the various stages of cultural and linguistic competence. In effect, these three models present guiding principles and goals designed to help COEs maintain a clear and constructive focus on cultural and linguistic competency as they negotiate the complexities of planning, designing, implementing, and evaluating cultural and linguistic competence training and education programs into existing curricula.

A. National Standards for Culturally and Linguistically Appropriate Services in Health Care (the CLAS Standards for Health Care Organizations)

The information in this section has been adapted from *National Standards for Culturally and Linguistically Appropriate Services in Health Care, Final Report,* U.S. Department of Health and Human Services, Office of Minority Health, March 2001. The full report of the CLAS standards and information about the development process OMH used is available online at http://www.omhrc.gov/clas/.

As stated, COEs may find the CLAS standards among the most useful when developing cultural and linguistic competence curriculum. These standards hold that as the U.S. population becomes more diverse, medical providers and other professionals involved in health care delivery are interacting with patients and consumers from many different cultural and linguistic backgrounds. Because culture and language are vital factors in how health care services are delivered and received, it is important that health care organizations and their staff understand and respond with sensitivity to the needs and preferences that culturally and linguistically diverse patients and consumers bring to the health encounter. Providing culturally and linguistically appropriate services (CLAS) to these patients has the potential to improve access to care, quality of care, and ultimately, health outcomes. In fact, some organizations consider the CLAS standards to be akin to quality standards, and thus all clinicians need to have an understanding of them.
Unfortunately, until recently, a lack of comprehensive standards left organizations and providers with no clear guidance on how to provide CLAS in health care settings. In 1997, the Office of Minority Health (OMH) started developing National standards to provide a much-needed alternative to the patchwork of independently developed definitions, practices, and requirements concerning CLAS. OMH initiated a project to develop recommended National CLAS standards that would support a more consistent and comprehensive approach to cultural and linguistic competence in health care.

The CLAS standards were published in final form in the *Federal Register* on December 22, 2000, as recommended National standards for adoption or adaptation by stakeholder organizations and agencies. The standards are proposed as a means to correct inequities that currently exist in the provision of health services, and to make these services more responsive to the individual needs of all patients and consumers. The standards are intended to include all cultures and are not limited to any particular population group or sets of groups; however, they are especially designed to address the needs of racial, ethnic, and linguistic population groups that experience unequal access to health services. Ultimately, the aim of the standards is to contribute to the elimination of racial and ethnic health disparities and to improve the health of all Americans.

The CLAS standards are primarily directed at health care organizations and are particularly useful in hospital settings. However, individual providers are also encouraged to use the standards to make their practices more culturally and linguistically accessible. The principles and activities of culturally and linguistically appropriate services should be integrated throughout an organization and undertaken in partnership with the communities being served.

It is particularly useful to study the CLAS standards in detail, in part because they say that culture and language have a considerable affect on how patients access and respond to health care services. The CLAS standards say that to ensure equal access to quality health care by diverse populations, health care organizations and providers:

1. Should promote and support the attitudes, behaviors, knowledge, and skills necessary for staff to work respectfully and effectively with patients and each other in a culturally diverse work environment.
2. Should have a comprehensive management strategy to address culturally and linguistically appropriate services, including strategic goals, plans, policies, procedures, and designated staff responsible for implementation.
3. Should use formal mechanisms for community and consumer involvement in the design and execution of service delivery, including planning, policy making, operations, evaluation, training, and, as appropriate, treatment planning.
4. Should develop and implement a strategy to recruit, retain, and promote qualified, diverse and culturally competent administrative, clinical, and support staff that are trained and qualified to address the needs of the racial and ethnic communities being served.
5. Should require and arrange for ongoing education and training for administrative, clinical, and support staff in culturally and linguistically competent service delivery.
6. Must provide all clients with limited English proficiency (LEP) access to bilingual staff or interpretation services.
7. Must provide oral and written notices, including translated signage at key points of contact, to clients in their primary language informing them of their right to receive interpreter services free of charge.
8. Must translate and make available signage and commonly used written patient educational material and other materials for members of the predominant language groups in service areas.
9. Should ensure that interpreters and bilingual staff can demonstrate bilingual proficiency and receive training that includes the skills and ethics of interpreting, and knowledge in both languages of the terms and concepts relevant to clinical or non-clinical encounters. Family or friends are not considered adequate substitutes because they usually lack these abilities.
10. Should ensure that the clients' primary spoken language and self-identified race/ethnicity are included in the health care organization's management information system, as well as any patient records used by provider staff.
11. Should use a variety of methods to collect and use accurate demographic, cultural, epidemiological, and clinical outcome data for racial and ethnic groups in the service area and become informed about the ethnic/cultural needs, resources, and assets of the surrounding community.
12. Should undertake ongoing organizational self-assessments of cultural and linguistic competence, and integrate measures of access, satisfaction, quality, and outcomes for CLAS into other organizational internal audits and performance improvement programs.
13. Should develop structures and procedures to address cross cultural ethical and legal conflicts in health care delivery and complaints or grievances by patients and staff about unfair, culturally insensitive or discriminatory treatment, or difficulty in accessing services, or denial of services.
14. 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.

B. The Lewin Model of Cultural and Linguistic Competence

While the CLAS standards explain what a culturally and linguistically competent health care organization must do to achieve cultural and linguistic competence, the Lewin model documents

how an institution must be organized in order to move through the stages of development and support cultural and linguistic competence within the organization. The formal name of the Lewin model is "Indicators of Cultural Competence in Health Care Delivery Organizations: An Organizational Cultural Competence Assessment Profile." It was prepared for the Health Resources and Services Administration of the U.S. Department of Health and Human Services in April 2002 by consultants with The Lewin Group, a health care and human services consulting firm in Falls Church, VA, and is available on the HRSA website at http://www.hrsa.gov/OMH/cultural1.htm.

The following table shows the domains and corresponding focus areas as identified by Lewin.

Table 1
The Lewin Model: Domains and Focus Areas

DOMAIN	FOCUS AREAS
Organizational Values: An organization's perspective and attitudes regarding the worth and importance of cultural competence, and its commitment to providing culturally competent care.	- Leadership, Investment and Documentation - Information/Data Relevant to Cultural competence - Organizational Flexibility
Governance: The goal-setting, policy-making, and other oversight vehicles an organization uses to help ensure the delivery of culturally competent care.	- Community Involvement and Accountability - Board Development - Policies
Planning and Monitoring/Evaluation: The mechanisms and processes used for: a) long- and short-term policy, programmatic, and operational cultural competence planning that is informed by external and internal consumers; and b) the systems and activities needed to proactively track and assess an organization's level of cultural competence.	- Client, Community and Staff Input - Plans and Implementation - Collection and Use of Cultural Competence-Related Information/Data
Communication: The exchange of information between the organization/providers and the clients/population, and internally among staff, in ways that promote cultural competence.	- Understanding of Different Communication Needs and Styles of Client Population - Culturally Competent Oral Communication - Culturally Competent Written/Other Communication - Communication with Community - Intra-Organizational Communication
Staff Development: An organization's efforts to ensure staff and other service providers have the requisite attitudes, knowledge and skills for delivering culturally competent services.	- Training Commitment - Training Content - Staff Performance
Organizational Infrastructure: The organizational resources required to deliver or facilitate delivery of culturally competent services	- Financial/Budgetary - Staffing - Technology - Physical Facility/Environment - Linkages
Services/Interventions: An organization's delivery or facilitation of clinical, public-health, and health related services in a culturally competent manner.	- Client/Family/Community Input - Screening/Assessment/Care Planning - Treatment/Follow-up

C. The Cross Model of Cultural competence (Cross et al., 1989)

One of the most important ways of identifying cultural competence was developed by Terry Cross, the executive director of the National Indian Child Welfare Association, in Portland, OR. The Cross Model (from the publication, *Towards a Culturally Competent System of Care*, Volume I, Washington, DC: CASSP Technical Assistance Center, Center for Child Health and Mental Health Policy, Georgetown University Child Development Center. March 1989, pp. v-viii) describes the various stages of competence at the organizational level. Cross et al define cultural competence as "a set of congruent behaviors, attitudes, and policies that come together in a system, agency, or amongst professionals and enable that system, agency, or those professionals to work effectively in cross-cultural situations." (Pg. iv) These authors view cultural competence as a continuum ranging from cultural destructiveness to cultural proficiency.

The six stages of Cross' cultural competence model are:

1. **Cultural Destructiveness.** Attitudes, policies, and practices within the organization are destructive to cultures and individual members of those cultures.
2. **Cultural Incapacity.** The organization does not intentionally seek to be destructive but rather lacks the capacity to help minority clients or communities.
3. **Cultural Blindness.** The organization functions with the belief that color or culture makes no difference and that all people are the same.
4. **Cultural Pre-Competence.** The organization recognizes its weaknesses and attempts to improve some aspects of its services to a specific population.
5. **Cultural competence.** The organization is characterized by acceptance and respect for differences, continuing self assessment regarding culture, careful attention to the dynamics of differences, continuous expansion of cultural knowledge, and a variety of service models to meet the needs of minority clients.
6. **Cultural Proficiency.** The organization seeks to develop a base of knowledge of culturally competent services by conducting research, developing new therapeutic approaches based on culture, publishing and disseminating information on cultural competence, and hiring specialists in culturally competent practices.

Other widely used models that educators and practitioners in COEs may wish to review include Bell and Evans, and Bennett. For more information on Bell and Evans see Bell, P., and Evans, J. (1981). Counseling the Black Client. Center City, MN: Hazelden Education Materials. Linda and Milton Bennett are a husband and wife team that run a Summer Institute on Intercultural Relations. Milton Bennett developed a staged model of personal development moving from cultural insensitivity to an advanced level of cultural sensitivity. Linda Bennett refined this model into an educational model best explained in: 1986 Modes of Cross-Cultural Training Conceptualizing Cross-Cultural Training as Education. International Journal of Intercultural Relations, Vol. 10: 117-134.

In their book, Bell and Evans explain that, in progressing through the stages of cultural awareness, there are different interaction styles that health care professionals may operate in either consciously or unconsciously. Bell and Evans (1981) describe five basic interpersonal styles that one may engage in when interacting with a client from another culture. Health care professionals must be

aware of what interacting style they are operating in and strive toward a culturally liberated interacting style. The five styles are as follows:

1. Overt racism is when the health care professional interacts out of deep-seated prejudices that he or she has toward a particular cultural group. The health care professional will use the power of his or her attitudes and behaviors to dehumanize the client.
2. Covert racism is an interacting style in which the health care professional is aware of his or her fears of a specific cultural group, but knows that open expression of those attitudes is inappropriate. The health care professional attempts to hide or cover-up his or her true feelings.
3. Cultural ignorance is when the health care professional has little or no prior exposure to the specific cultural group and experiences fear due to his or her inability to relate to the client.
4. The color blind health care professional denies the reality of cultural differences that are important for effective interactions. In this interacting style, the health care professional has made a decision that he or she is committed to equality for all people and therefore treats all people alike, regardless of cultural background.
5. Finally, the culturally-liberated health care professional does not fear cultural differences and is aware of his or her attitude toward specific cultural groups. This health care professional encourages the client to express feelings about ethnicity and then uses these feelings as a shared learning experience.

Chapter 10, Section IIIB is a section that references many other assessment approaches and instruments appropriate to evaluating the cultural and linguistic competencies of organizations. Review of some of these materials may be useful in initial and ongoing assessment of progress related to achieving cultural competence within the COE.

Chapter 4: Establishing a Multi-Dimensional Framework for Cultural and Linguistic Competence Curriculum

In this chapter, we highlight several multi-dimensional models for teaching the concepts underlying cultural and linguistic competency, and for designing, modifying, and delivering cultural and linguistic competency curricula. The topics covered in this chapter are: 1. the dimensions of multicultural education when designing and modifying curricula, 2. incorporating the process of cultural competence in the delivery of health care services model, and 3. adhering to standard principles of instructional systems development (ISD).

The basic challenge is: How can we successfully "talk the talk" <u>and</u> "walk the walk." Although curriculum content obviously will need to be adjusted depending on the focus of each institution, this chapter includes some of the basic knowledge, skills, and attitudes that should be addressed in any curriculum related to cultural and linguistic competency.

As one COE director commented, "A COE should demonstrate how cultural and linguistic competency will be integrated into the matrix of what all students receive." Educational content is embedded in what Elliot Eisner (http://www.teachersmind.com/eisner.htm) has termed the *explicit* (formal and co-) curriculum and the *implicit* ("hidden") curriculum. In addition, there is a "*null* curriculum" of topics that are not taught on campus. Ignoring cultural and linguistic competence makes it part of the null curriculum, meaning that if a school does not teach it, it is ignoring it.

Cultural and linguistic competency content is best presented in both stand-alone cultural and linguistic competence courses and as components of general or core courses. The programming will vary according to the unique needs and capabilities of each COE's student and faculty. The content, however, should reach all students.

When designing a cultural and linguistic competence curriculum, the sequencing of cultural and linguistic competency knowledge and skills is vital. For example, while it is possible to discuss communicating with patients of diverse languages and cultures at any time, students will retain the lessons much more easily when they are actually experiencing difficulties in communicating with culturally and linguistically diverse patients in community clinics. At one time, students were not exposed to patients until their third year of medical school, but today students are seeing patients in their second year in some schools and in their first year in other schools. As a result, each school should carefully consider sequencing and when to integrate specific aspects of cultural competence into the curriculum. Curriculum designers should view cultural and linguistic competence education as proceeding on a developmental trajectory with each step building on the prior one, moving from the purely informational to the actual practice of competencies in hands-on patient care.

An effective way to introduce cultural and linguistic competence, for example, might be to invite representatives of the community to speak with students about the cultures and beliefs that are present in the community at large and to invite the students to question these representatives about the attitudes and beliefs they are likely to encounter among patients in community clinics.

I. Consider the Dimensions of Multicultural Education When Designing and Modifying Curricula

The National Association for Multicultural Education (NAME), at www.nameorg.org, in Washington, D.C., defines multicultural education as a philosophical concept built on the ideals of freedom, justice, equality, equity, and human dignity. NAME says multicultural education:

- Affirms our need to prepare students for their responsibilities in an interdependent world

- Recognizes the role schools can play in developing the attitudes and values necessary for a democratic society

- Values cultural differences and affirms the pluralism that students, their communities, and teachers reflect

- Challenges all forms of discrimination in schools and society through the promotion of democratic principles of social justice.

Those charged with developing such a curriculum should consider the following recommended processes for including elements on cultural and linguistic competence. However, since each curriculum must serve its own particular audience, not all of these processes may meet all needs. Many educators have a narrow understanding of multicultural education as one that involves merely content integration or including content about ethnic groups into the curriculum. Professor James A. Banks, the Russell F. Stark University Professor and Director of the Center for Multicultural Education at the University of Washington, in Seattle, has developed a model that he calls *The Dimensions of Multicultural Education,* which depicts a broad and progressive concept of multicultural education. Banks is also the editor of the *Handbook of Research on Multicultural Education*, second edition, 2004, Jossey-Bass, San Francisco. Banks defines the dimensions of multicultural education as:

- *Content integration,* which deals with the extent to which teachers use examples, data, and information from a variety of cultures and groups to illustrate key concepts, principles, generalizations, and theories in their subject area or discipline

- *The knowledge construction process,* which describes the procedures by which social, behavioral, and natural scientists create knowledge and how the implicit cultural assumptions, frames or references, perspectives, and biases within a culture influence the ways that knowledge is constructed

- *The prejudice reduction dimension* describes the characteristics of racial attitudes and suggests strategies that can be used to help students to develop more democratic attitudes and values

- *An equity pedagogy* that exists when teachers modify their teaching in ways that facilitate the academic achievement of students from diverse racial, cultural, and social-class groups

- *An empowering school culture and social structure* which describes the process of restructuring the culture and organization of the school so that students from diverse racial, ethnic, and social-class groups will experience educational equity and empowerment

II. Incorporating The Process of Cultural Competence in the Delivery of Health care Services Model (Campinha-Bacote)

This cultural competence model developed for health care professionals by Dr. Josepha Campinha-Bacote is defined as the process by which the health care professional continuously strives to achieve the ability to effectively work within the cultural context of a client, individual, family, or community. This model has broad applicability for health care professionals in a variety of disciplines. "This process requires health care professionals to see themselves as *becoming* culturally competent, rather than *being* culturally competent. It includes the integration of cultural desire, cultural awareness, cultural knowledge, cultural skill (conducting culturally sensitive assessments) and cultural encounters" (Campinha-Bacote, 2002). These constructs of Dr. Campinha-Bacote's model are summarized below:

a.) *Cultural awareness* is the examination and in-depth exploration of one's own cultural background. This process involves the recognition of one's biases, prejudices, and assumptions about individuals who are different from oneself. In seeking cultural awareness there must be a commitment to "cultural humility," a life-long commitment to self-evaluation and self-critique, redressing the power imbalances in the relationship between the patient and the health care professional, and developing mutually beneficial partnerships with communities on behalf of individuals and defined populations (Tervalon and Murray-Garcia, 1998).

b.) *Cultural knowledge* is the process of seeking and obtaining a sound educational foundation about diverse cultural and ethnic groups. In the acquisition of cultural knowledge, the health care professional must focus on the integration of three specific issues: health-related beliefs, practices, and cultural values; disease incidence and prevalence; and treatment efficacy (Lavizzo-Mourey, 1996).

c.) *Cultural skill* is the ability to collect relevant cultural data regarding the patient's presenting problem as well as accurately performing a culturally based physical assessment. This process involves learning the skills involved in conducting a cultural assessment and performing physical assessments on ethnically diverse clients.

d.) *Cultural encounter* is the process in which the health care professional is directly engaged in face-to-face and other types, of interactions with patients from culturally diverse backgrounds. Interacting with patients from diverse cultural groups will refine or modify one's existing beliefs about a cultural group and prevent stereotyping.

e.) *Cultural desire* is defined as the motivation of the health care professional to want to engage in the process of becoming culturally aware, culturally knowledgeable, culturally skillful, and seek cultural encounters. It stands in contrast to the feeling of *having* to participate in this process. Cultural desire is the pivotal and key construct of cultural and linguistic competence.

Encounters between patients and health care practitioners are fraught with cultural biases, some

seen and others unseen. Recognizing these biases, obstetrician-gynecologists, for example, often will discuss cross-cultural perceptions about the birthing process with their patients. Such discussions help ob-gyns who have the desire to elicit their patients' cultural biases and beliefs, and thus help them to better understand their patients' needs.

Likewise, cardiologists may understand that the heart is a symbol of the life force in many cultures, so that they can begin to understand their patients' emotional response to the cardiac disease they are experiencing.

Cultural perceptions about organs and bodily functions often strongly affect patients' perceptions about the etiology and appropriate treatment of a disease or disorder. When discussing high blood pressure with the patient, for example, a provider may elicit an unexpected response from an African-American since the term "high blood" has a meaning among some African-Americans that is quite different from the biomedical concept of high blood pressure. Accordingly, there is a very different perception of correct treatment.

Religious perceptions among patients also are important for clinicians to understand. Some patients may believe that their illness is a result of a punishment from God, for example, or that all results of care are "in God's hands" regardless of the efforts of health care practitioners. Or they may believe an illness is a result of a punishment from ancestors beyond the grave.

The existence of such widely varying understandings and beliefs about bodily processes, etiology, treatment, and expected outcomes, in addition to differences in expectations about the behavior and attitude of health care providers, makes it necessary for health care professionals to be acquainted with the scope and breadth of such beliefs in their communities of practice. In order to create a plan of care that ensures patient adherence, the provider will often need to negotiate an approach that respects the patients' beliefs while incorporating a biomedically correct treatment.

For clinicians seeking to understand their own biases, the mnemonic "ASKED" is useful in helping them to work with patients from a variety of cultures. The mnemonic summarizes The Process of Cultural Competence in the Delivery of Health care Services Model (Campinha-Bacote, 2003):

A wareness:	Am I aware of my personal biases and prejudices towards cultural groups different than mine?
S kill:	Do I have the skill to conduct a cultural assessment in a culturally sensitive manner?
K nowledge:	Do I have knowledge of the client's worldview and the field of biocultural ecology?
E ncounters:	How many face-to-face and other encounters have I had with clients from diverse cultural backgrounds?
D esire:	Do I really "want to" be culturally competent?

While we have included all five dimensions of the ASKED mnemonic, it is possible to adapt this mnemonic to focus on the first three elements only, ASK. In many ways, these three are the most important components of the ASKED mnemonic. Also, it should be noted that in addition to ASKED, there are other mnemonics that could be used in health care settings. Mnemonics are useful memory tools in medicine and other fields to assist practitioners in recalling concepts, steps, or ideas that might not easily come to mind otherwise. When conducting the research for this guide,

the Expert Team found a number of useful mnemonics in the field of cultural diversity and these memory tools will be introduced in later chapters and are referenced in the Resources Chapter, Section IIA.

III. Adhere to Standard Principles of Instructional Systems Development (ISD)

Any initiative to design and implement a culturally and linguistically competent curriculum should take into consideration the principles for adult learning and well accepted curriculum development processes. An instructional systems development (ISD) process involves analyzing, designing, developing, implementing, and evaluating as follows:

a.) *Analyze:* The first phase of the ISD process involves data gathering and assessment. Curriculum developers analyze the organization or institution where people work and learn; the people whose performance is to be affected; and the environment in which they perform or will perform in the future. Through this data gathering and assessment process, curriculum developers must first determine whether there is a need for education or training. This determination can best be confirmed with a thorough needs assessment. Various methods can be used to conduct an effective needs assessment, including interviews, focus groups, surveys or questionnaires, observation, and document analysis.

b.) *Design:* A learning design specifies the behavioral objectives to be met by focusing attention on the objectives and not on extraneous or peripheral content. It also helps the instructor develop a logical, sequential, step-by-step learning experience. A functional learning design helps the instructor become more effective and efficient. Design takes into account what is likely to happen in the learning session and allows for contingencies.

c.) *Develop:* During the development phase, curriculum developers focus on the identification and selection of methods of instruction, instructional aids, media, activities, and equipment. Based on their knowledge of the learning objectives, the audience, and the time and resources available, curriculum developers create learning events and activities. When selecting instructional methods it is important to consider that individuals have a variety of different learning styles.

d.) *Implement:* In the implementation phase, the transfer or incorporation of knowledge, skills, and attitudes takes place. Ideally, this interaction is not a one-way transfer from an instructor to students, but rather a process that enables students to learn from the instructor, from one another, and from their larger community and environment. Instructors will need to develop a plan to ensure the successful implementation of their education program. This plan should include administrative details, a clear description of the audience to be educated, schedules and venues, logistics, test and evaluation procedures, instructor assignments, and a budget.

e.) *Evaluate:* The evaluation component of the ISD process focuses on the development of methods for tracking student performance and for evaluating the effectiveness of the education program. As outlined by Kirkpatrick (Kirkpatrick, 1994), the evaluation of training programs can be conducted on four distinct levels, as follows:

f.) Level 1 – Reaction: An assessment by learners of the value and effectiveness of the program.

g.) Level 2 – Learning: An assessment of the learners' achievement of the program's learning objectives. This assessment is usually conducted through pre- and post-tests.

h.) Level 3 – Behavior: An assessment of behavior change among learners in work or other performance situations resulting from the program. This assessment can be conducted via observations, surveys, interviews, or focus groups with learners and supervisors.

i.) Level 4 – Results: An assessment of the effect of the learning program in the larger environment. This assessment is usually carried out as part of a formal research program.

As is the case when incorporating any new and significant set of educational skills and knowledge into a preexisting curriculum, the work of incorporating a carefully constructed cultural and linguistic competency component into the education of health care professionals may require consultation with experts from both within and outside the school itself. Fortunately, many COEs have developed expertise in specific areas of cultural and linguistic competency education and could be asked to share their experience. Additionally, the field of cultural and linguistic competency education has matured sufficiently in the past decade so that there are many experts working in the various facets of the field. Curriculum designers are encouraged to review the many resources in Chapter 10, Resources, in which specific educational strategies have been described by those who have had success in implementing them. (In particular, see Betancourt, et al, 2002, and Culhane-Pera, et al, 2004.)

Chapter 5: Curriculum Content

According to the Liaison Committee on Medical Education an accreditation standard for medical schools is that "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," and that "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." Medicine, however, is only one of the many health care fields that now require cultural and linguistic competency training for its professionals (see Chapter 10, Resources, Section I, for statements from several health care fields regarding this requirement).

This chapter provides guidance and recommendations to COEs on content areas that should be considered for inclusion in a cultural and linguistic competency curriculum in any health care profession. This chapter begins with a discussion about the theory of learning objectives and core topics and ends with practical examples from organizations that have put these theories into practice. The topics covered in this chapter include: learning objectives, recommended core competencies, recommended core curriculum topics, and examples of curriculum models. The last section includes three models that are used in curriculum development.

As stated in the Executive Summary, this curriculum guidance is provided to COE grantees as a generic model for use in planning and developing cultural and linguistic competence educational activities with faculty and students. Naturally, practitioners and educators in COEs focused on different areas of health care will need to concentrate on different core competencies and content topics, identify appropriate and discipline-based learning objectives, use various teaching methods and tools, and employ appropriate assessment and evaluation strategies. The curriculum can build on work many COEs are already doing and is not mandatory or intended to replace existing or planned cultural and linguistic competency activities.

COEs are strongly encouraged to use these recommendations to develop collaborative partnerships with communities and other university departments and to share experiences in using these recommendations with other COEs. Of course, each COE following these suggestions will need to tailor them to meet its individual needs.

I. Learning Objectives

COEs developing content for a curriculum on cultural and linguistic competence will want to meet objectives in three areas:

A. Awareness/attitudinal
B. Skills
C. Knowledge

A. Awareness or attitudinal objectives

Awareness or attitudinal objectives include self-awareness and awareness of the dangers of bias, stereotyping and overgeneralization. These objectives also include awareness about the following variations in patient populations, among others:

- Immigrants, refugees, and other stigmatized groups

- Those who live in poverty and other class-based differences

- Those who have limited English proficiency; believe in complementary, alternative, and integrative medicine and other healing traditions; and who believe in traditional, alternative, and folk healers

B. The skills objectives

The skills objectives naturally involve communication, such as interacting with and interviewing patients, and include other communication skills related to:

- Forming a therapeutic alliance and achieving common ground

- Greeting and closing behaviors in clinical settings

- Negotiating and problem solving

- Communicating appropriately with culturally diverse patients and families

- Working effectively with interpreters using different modalities, such as those who are on-site and over-the-phone; having a pre-session with an interpreter, and working to ensure the patient's understanding through an interpreter

- Eliciting a patient's history or use of traditional/alternative/folk remedies; recognizing symptoms or signs related to the use of traditional/alternative/folk remedies; and collaborating with traditional/alternative/folk healers

- Negotiating cross-cultural conflicts relating to diagnosis, treatment, and compliance with treatment and prescription plans

- Apologizing for cross-cultural errors and seeking clarification from patients on these issues.

In interacting with diverse patients along the lines outlined above, it is critically important for health care providers to understand that communication patterns, perception of provider and patient/family interactive roles, and interpretation of diagnoses and treatment information may be very different from what they are accustomed to if they are unaccustomed to working with patients from different cultures. Additionally, since cultures tend to differ along these communication dimensions, having a facility for working with one cultural group does not always carry over when working with another group.

Communication skills also involve having the ability to develop a culturally and linguistically appropriate diagnostic, treatment, and care plan with patients and their families (see Appendix A, The Toolbox, for samples and Chapter 10, Resources, for other resources in patient assessment) and for having a format to use when assessing a patient's family and community support.

C. The knowledge objectives

The knowledge objectives involve having an understanding of a wide variety of historic, demographic, health, and other factors within the general and local populations and within the health and mental health professional workforce. For example, health care practitioners will need a thorough understanding of the historic and contemporary effect of racism, bias, discrimination, prejudice, and other forms of oppression various population groups have experienced in accessing and using the health care system.

These practitioners also may need to understand the cultural issues relating to spirituality, health, and illness and the different healing traditions, such as Ayurvedic and Traditional Chinese Medicine, among others. They will certainly need to understand the concept of culture-driven behavior as it may affect the onset, distribution, course, treatment, and outcome of disease processes. They will need to know the difference between interpretation and translation and how to use each of these professional resources when working with patients with limited English proficiency.

They will also need to know the:

- Health risks and illnesses experienced by individuals who are homosexual, bisexual, and/or transgender

- Health risks and illnesses and wellness, health promotion, and utilization of preventive services experienced by African American, Hispanic American, Asian American/Pacific Islander American, American Indian/Native American, European American populations, and multi-racial/ethnic populations

- Potential benefits and side effects of various complementary and alternative medicine (C/AM) treatment modalities and potential drug interactions between C/AM treatment modalities and allopathic medications

II. Recommended Core Competencies

The recommended core competencies in this section were developed by the University of Medicine & Dentistry of New Jersey–New Jersey Medical School in collaboration with Dr. Maria L. Soto-Greene, chief of staff and vice president, director of the Hispanic Center of Excellence. A fundamental part of the development of the core competencies was the IOM report, *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care* (2002), the findings of which are discussed at the end of this section.

Among the specific areas related to cultural competency that a COE should require of its students and faculty are knowledge and skills in the following:

- The effect that race, ethnicity, gender, age, language, country of origin, sexual orientation, religion/spirituality, socioeconomic class, political orientation, educational/intellectual levels, and physical/mental ability have on creating and contributing to health disparities

- The demographic influences on health care quality and effectiveness in the diagnosis and treatment of disease at an individual and community level

- The total health needs of their patients and the effects that social and cultural circumstances have on their health and their community

- The effect of provider bias on the practitioner-patient relationship and health outcomes.

Students and faculty also should be able to:

- Define the terms frequently used in cultural/linguistic competency development

- Identify ways to eliminate provider bias in the practitioner-patient interaction and the health care system

- Recognize the influence gender, sexual orientation, race/ethnicity, religious, socio-economic status (SES), and cultural biases have on care

Among the skills students and faculty should have are the ability to recognize and appropriately address:

- Gender, sexual orientation, race/ethnicity, religious, SES, and cultural biases in patients

- Gender, sexual orientation, race/ethnicity, religious, SES, and cultural biases in health care delivery.

Students and faculty also should be able to:

- Work effectively with limited English speaking patients

- Demonstrate the ability to perform a clinical assessment including a diagnostic and treatment plan that accommodates the belief system, gender, language, and cultural and socioeconomic context of the patient

- Negotiate with the patient or family a treatment plan that is medically appropriate and compatible with the patient's beliefs, needs, and desires

- Apply knowledge of the patient's gender, sexual orientation, race/ethnicity, religious, socioeconomic status (SES), and culture to provide culturally competent care

- Identify suspected gender, sexual orientation, race/ethnicity, religious, SES, and cultural biases in another health care professional and respond appropriately

The IOM report, *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care* (2002) makes clear the problem of bias, stereotyping, and prejudice in health care settings. The report found that while it is reasonable to assume that most health care providers find prejudice

morally abhorrent and at odds with their professional values, these providers are like other members of society who may not recognize manifestations of prejudice in their own behavior.

The report's executive summary explains the problem of bias in health care settings:

> "While there is no direct evidence that provider biases affect the quality of care for minority patients, research suggests that health care providers' diagnostic and treatment decisions, as well as their feelings about patients, are influenced by patients' race or ethnicity. Schulman et al (1999), for example, found that physicians referred White male, Black male, and White female hypothetical "patients" (actually videotaped actors who displayed the same symptoms of cardiac disease) for cardiac catheterization at the same rates (approximately 90 percent for each group), but were significantly less likely to recommend catheterization procedures for Black female patients exhibiting the same symptoms. Weisse et al. (2001), using a similar methodology as that of Schulman, found that male physicians prescribed twice the level of analgesic medication for White "patients" than for Black "patients." Female physicians, in contrast, prescribed higher doses of analgesics for Black than for White "patients," suggesting that male and female physicians may respond differently to gender or racial cues.

> "In another experimental design, Abreu (1999) found that mental health professionals subliminally "primed" with African American stereotype-laden words were more likely to evaluate the same hypothetical patient (whose race was not identified) more negatively than when primed with neutral words. And in a study based on actual clinical encounters, van Ryn and Burke (2000) found that doctors rated Black patients as less intelligent, less educated, more likely to abuse drugs and alcohol, more likely to fail to comply with medical advice, more likely to lack social support, and less likely to participate in cardiac rehabilitation than White patients, even after patients' income, education, and personality characteristics were taken into account. These findings suggest that while the relationship between race or ethnicity and treatment decisions is complex and may also be influenced by gender, providers' perceptions and attitudes toward patients are influenced by patient race or ethnicity, often in subtle ways."

As a result of the problems of bias, stereotyping, and prejudice in health care settings, it is clear that education designed to meet the standards of multicultural evidence-based clinical care should cover a wide variety of topics, including the human genome project, population genetics, and ethnopharmacology. Such care for different populations should also involve tailoring clinical practice and preventive service guidelines for health and mental health conditions, and should recognize the role of complementary, alternative, and integrative medicine; of various healing modalities; and of traditional healers. By taking these steps, health care practitioners will improve the quality of care they deliver while also improving patient safety by helping to manage risks more effectively and reduce the rate of medical errors.

Health care providers need to strike a balance between understanding existing statistics about patients who represent various populations and not allowing these statistics to unduly influence their decision making. The process of addressing a patient should be guided by a thorough understanding

of health statistics but not determined by it. For example, when a provider examines a Black male in his 50s, the practitioner understands that many Black males in this age group are prone to conditions of the prostate, and so the practitioner would need to examine the patient's prostate. But not all Black males in this age group have such problems. In other words, clinicians need to balance data while avoiding using data to reinforce stereotypes.

III. Recommended Core Curriculum Topics

Given the disparities cited in the IOM and other reports, the recommended core curriculum topics should include eliminating health and health care disparities in a variety of forms. These include historic and contemporary experiences of diverse population groups with the health care system, such as racism and other forms of discrimination and prejudice and barriers to care. The core curriculum also should address health and health care disparities that are related to access, service utilization, quality, and outcomes. In an effort to eliminate disparities, faculty should encourage collaboration with communities, and should comply with legislative and institutional guidelines, such as those put forth by the LCME.

A core curriculum also should address the effect of stereotyping in clinical decision-making. Course work on this topic should include a history of stereotyping to show how it can limit access to health care and to education, and a thorough discussion of bias, discrimination, racism, and privilege. These courses also should address the effects of stereotyping on outcomes.

In many health care settings, practitioners may fail to recognize the role of culture and language in health and illness behavior, and in health care delivery. Many Americans believe strongly in self-care and alternative healers, for example, or their culture may have healing traditions of which those who were trained in traditional medicine are unaware. Religion and spirituality also play a significant role in how a patient will respond to a prescribed treatment plan. The professional cultures of medicine, dentistry, pharmacy, psychology, and other health care disciplines may not address the cultural issues involved in delivering care. In some cultures, for example, it is not appropriate to look directly into a person's eyes, and a physician or nurse trained in the American health care system may do so out of habit as result of his or her training. In many cultures, patients will be reluctant to speak directly about some topics, meaning health care practitioners will need to make a professional judgment based on what can be implied from a patient's words.

For these reasons, health care providers should never make assumptions based on the color of a patient's skin, may need to be exposed repeatedly to patients from a variety of cultural settings, and may need to rely on a variety of experts to help them understand the needs of their patients.

COEs seeking to address the challenges of cross-cultural or intercultural communication will want to describe the cultural and linguistic components involved in physician-patient communication, identify the cultural differences that may affect patient—clinician communication, and solutions to bridging linguistic and cultural differences. They will also want to teach students how to work with interpreters and translators. Doing so will involve developing a thorough understanding of the CLAS Standards and the guidance on working with those who have limited English proficiency (LEP) issued by the Federal Department of Health and Human Services Office for Civil Rights

(OCR). The OCR issued revised *Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons*. More information on the OCR's LEP guidance is available online at (http://www.hhs.gov/ocr/lep/).

An area of health care that is related to cross-cultural or intercultural communication involves health literacy. Nearly half of all American adults—some 90 million people—have difficulty understanding and using health information. There is a higher rate of hospitalization and use of emergency services among patients with limited health literacy, according to a report in 2004 from the Institute of Medicine, *Health Literacy: A Prescription to End Confusion* (http://www.iom.edu/report.asp?id=19723). Health literacy involves reading skills as well as writing, listening, speaking, knowledge of health concepts and arithmetic, and is defined as the degree to which individuals have the capacity to obtain, process, and understand basic information and services needed to make appropriate decisions regarding their health, the report says.

Public health agencies, health care systems, the health care education system, the individual health care practitioner, the media, and health care consumers need to work together to improve the Nation's health literacy, the IOM report explains. Limited health literacy affects more than just the uneducated and poor. Even well educated people with strong reading and writing skills may have trouble comprehending a medical form or doctor's instructions regarding a drug or procedure, the report noted. More than 300 studies show that most of the people for whom health-related materials are intended cannot understand the materials.

Recognizing that low literacy may negatively affect health and well-being, the Federal Agency for Health care Research and Quality (AHRQ) Rockville, MD, commissioned an evidence report from the RTI International-University of North Carolina Evidence-based Practice Center (RTI-UNC EPC) on the topic. In the report, the researchers consolidate and analyze the body of literature that has been produced to date regarding the relationship between literacy and health outcomes and the evidence about interventions intended to improve the health of people with low literacy. The report, *Literacy and Health Outcomes, Summary, Evidence Report/Technology Assessment No. 87,* by Berkman, N.D., DeWalt, D.A., Pignone, M.P., Sheridan, S.I., Lohr, K.N., Lux, L., Sutton, S.F., Swinson, T., Bonito, A.J., is AHRQ Publication No. 04-E007-1.: Agency for Health care Research and Quality, January 2004. (http://www.ahrq.gov/clinic/epcsums/litsum.htm).

Recognizing these problems, health care professionals can be taught to assess their patients' health care literacy and devise strategies to work effectively with low literacy patients. Students and faculty can identify patients with limited or low health literacy skills by using the following tools (see Appendix A, The Toolbox, for more information):

- Ask Me 3™ (Partnership for Clear Health Communication; http://www.askme3.org)

- Rapid Estimate of Adult Literacy in Medicine (REALM) – English and Spanish language versions

- Test of Functional Health Literacy in Adults (TOFHLA)

A number of useful overall curriculum guides are available to COEs developing curriculum content in cultural and linguistic competence.

In 1996, the Society of Teachers of Family Medicine's Task Force on Cross-Cultural Experiences published (Like, Steiner, & Rubel, 1996) an extensive set of guidelines on necessary curriculum elements for the cultural competency education of family practice residents. The curriculum brought together the thinking of family practice clinicians and medical anthropologists and is an excellent and comprehensive model, based on a framework of clinically appropriate attitudes, knowledge, and skills. While created for family practice graduate students, the elements in the curriculum will serve as a useful guide for persons designing curricula for any health professionals directly involved in patient care (see Appendix A). The framework does not suggest any particular order in which the elements are to be taught, but the framers envisioned a three-year developmental course of study that included applying the information in the context of patient care and community contact. The authors suggest a variety of techniques for delivering the curriculum: hospital rounding, including grand rounds, lectures, clinical case conferences, small group seminars, Balint groups, precepting, video viewing, journal club, home visits, and community fieldwork experiences.

Additionally, in 2002, a National group of physicians, nurses, health educators, medical anthropologists, and health administrators gathered under the sponsorship of The California Endowment to define a cultural competence curriculum appropriate to health providers, also used the attitudes, knowledge, and skills framework. That curriculum, referenced in Chapter 10, can be found in the publications section at the website of The California Endowment, www.calendow.org. The materials also contain information on delivery strategies, evaluation issues, and appropriate trainers.

Finally, the American Association of Medical Colleges plans to publish guidance in 2005 for creating and evaluating cultural and linguistic competency in medical colleges. Called the *Tool for Development of Cultural Competence Training* (TAACT), the guidance will outline necessary content for a comprehensive cultural and linguistic competency curriculum in medicine. All of these curriculum guides are referenced in the resources chapter.

IV. Examples of Curriculum Models

The examples of curriculum models that follow could be used or adapted for use in a program on cultural and linguistic competence. Each one offers a highly useful example of how the teaching of cultural and linguistic competence has been developed for different settings: a medical school, a primary care physician's office practice, and for psychiatrists. These models are applicable to a wide variety of health care practitioners seeking a systematic review of an individual's cultural background, the role of the cultural context in the expression and evaluation of symptoms and dysfunction, and the effect that cultural differences may have on the relationship between the individual and the clinician.

The three examples are:

    A. A Cross-Cultural Care Primer from the Harvard Medical School
    B. A Family Physician's Practical Guide to Culturally Competent Care, an online course from the Federal Office of Minority Health's Cultural Competency Curriculum Modules (CCCMs)

C. The Outline for Cultural Formulation in *The Diagnostic and Statistical Manual-IV* (*DSM-IV TR*), published by American Psychiatric Association – NAAPIMHA Curriculum on AAPI Mental Health

A. Cross-Cultural Care Primer—Harvard Medical School

The Cross-Cultural Care Primer was developed under the direction of Joseph R. Betancourt, MD, MPH, and the Culturally Competent Care Education Committee (CCCEC) at the Harvard Medical School (HMS). Based on the work of Betancourt; J. Emilio Carrillo, MD, MPH; and Alexander R. Green, MD, the primer was developed to provide a patient-centered care framework that could be used for teaching medical students and for caring for patients in cross-cultural situations. In 2003, the primer was distributed to all second-year students at the Harvard Medical School and to all Patient-Doctor II course directors and preceptors. Students used the primer to prepare for the Observed Structured Clinical Exam II (OSCE II), which includes a section on cross-cultural care. The primer has also been distributed throughout the school and its affiliated hospitals. Dr. Augustus A. White, III, chair of the CCCEC, is recommending that students use the primer with at least one patient.

The goals of the primer are to:

- Establish the importance of socio-cultural factors and their effect on health beliefs, behaviors, and medical care

- Learn a set of key concepts and skills that enhance the ability to communicate with, diagnose, and treat patients from diverse socio-cultural backgrounds (including identifying core cross-cultural issues, eliciting the explanatory model, determining the social context, using an interpreter, and provider-patient negotiation)

- Learn the practical application of these concepts and skills in the clinical setting

The primer says clinicians should follow four steps when caring for all patients, but in particular those patients who are from a social or cultural background different from that of the care provider. Clinicians should think of these four steps as a "review of systems" focused on issues that, if not addressed, may lead to poor health outcomes. The four steps are:

1. Identify the core cross-cultural issues
2. Explore the meaning of the illness
3. Determine the social context
4. Negotiate

Step 1—Identify the Core Cross-Cultural Issues. When a clinician sees a patient from a different or unfamiliar socio-cultural background, he or she should consider a broad set of core cross-cultural issues that may be important for that individual. The clinician should try to place the individual patient on a continuum as it relates to issues that are important to all cultures by considering the following:

- Styles of communication: How does the patient communicate? Communication includes issues relating to: eye contact, physical contact, and personal space; and issues about how

the patient may prefer to hear "bad news." For example, is the patient deferential or confrontational? Does the patient display stoicism or express symptoms willingly?

- Mistrust and prejudice: Does the patient mistrust the health care system? If so, clinicians should recognize prejudice and its effects and attempt to build trust by reassuring the patient of one's intentions. Keep in perspective "what's at stake" for the patient, and show respect for the patient's concerns.

- Autonomy, authority, and family dynamics: How does the patient make decisions? What is the role of the family versus the individual in decision making? What support does the patient have from his or her family of origin, partner, and friends? What is the role of the authority figure within the family or social group? What role does community or spiritual leaders play in important decisions?

- The role of the practitioner and biomedicine: What does the patient expect of clinicians and what is the clinician's role? What are the patients' expectations for the practitioner and biomedicine? What perspectives does the patient have about the practitioner? Does the patient consider the clinician to be a service provider or gatekeeper, for example? What are the patient's views on alternative medicine versus biomedicine?

- Traditions, customs and spirituality: How do these factors influence the patient? These attitudes include issues regarding medical procedures, such as drawing blood, and rituals pertinent to the medical encounter. What culturally specific "alternative" therapies does the patient consider, including culturally specific diet and preferences?

- Sexual and gender issues: How central are these issues to the patient's life? Is there gender concordance or discordance? What attitudes does the patient have toward the physical exam and the gender of the practitioner? Clinicians should use the preferred pronoun for patients who are transgender or transsexual and consider the issue of shame or embarrassment when discussing sexual issues. Consider also the differences in sexual behavior, orientation, and identity.

Step 2—Explore the Meaning of the Illness. Each patient will have a different understanding about disease and treatment. These perspectives will shape the patient's behavior. It may be particularly helpful to assess the patient's concept of illness, or "explanatory model," when the practitioner does not feel he or she understands the patient's behavior, when there is non-adherence to a treatment plan, or when there is some sort of conflict.

Clinicians can make such determinations by asking the patient the following questions:

- What do you think has caused your problem? How?

- Why do you think it started when it did?

- How does it affect you?

- What worries you most: the severity of the condition, or duration of the illness, or both?

- What kind of treatment do you think you should receive? What expectations do you have?

Step 3—Determine the Social Context. The "social context" is of equal importance as an area of exploration, given how social and cultural factors are intertwined. Certain key areas should be considered when identifying the patient's social context:

- Tension (social stress and support systems): Does the patient have social support, or is he or she isolated?

- Environment change (degree and reason for change, expectations, and acculturation): What was the patient's previous health care experience, and how does that experience shape his or her interaction with the health care system now?

- Life control (including social status, poverty, and education): What resources does the patient have? Can he or she afford medications?

- Literacy and language: Does the patient have limited English proficiency or literacy, and how does such a limit affect his or her health care?

Step 4—Negotiate. Once the above information is obtained, the clinician should engage in negotiation with the patient to try to achieve the best possible outcome. Sometimes what is acceptable is better than what is optimal, if the risk of trying to secure the optimal would involve losing the patient's trust. Such negotiation requires exploring the meaning of the illness for the patient and formulating a mutually acceptable plan.

When the clinician is caring for a patient with limited or no English proficiency, securing a trained interpreter is critical. Once the clinician has secured an interpreter, he or she should follow these guidelines:

- Pre-interview: Prior to interviewing the patient, meet briefly with the interpreter to discuss logistics, known issues, and the goals for the encounter.

- Etiquette: When possible, try to arrange triangular positioning, in which the clinician faces the patient and the interpreter is on the side or behind the patient. Positioning should be done so as to encourage a therapeutic and supportive relationship and to ensure that all parties can hear during the session. But positioning should also take into account the interpreter's safety. In general, first person is encouraged. In some instances, however, first person may not work because of the linguistic nuances, or when using the first person might cause confusion. Confusion is not uncommon with elderly patients, and when the conversation is over the phone where there are no verbal cues. Also, direct eye contact with the patient is recommended, but making eye contact—or not—is a cultural norm that should be respected. If the clinician has a question about the patient's meaning or length of response, ask the patient and interpreter to clarify. Be aware that there are cultural variations regarding preferred etiquette, and having a team approach—involving the patient and provider in which the interpreter serves as a culture broker—may help address differences.

- The dialogue: Try to use single questions and short phrasing, attend to the interpreter's need to interpret what the each party is saying, and break long statements and questions down to shorter segments.

- Debriefing: Give and get feedback from the interpreter and ask for questions.

In some instances, the clinician may not have a formal interpreter or telephone-based interpretation service available. In such cases, the clinician may need a casual or ad-hoc interpreter, which could be a co-worker or family member, but never a child. Be aware that when using ad hoc interpreters, there is a higher risk of error than when using trained interpreters. Ideally, an interpreter should be neutral, and qualified to transmit confidential and sensitive information. It is the clinician's responsibility to ensure that the communication is effective, especially if the patient insists on using a family member or friend. Children who are minors should not be used as interpreters in any clinical situation unless it is an emergency. A professional interpreter should be obtained as soon as possible. What's more, clinicians must be aware of state laws regarding the use of health care interpreters. In Massachusetts, for example, interpreters are required in emergency rooms and mental health settings.

In the unusual circumstance of having to use an ad hoc interpreter, the following can serve as a guide on how to proceed:

- Recognize the importance of the perspective of the family member or friend, get that perspective, and then emphasize the importance of getting as much information as possible directly from the patient

- Trust one's senses: If the responses seem inadequately translated, or the history is confusing, insist on getting a trained interpreter

- Keep in mind that when using a family member or friend, there may be significant issues involving confidentiality and accuracy, which could embarrass the patient, and so using an ad hoc interpreter might be ill-advised. Additionally, when domestic violence is involved or suspected, do not use spouses or partners as interpreters. In such cases, what may seem routine may not be true, and so a neutral person would be most effective as an interpreter in such situations

For more information on using interpreters, see *General Guidelines for Effective Use of Interpreters in a Medical Setting*, by M. Jean Gilbert, Ph.D., in Appendix A, The Toolbox.

B. A Family Physician's Practical Guide to Culturally Competent Care–An Example of an Online Training Course

A Family Physician's Practical Guide to Culturally Competent Care is a free online self-directed training course for family physicians offered by the Federal Office of Minority Health's Cultural

Competency Curriculum Modules (CCCMs). The Website for A Family Physician's Practical Guide to Culturally Competent Care offers continuing medical education (CME) credit and is designed to provide family physicians with awareness, knowledge, and skills to better treat the increasingly diverse U.S. population they serve. The CME activity is supported through funds from the Office of Minority Health (ORM) of the U.S. Department of Health and Human Services.

ORM recognizes that there is growing concern about racial and ethnic disparities in health, that the health care systems needs to accommodate increasingly diverse patient populations, and that cultural and linguistic competence has become a matter of National concern. To train family physicians to care for diverse populations, ORM commissioned the modules.

The CCCMs were developed because cultural and language differences may engender misunderstanding, lack of compliance, or other factors that negatively influence clinical situations. By becoming aware of their own attitudes, beliefs, biases, and behaviors that influence patient care, health care providers can help improve access and quality and enhance outcomes. Among the specific objectives of the CCCMs are to:

- Improve the health of racial and ethnic minority populations

- Close the gap between minority and non-minority populations

- Coordinate the development and implementation of policies and programs affecting these populations.

The modules were developed with the intent that they would serve as a valued educational resource to equip family practitioners with specific cultural and linguistic competencies required to improve the quality of care for minority, immigrant, and ethnically diverse communities. Critical to their use, and hence to their effect on health care, is their widespread dissemination. Toward this end, the CCCMs were developed for CME credit. Participants are eligible for nine hours of CME credits. In addition, the modules were developed in several formats to increase usage by physicians and increase their dissemination in mainstream health care.

The modules are available as an interactive Website, on a DVD, and in a print version. Among the features of the Website are streaming video case studies, chat room functionality, instant scoring and CME certificate issuance, and links to additional resources. The site is designed to meet the needs of busy health care providers.

The Interactive Website

The Website for A Family Physician's Practical Guide to Culturally Competent Care contains a variety of self-assessment tools, case studies, video vignettes, learning points, CME posttests, and the opportunity to submit and receive feedback regarding specific cases and content. The Website at http://cccm.thinkculturalhealth.org/ is free and serves not only as the portal to the CME program but also provides references on the latest issues in cultural and linguistic competency.

The CME program keeps track of which sections practitioners have completed, gives instant, on-line certifications for as many as nine hours of American Medical Association Category 1 CME credit and nine hours of American Academy of Family Physicians' credit.

Once a practitioner registers on the Website to use the guide, he or she will be instructed to read the curriculum introduction and the overview of the National Standards for Culturally and Linguistically Appropriate Services in Health Care (the CLAS standards). Practitioners also are instructed to read the themes and the background information about the cases, physicians, and patients introduced in the modules. Then the practitioner can begin to work through the contents of the modules and could start with any of three themes:

1. Culturally competent care
2. Language access services
3. Organizational supports.

Each theme includes three modules. The user must complete the modules in the theme in chronological order. Each module is organized in the following format:

The doctors' week (case). This area introduces a case study in which a family physician must identify and meet the challenges of cultural or linguistic issues in clinical care. A supplementary video vignette is offered as well.

Self-exploration. This area includes questions designed to help clinicians understand their insights about and reactions to clinical situations. The user will be asked to answer, from different perspectives, questions about the case that follow the pattern of a modified BATHE (Background, Affect, Trouble, Handling, and Empathy) interviewing technique.

Learning points. This area informs course participants about the module topic.

Further exploration. The area asks the user to apply the module content to questions about the case and his or her medical practice.

Other perspectives. This section provides ideas from other curriculum participants about cultural and linguistic competency issues and their opinions about handling the cases.

Module posttest. The CME posttest includes 10 multiple-choice questions to test the participants' knowledge of the module content. In order to receive CME credit, the user must achieve a score of 70 or higher.

Module components, learning objectives, and key points are provided in each module. Highlights throughout the text provide summaries of important concepts. Text boxes include facts about noteworthy aspects of culturally competent care.

Upon completion of this program, the user will be able to:

- Define issues related to cultural and linguistic competency in medical practice

- Identify strategies to promote self-awareness about attitudes, beliefs, biases, and behaviors that may influence the clinical care he or she provides

- Devise strategies to enhance skills used in the provision of care in a culturally competent clinical practice

- Demonstrate the advantages of the adoption of the CLAS standards as appropriate in a clinical practice

C. The *DSM-IV TR* Outline for Cultural Formulation When Assessing and Diagnosing Patients

Rendering psychological and psychiatric assistance to a diverse population carries with it some special issues as well as those more generally noted in other curricula. Consequently, faculty and clinicians in the mental health and behavioral health fields have been working to include diagnostic and clinical criteria that would assist practitioners in becoming more culturally and linguistically competent. One concise clinical tool to aid the clinician in this process is the Outline for Cultural Formulation (OCF) found in Appendix I of the *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision* (known as *DSM-IV-TR*) from American Psychiatric Association in Arlington, VA (www.appi.org).

Although intended for use with the *DSM-IV TR* in assessing mental disorders, the OCF is applicable to other clinical health care encounters. It provides a systematic review of the individual's cultural background, the role of the cultural context in the expression and evaluation of symptoms and dysfunction, and the effect that cultural differences may have on the relationship between the individual and the clinician. As a result of using the OCF, the clinician provides a narrative summary for each of the following categories:

1. Cultural identity of the individual
2. Cultural explanations of the individual's illness
3. Cultural factors related to the psychosocial environment and levels of functioning
4. Cultural elements of the relationship between the individual and the clinician
5. Overall cultural assessment for diagnosis and care

1. Cultural identity of the individual. Note the individual's ethnic or cultural reference groups. For immigrants and ethnic minorities, note separately the degree of involvement with both the culture of origin and the host culture, where applicable. Also note language abilities, use, and preference, including multilingualism.

2. Cultural explanations of the individual's illness. The following may be identified: the predominant idioms of distress through which symptoms or the need for social support are communicated (such as "nerves," possessing spirits, somatic complaints, and inexplicable misfortune), the meaning and perceived severity of the individual's symptoms in relation to norms of the cultural reference group, any local illness category that the individual's family and community use to identify the condition (such as those explained in the *DSM-IV TR's* "Glossary of Culture-Bound Syndromes"), the perceived causes or explanatory models that the individual and the reference group use to explain the illness, and current preferences for and past experiences with professional and popular sources of care.

3. Cultural factors related to the psychosocial environment and levels of functioning. Note culturally relevant interpretations of social stressors, available social supports, and levels of

functioning and disability. These stressors would include those in the local social environment and the role of religion and kin networks in providing emotional, instrumental, and informational support.

4. Cultural elements of the relationship between the individual and the clinician. Indicate differences in culture and social status between the individual and the clinician and problems that these differences may cause in diagnosis and treatment, such as difficulty in communicating in the individual's first language, in eliciting symptoms or understanding their cultural significance, in negotiating an appropriate relationship or level of intimacy, and in determining whether a behavior is normative or pathological.

5. Overall cultural assessment for diagnosis and care. The formulation concludes with a discussion of how cultural considerations specifically influence comprehensive diagnosis and care.

The clinician assesses the first four interrelated sections, which provide information that will have an effect (in the fifth section) on the differential diagnosis and the treatment plan. Clinicians must cultivate an attitude of "cultural humility" in knowing their limits of knowledge and skills in applying the OCF with accuracy rather than reinforcing potentially damaging stereotypes and over-generalizations.

Cultural identity involves a range of variables not only including ethnicity, acculturation and biculturality, and language, but also age, gender, socioeconomic status, sexual orientation, religious and spiritual beliefs, disabilities, political orientation, and health literacy, among other factors. In addition, assessment of cultural identity must move from merely the clinician's perspective to include the patient's self-construal of identity over time.

The second section asks the clinician to inquire about the patient's idioms of distress, explanatory models, and treatment pathways (including complementary and alternative medicine and indigenous approaches) and to assess these pathways against the norms of the cultural reference group. The third section highlights the importance of the assessment of family and kin systems and religion and spirituality. The fourth section focuses on the complex nature of the interaction between the clinician and the individual including transference and counter-transference, which may either aid or interfere with the treatment relationship. In the final section, the clinician summarizes his or her understanding of the previous sections and can apply this understanding to a differential diagnosis and treatment plan.

NAAPIMHA Curriculum on AAPI Mental Health

The National Asian American Pacific Islander Mental Health Association (NAAPIMHA) has found the *DSM IV TR* Outline for Cultural Formulation provides a rich theoretical framework in making culturally appropriate assessments, diagnosis, and treatment plans. Using the *DSM IV TR*, NAAPIMHA developed a curriculum and pre-service training program in 2002 that is designed to help reduce disparities in mental health care for diverse populations by building a workforce capacity. The aim of the curriculum was to address the mental health needs of Asian Americans and Pacific Islanders and was developed under a grant from the U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services.

The curriculum, called *Growing Our Own,* is for the disciplines of psychiatry, psychology, social work, and counseling. It draws upon years of experience, assessing what does and does not work in providing culturally competent mental health services to the AAPI communities. It is being implemented at the Asian Counseling and Referral Services in Seattle, Wash.; the Asian Pacific Development Center in Denver, CO; Hamilton Madison House in New York, NY; Hale Na'au Pono in Wai'anai, Hawaii; and at two sites in San Francisco, CA: RAMS, Inc. and The University of California, San Francisco (UCSF) at San Francisco General Hospital. The sites were chosen based on their history of providing culturally competent services and training and their diverse geographical representation.

The five modules of the *Growing Our Own* curriculum build on each other and are intended to help the intern or resident develop an approach that avoids simplistic cookbook conclusions. The five modules are as follows:

Module 1 – Self Assessment helps interns or residents to recognize the biases that influence what we see and how these biases affect decision-making.

Module 2 – Connecting With Your Client is designed to help trainees become familiar with AAPI in general and provide them with the requisite knowledge, skills, and attitudes to communicate effectively with consumers and work with interpreters.

Module 3 – Culturally Responsive Assessment and Diagnosis is designed to identify factors that lead to the development of a culturally competent assessment and diagnosis.

Module 4 – Culturally Responsive Intervention focuses on concepts and strategies the intern or resident should consider in formulating and implementing a culturally responsive intervention plan, regardless of the particular intervention model employed.

Module 5 – Culturally Responsive Systems identifies barriers that consumers and service providers face under the current mental health system, highlights the important role of mental health professionals as agents of institutional change, and offers recommendations to help guide culturally competent systems change.

Chapter 6: Delivering a Cultural and Linguistic Competence Curriculum

The preceding chapters focused on the essential content of cultural and linguistic competence training for health professionals. This chapter suggests some basic pedagogical strategies for incorporating this content into curricula. It begins with a discussion about the theory of delivering a curriculum, and ends with practical examples from organizations that have put these theories into practice. Included are discussions about:

- developing faculty commitment

- providing a rationale for building cultural and linguistic professional competencies

- creating a developmental learning path

- integrating cultural and linguistic subject matter into basic and elective courses

- sample tools for delivering cultural and linguistic curricula

Specific areas of cultural and linguistic subject matter, such as health care disparities and cross-cultural communication skills, require special attention. Suggested methods for enhancing the delivery of a cultural and linguistic curriculum include bringing in outside expertise from other disciplines in the university and from the community. Some of the subject matter inherent in teaching cultural and linguistic competency can create emotional responses in students, requiring excellent facilitation skills on the part of faculty. Methods of dealing with such responses are briefly discussed.

The goal of a comprehensive cultural and linguistic competence focus within the Centers of Excellence is to give health professionals the skills and knowledge to care effectively for a diverse patient caseload and aid them in forming good therapeutic alliances with those patients. More important, however, such a curriculum should move students to embrace lifelong attitudes that allow them to learn from their diverse patients, to continue to seek new and developing information on health care disparities, and to practice their professions in such a way as to promote equity in health care. The students should leave their formal professional educations with a willingness and strong desire to pursue cultural and linguistic competence throughout their professional lives. In order to create this response at both affective and intellectual levels, cultural and linguistic competence curricula need to be lively, intellectually stimulating, and emotionally rewarding. It needs to be inserted in many ways throughout the course of the students' studies and learning experiences.

Since many medical, nursing, dental, and pharmacy schools have been incorporating cultural and linguistic competency education into their curricula in the last decade, there is extensive literature on the topic (see Chapter 10, Resources). It would be useful for any group charged with integrating cultural and linguistic elements into a curriculum to systematically review these resources, many of which document successful and innovative strategies for incorporating cultural and linguistic materials into curricula. Review of the resources currently available also may help to identify

experts willing to serve as consultants on program development or to train clinicians in specific areas.

I. Developing Faculty Commitment

There is probably no more important strategy for implementing cultural and linguistic competency education than having a broad-based, multidisciplinary cadre of committed, knowledgeable, and enthusiastic faculty dedicated to developing and including cultural and linguistic information in the curriculum. Students will grasp the importance of such information readily if faculty clearly and vigorously endorses it as an essential ingredient of professional training. Ideally, such faculty should represent every sub-discipline or specialty and the various ethnic, racial, and professional backgrounds.

The experience of such schools as the Medical College of Wisconsin in Milwaukee and the University of California San Francisco School of Medicine that have implemented cultural and linguistic competence training longitudinally into their curricula suggests that faculty development needs to precede the planning and implementation of the curricula. Faculty acceptance of the evidence-based need for integrating these materials into the coursework frequently requires a well-articulated rationale, a familiarity with the perspectives and content of cultural and linguistic competence training, some specific knowledge development for their specialties, and a good level of comfort with the techniques they can use for such training. Special stipends could be offered to educators who would develop courses in topics related to cultural and linguistic competency or who wish to become master teachers in the subject.

Some aspects of cultural and linguistic competence education, particularly those that deal with attitudes, prejudices, and biases, are sensitive and require more fully developed facilitation skills than are usually needed in lectures and course work. Educators should have initial and ongoing opportunities to develop these skills and deepen their understanding of the content areas of cultural and linguistic competency. Since such skills and understandings generally are not part of a faculty's background, they should be given every opportunity, through workshops and cross-disciplinary discussions, to develop the necessary expertise. Some of the Web-based training modules listed in Chapter 11, Resources, could serve as the basis for discussion. Most are clinically oriented and are accompanied by materials that guide discussion. Training and workshops in facilitation techniques are widely available through university communications departments.

II. Providing a Rationale for Building Cultural and Linguistic Professional Competencies

Many students in the health care professions do not initially recognize the need for developing competencies in cultural and linguistic issues. Failing to see the relevance of such teaching, they, in fact, may at first resist the content areas and skills involved. Fortunately, there is strong evidence for these understandings as an essential aspect of providing quality patient care and an increasingly sophisticated discourse around the related issues. From the Institute of Medicine's report, *Unequal Treatment* (2002), to the DHHS' Culturally and Linguistically Appropriate Standards for Health care Organizations (Office of Minority Health, 2000) and the DHHS' Office of Civil Rights Guidance on the Provision of Language Services, there is public and professional endorsement of these essential aspects of quality health care. At every opportunity, when issues relating to cultural and linguistic competence are addressed in the curriculum, educators should take care to link the issues directly to quality patient care and enhanced therapeutic alliances between health care

professionals and their patients. Examples of statements in support of this linkage from numerous health care professional organizations are reviewed in Chapter 10, Resources.

There is widespread documentation of disparities in health care status and access across populations. Many professional and practice associations have explicit statements about the importance of addressing cultural differences and health care disparities. The American Association of Medical Colleges, the Accreditation of Graduate Medical Education, the American Medical Association, The American Dentistry Association, and the American Nurses Association, among others, have underscored the importance of this subject matter in the training of professionals. As part of their early training, students in the health care professions should be made aware of the support for such training, both within and outside their potential professions. Such early awareness of the importance of cultural and linguistic competency can form an initial rationale on which ongoing subject matter and experiential learning can consistently build through the students' educational career. Educators can use the information in Chapter 11, Resources, Section I A and B, to begin a discussion of rationale and build the case. Many of the Websites listed in the Resources chapter, such as that of the Commonwealth Fund and the Kaiser Family Foundation, can provide ongoing and current statistical support for and policy discussions of cultural and linguistic competence issues in health care.

Finally, using census and other demographic data, educators can develop an understanding of the extensive changes in the cultural and linguistic characteristics of the U.S. population that have occurred as a result of alterations in immigration policy, refugee resettlement, and other social and economic factors. Often, examining data on population groups helps educators and students to understand the epidemiological patterns and health risk factors of various populations, information that is useful in developing the rationale for exploring cultural variation in belief and lifestyles. Whenever possible, detailed population characteristics of the immediate locale should be explored, either in lecture or as part of student assignments. These data can then form the basis for further exploration into the epidemiological implications for service delivery, community mapping, and community service.

III. Creating a Developmental Learning Path

Most professional schools that have successfully developed a cultural and linguistic competence focus within their curricula have recognized that multicultural content cannot and should not be taught in just one course or workshop, but needs to be reinforced in many different ways over the course of the students' education. Integrating a cultural and linguistic competency focus into most aspects of health professional training requires thoughtful planning. It initially requires reviewing the existing curricula and identifying where this focus might be placed most advantageously to enhance the curriculum. The placement will vary in terms of the overall objectives for each level of training from pre-clinical to clinical to graduate education. It will be necessary to develop goals and objectives around cultural and linguistic competence in attitudes, knowledge, and skills in each level and segment of the curriculum.

In the area of patient-provider communication, for example, students should have an opportunity early in their education to explore how their own backgrounds have influenced attitudes toward health care and toward specific groups of patients. Ideally, students will come from varying cultural and linguistic backgrounds and then could express strong and highly divergent views on cross-

cultural issues. It is important for students to recognize the effect of their cultures on their own emotional, social, and intellectual development. One of the best tools for increasing their understanding in this area is constructing a personal genogram such as that developed by Hardy and Laszloffy (1995). Students can be encouraged to discuss aspects of these "family trees" and the influences that have shaped their views. Moving forward with an enhanced understanding of the effect of culture in their lives, they can begin to explore and reflect on their own biases toward patients and patient care, and how these attitudes can impede or enhance good communication with patients. Significantly, such approaches help health care professionals understand the affective component of their approaches to their lives and their professions.

A. Attention to Disparities and Bias in Health care

Discussions focused on issues of racism, homophobia, prejudices, and biases of all kinds must be an intrinsic part of the curriculum. Early attention to these issues is important and should not be given cursory treatment. Cultural and linguistic competence experts are unanimous in their insistence that developing attitudes that are open and accepting of diversity and differences are an essential first step toward integrating the knowledge and skills necessary for cultural and linguistic competence. Addressing these subjects in depth always carries some risk, since students may be reluctant to discuss their biases, or even hostile when confronted with them. Skillfully facilitated classroom discussions, videos, and small group work, all in a safe, non-judgmental environment, are necessary in promoting the self-reflection needed to uncover and deal with bias and stereotyping. While careful attention to these issues should receive early attention in the curriculum, the faculty needs to be attentive to bias, prejudice, and stereotyping as they emerge throughout the curriculum or work with patients in the later stages of the students' education.

Discussions about disparities in health care across racial and ethnic populations frequently produce various types of strong denial among students and health care professionals alike. However, the reality of these disparities is evidence-based. In Chapter 11, Resources, the section titled "Racial and Ethnic Issues in Health care Access and Delivery" provides many references that document this evidence. Additionally, the landmark IOM report, *Unequal Treatment* and its appendices include a comprehensive discussion of the reasons for inequalities in health care. Taken together, these publications provide rich discussion materials for an objective examination of racial and ethnic bias in health care. It is essential for a cultural and linguistic competence curriculum to include careful attention to these issues. It is also critical for educators to become familiar with this material in order to introduce it to students, integrate it into course work, and to lead reasoned discussions.

The issue of disparities in health status across populations should be given careful attention at several levels, and problems in the types of epidemiological and other currently available statistical data should be addressed. In the early stages of reviewing health statistics across populations, it would be helpful to review the data drawn from National samples, starting with the early data developed in the 1980s that showed a large discrepancy between the health of African-Americans and the rest of the U.S. population. This disparity continues to be problematic. Subsequent research, however, has revealed significant differences between the health status of the larger population and that of Latino, American Indians, and some Asians. Students can be asked to trace the historical patterns of health status within specific groups. An excellent exercise would be to have students create health profiles for different racial and ethnic groups. Reviewing these data will give students a sense of enduring disparities and developing issues relative to the health of different population groups.

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When reviewing National data, it will be important to discuss problems in adequately interpreting these large data sets, most of which do not show important variation within groups such as that related to region, class, and specific culture. In most National data sets, for example, ethnic terms such as "Asian" and "Hispanic" are used as group identifiers. These labels include very different populations, such as Chinese, Korean, and Hmong; or Puerto Rican, Cuban-American, and Mexican-American under the same label. Such labeling masks important differences among groups in health status. Several sources of statistical data are available through the National Center for Health Statistics, the Office of Minority Health Resource Center, and MedlinePlus (see the Website section of Chapter 11, Resources). As students become more sophisticated in understanding epidemiological data, their research assignments and analyses can focus on data for discrete populations, such as those for specific Hispanic or American-Indian populations. Data from various regions also can be compared.

Further, faculty should be encouraged to review and discuss ethnic and racial health status data pertinent to the individual courses they teach. Data pertaining to racial and ethnic variation in relative risk, disease incidence, prevalence, severity, and treatment efficacy and modalities now exist in many, if not most, health disciplines and practice specialties. The bibliographies listed in Chapter 10, Resources, will be helpful in directing faculty and student attention to these data sources. Use of key word searches in Medline will unearth data related to specific populations. Students should be encouraged to hone their skills in using the search facilities of various databases to uncover data on specific populations.

B. The Need for Skills in Cross-Cultural Communication

Students should consistently be helped to understand how cultural and linguistic differences between a patient and a provider can influence communication, rapport, and treatment compliance. Such training can be initiated early as part of coursework in the fundamentals of patient care in medicine or nursing. Students can be taught to conduct a respectful, culturally sensitive clinical interview with a patient whose background is different from their own, beginning with role playing and progressing in later years to working a cultural focus into history taking and patient assessment. Instruction in how to conduct an interpreted encounter effectively would be an important aspect of training in patient-provider communication, as would information on how culture is reflected in different languages and communication styles. It will be important to create an understanding of how the students' own language informs their perceptions, including the language of U.S. health care.

In later clerkships and preceptorships, students can sharpen their language skills and understanding in community settings with actual patients by doing assessments, taking histories, and completing diagnostic work-ups and care plans as they rotate through community clinics that serve diverse populations. Preceptors of diverse backgrounds can be recruited from community clinics in the surrounding locales. Students can develop culturally and linguistically appropriate diagnostic, treatment, and care plans with patients and their families (see the section on patient assessment tools in Chapter 11, Resources). At each step, they should be given an opportunity, through such activities as journal-keeping and small group discussion, to review issues of bias and record successful communication practices. Objective standardized clinical examinations or patient assessments can then include diverse patients and cross-cultural issues.

In the area of understanding disease and disorder processes, electives or required courses focused on special population groups could be offered to explore the epidemiology of diseases across population groups, as well as cultural practices and environmental factors that affect the differential health status of specific groups. These courses could be followed by such activities as cooperative community health projects that profile segments of the community and demonstrate an understanding of historic, cultural, and social factors such as immigration and acculturation that affect the health care of that segment. Students can work with community members, public health agents, and non-profit agencies to develop practical, culturally sensitive outreach, education, and prevention projects.

Integration of cultural and linguistic competencies should follow the movement from knowledge and theory to practical application that characterizes almost all education in the health professions.

IV. Integrating Cultural and Linguistic Subject Matter

Integrating a cultural and linguistic focus into existing coursework often depends on the instructor involved, meaning the whole faculty needs to be involved in the initial stages of curriculum development. Such integration requires subject matter expertise, knowledge of how subject-related information is applied in a clinical setting, and specific information on cultural and social issues as they apply to the subject matter or clinical work. Normally, all health care faculty demonstrate the first two requirements, and the last may require that they develop additional expertise, often through research into how cultural or linguistic factors affect their specialty. As previously mentioned, support for research and development of expert knowledge might be through stipends or funds to attend the several excellent conferences or workshops offered in cultural and linguistic competence in health care.

Fortunately, the literature on cultural factors in all specialties and aspects of health care has grown in the last two decades. There is extensive information on health beliefs and practices in many cultural groups; population epidemiology relative to specific diseases; disparities across groups with respect to diseases, risk, and protective factors; variation in acceptance and practice of illness prevention; ethnic pharmacology; cross-cultural pain management; death and dying issues; and much more. Information relative to specific cultural, ethnic, or racial groups as it applies to the subject matter can be integrated into lectures and grand rounds, diagnostics, and patient assessments. Examples, data, and information from a variety of cultures and cultural situations can be used to illustrate the key concepts and principles being taught in each course or practicum. Culturally or linguistically oriented case study examples, which are plentiful in the literature, can be used as the basis for class discussion or assigned to individual students for analysis. A number of mnemonic tools, such as LEARN, TRANSLATE, and ETHNIC have been developed to aid students in remembering cultural and linguistic competence precepts and concepts. These approaches are described in articles listed in Chapter 11, Resources (particularly Berlin and Fowkes, 1983; Levin, Like, and Gottlieb, 2000; Dobbie et al., 2003) and in Appendix A, The Toolbox.

The bibliographies listed in the final section of Chapter 11, Resources, contain cultural and linguistic competence references broken down into specialty areas. These resources can serve as a beginning point for research that can augment course offerings. Additionally, Medline, PsychInfo,

and other databases in the social and behavioral sciences can identify emerging information on culture, ethnicity, race, and language in health care. Such databases can be useful in developing specialized bibliographies, research papers, and class presentations that can form the basis for student research assignments and in-depth class discussion in specific practice areas. Summer research opportunities focused on specific subjects or populations can be offered to students.

Research on cultural and linguistic competence issues can be organized and conducted by faculty members and presented in team-taught seminars or workshops. Some professional schools have hired research associates to organize, coordinate, and support faculty research projects. Others have sought external funding and developed research centers organized around research and specialized health services to specific racial or ethnic groups.

A. Using Experts from the Social, Linguistic, and Behavioral Sciences

Most large universities have anthropology, sociology, psychology, communications, and linguistics departments that can be tapped. Medical anthropologists, in particular, have frequently worked with medical and nursing schools in developing courses on culture and medicine, lecture series, and workshops for pre-clinical and clinical students. Some have done collaborative research in clinical or health care settings. Historically, these linguists have focused on the intersection of culture and disease. Many have studied the people of non-Western cultures who are now immigrating in large numbers to the United States. Medical sociology, a newer social science, is more focused on Western health systems and the social factors that affect those systems. Some linguistics departments may offer courses in translation and interpretation. Communications departments often have experts in cross-cultural communication. Many university public health departments have educators with expertise in specific ethnic and racial communities. Working with established professionals in these fields is useful in faculty development as well as in developing curriculum content and teaching modalities.

Having cross-cultural, cross-disciplinary teaching teams sends a strong, non-verbal message of respect for different cultures and diverse approaches to health problems. Professional schools that have done so have found that partnering with other campus schools and disciplines promotes significant institutional support and respect for their programs, and can facilitate opportunities for cross-disciplinary projects and outside funding for programs.

B. Use of Web-Based and Video Tools

Over the last few years, a number of organizations have developed two highly useful cultural and linguistic competence training modalities: interactive, Web-based modules and video tapes. These tools are almost all case-based, depicting patients in a wide variety of clinical settings. The Web-based, interactive modules are designed for health care professionals and cover specific objectives, require clinical decision making, and test students on their grasp of the material. These modules carry continuing medical education credit and could be used to augment classroom content or as the basis for small-group discussion.

The teaching videos currently available encompass a wide variety of clinically oriented subject matter. Among the topics covered are racism and heart disease, cultural barriers in patient-physician communication, learning to use face-to-face interpreters and telephonic interpretation in medical encounters, caring for gay adolescents, the effect of religious practices on hospital routines, dealing

with HIV and sexually transmitted diseases in a cross-cultural context, and the effects of poverty and social factors on response to treatment.

In almost every case, the video materials are broken down into modules with accompanying contextual information and guides to facilitate discussion. This flexible modular approach facilitates the integration of 30- to 40-minute units that can be integrated into lectures in existing courses or used in groups that could comprise half-day workshops or seminars that incorporate other educational modalities. Often, the accompanying facilitator's guides offer tips on how to conduct discussions about sensitive issues and provide sample questions to guide discussion.

C. Using Community Expertise and Student Community Immersion Strategies

Within most communities there are informal and traditional healer and healing modalities. Effort should be made to find local individuals who fill these roles and provide students with opportunities to hear their views on health care as it is viewed and practiced within the community. "Healers" can vary from grandmothers, herbalists, bone-setters, and traditional midwives to spiritual healers and funeral arrangers, to name just a few possibilities. Often, it is possible to arrange field trips to such places as Latino botanicas or traditional Chinese pharmacies to learn how patients are assessed and provided with medications and treatment regimens. Students can take this information back to the classroom or to clerkship discussions to analyze the similarities and differences in concepts of etiology and treatment as compared with bio-medical concepts.

Students can be assigned research projects that involve immersion in community health settings such as creating and analyzing a set of real life case studies drawn from their experience and observation of health care access, patient interviews, and interviews with health administrators, directors of programs, and case workers. Students can be assigned group projects, such as creating a community-based health resource directory for a specific population group or groups. They can design social marketing strategies for preventive health care activities involving diet, obesity, exercise, mammograms, diabetes, or prenatal care that take into consideration the needs and perspectives of specific local groups. Community "safety net" clinics offer multiple opportunities for clerkships that involve students in diverse communities.

Service learning programs, available at most universities, offer semi-structured opportunities for involvement in local non-profit agencies and clinics that could be particularly useful early in a student's career. These programs help instructors integrate community work with classroom learning, usually involving limited and structured activities to help students reflect on what they are experiencing and how it relates to coursework.

Many health professional schools have worked with Area Health Education Centers (AHECs) to organize conferences and workshops focused on cultural and linguistic competence. Participation in these community-based events helps faculty and students develop expertise in aspects of cultural and linguistic competence through the eyes of persons working in community health care and local service agencies.

Numerous individuals in health care have developed focused workshops in both general and specific aspects of cultural and linguistic competence. Some of these are referenced in Chapter 11, Resources. Depending on their content and methods of delivery, these workshops can be used to begin self-exploration, become familiar with overall concepts in the field, or focus on a specific

subject area, such as how to use interpreters or how to do culturally appropriate patient assessments. They provide a concentration that may be more intense and synergistic than other strategies simply because of the large block of time devoted to the subject matter.

Workshops given by outside experts are useful in presenting varied and fresh perspectives on issues in cultural and linguistic competence. They frequently involve well-paced developmental processes involving didactics, lectures, small-group work, interactive exercises, and video presentations, and can serve as models of strategies to use in addressing cultural information. They may cover a half-day, a whole day, or even several days. In selecting workshops, care must be taken to assess the expertise of the presenters, the content of the workshop, how it fits within the overall curriculum, and the timing of its integration into the curriculum. It is important that the presenter have expertise or knowledge of clinical settings and patient care, and can speak the language of the health care professionals to whom the education is directed.

On the other hand, half or full day workshops developed and presented by students and faculty result in a multifaceted, collaborative learning experience that can involve research, developing activities, accessing the community, and tapping student and faculty expertise. Such collaborative workshops can be integrated easily into ongoing cultural and linguistic approaches in the overall curriculum.

It is important to recognize, however, that no matter how well a workshop is planned and executed, it will not substitute for an overall, comprehensive and integrated developmental curriculum.

D. Elements of Risk and the Need for Strong Facilitation Skills

Addressing issues of personal bias, accountability in the area of health care disparities, and strongly held individual views and attitudes carries a number of risks, but it is essential work at each level of education in cultural and linguistic competence. Some frequent risks involve the expression of negative stereotypes, conflicting personal and political views held by members of classes and discussion groups, and reluctance to participate in, or disdain for, specific learning strategies, such as role playing and interactive exercises. These risks require practiced facilitation skills on the part of group leaders, instructors, and trainers, and it is helpful that training in facilitation skills be available to them.

The following outline of general facilitation skills that encourage student participation and exploration are adapted with permission from *Teaching Skills and Cultural Competency: A Guide for Trainers*, a manual published by the National MultiCultural Institute, in Washington, D.C., fourth edition, 2000. A review of the skills outlined here is not a substitute for interactive training in their use and application.

Practice active listening skills:

- Check for understanding often

- Paraphrase one's understanding of what has been said and recap periodically

- Allow sufficient time to debrief adequately

Be sensitive to subtle cues and body language:

- Watch for glazed, unfocused eyes or a tendency to look away

- Notice grins, laughter, nods, or constant nodding

- Note facial expressions

- Note degree of body tension

Express oneself clearly:

- Organize one's thoughts

- Avoid slang, idioms, and sarcasm

- Allow for individual differences and avoid stereotypes

- Recap periodically

Pose questions carefully:

- Ask open-ended questions

- Be careful about asking direct, private, or confrontational questions until a trusting relationship has developed

- Allow time for adequate processing of material and closure

- Ask clarifying questions

Consult with colleagues and participants for feedback on one's facilitation skills. Be open to hearing honest feedback on areas that need improvement.

Creating a safe environment for discussions of discrimination, biases, difficult patient situations, and the emotional reactions to these discussions is not always easy. However, specific attention to group dynamics is useful. One of the most effective approaches is to have the group or class think through and agree on a set of norms to be followed in their large and small group discussions. These norms can be written, referred to when appropriate, and added to as needed.

Another helpful and critical procedure is to develop a glossary of terms and definitions to which all parties can agree. What, for example, is the difference between a stereotype and a generalization? What is a health care disparity? What definition of discrimination can the group agree on? Who are people of color? What is homophobia? What is racism? Who are the aged? What does the term minority mean in terms of the present U.S. population? What is homosexuality? What is feminism? Who are illegal immigrants? What does non-proficient in English mean? Defining such terms helps students and faculty to approach difficult subjects objectively, though the process may yield some

emotional reactions and strong opinions. Group-produced definitions are important because they begin to yield common understandings and, at the same time, clarify variation around the meanings of terms as different individuals understand them. Definitions and meanings provide a safe first step in clarifying difficult concepts. Over time, it is useful to create a written group glossary of terms.

Although some pedagogical modalities may seem less risky in terms of potentially eliciting negative affective response or resistance from students, the potential for both reactions is present in many aspects of cultural and linguistic competence education. For example, a lecture and discussion on epidemiological variation in chronic lifestyle disease across ethnic and racial groups may appear to be about objective and clinically relevant data, but some students may respond to such data with a "blame the victim" reaction. While a discussion of cultural beliefs related to somatic disorders or herbal medicines may be meant to aid students in understanding and relating to persons from cultures different from their own, students may express their belief that such ideas are "primitive," and so should be ignored. Watching videos may seem to be a safer approach to informing about cultural, social, and linguistic differences. However, the utility of videos usually lies in debriefing discussion about their content, and such discussion has the potential for revealing strong opinions and biases. The reality is that cultural and linguistic competence in health care is best promoted and developed through involved, rich, and continuing interactive dialog with educators, other students, and patients. Along with such discourse and dialog lies the potential for strongly held differences in opinion. Preparing educators and leaders for this potential is important and requires the development of good facilitation techniques.

V. Sample Tools for Delivering Cultural and Linguistic Curricula

An extensive number of specific tools developed to teach the attitudes, skills, and knowledge basic to cultural and linguistic competency curricula have been developed over the last decade as health care organizations and professional schools have worked to include this focus in their training. The Resources chapter provides references to many strategies used in these trainings as well as to useful videos and websites.

Appendix A, The Toolbox, also provides examples of pedagogical tools. Here we will give a quick sampling of the kinds of teaching tools that are available.

Among the tools that are useful when developing curriculum content are those specifically designed to help faculty and students increase their own self-awareness. Building awareness of the effects of one's own culture on one's behavior and of one's biases is critically important to the success of a COE's efforts to develop such curriculum content.

COEs can increase the self-awareness of staff and students about their personal cultural identity and their perspectives on differences through the use of cultural genogram exercises (see Appendix A, The Toolbox). They can increase awareness of their blind spots and comfort zones by exploring their community maps, and can explore similarities and differences that exist within and between ethnic groups by using the context grid (see Appendix A, The Toolbox). The context grid helps to highlight points of connection or similarities that exist among different cultural groups, and can be

used with providers or patients to explore similarities and differences between the two. (See Appendix A for samples of the Cultural Genogram Exercise, Exploring One's Own Community Map, and Context Grid, which are used by the Harvard Medical School in its course on self-awareness and cultural identity course.)

Next, tools that are useful in promoting understanding of how culture influences an individual's beliefs and behaviors include using the Iceberg Metaphor or model to visually and conceptually describe culture as having both visible and invisible components, requiring the need for clinicians to explore hidden concepts, values, and norms guiding the responses and behaviors of their patients. Likewise, the diversity wheel is a visual tool often used by diversity instructors to help practitioners to understand the personal, cultural, and societal elements that contribute to patients' diverse perspectives on health, illness, and health care.

- Many professionals are improving communication and helping to improve patient-centered care during cross-cultural clinical encounters by making use of the following mnemonic interviewing tools (see Appendix A, The Toolbox, for more information): LEARN (which stands for Listen, Explain, Acknowledge, Recommend, and Negotiate)

- ESFT (Explanatory model of health and illness, Social and environmental factors, Fears and concerns, and Therapeutic contracting)

- ETHNIC (which is a framework for culturally competent clinical practice that stands for Explanation, Treatment, Healers, Intervention, and Collaboration

- BATHE (which is used for eliciting a patient's psychosocial context and stands for Background, Affect, Trouble, Handling, and Empathy.

- ADHERE (is a mnemonic for improving patient adherence with therapeutic regimens, and stands for Acknowledge, Discuss, Handle, Evaluate, Recommend, and Empower.

- RESPECT (which stands for Respect, Explanatory model, Socio-cultural context, Power, Empathy, Concerns, and Therapeutic

- BELIEF (stands for health Beliefs, Explanation, Learn, Impact, Empathy, and Feelings)

One patient assessment tool that has been particularly useful to clinicians is often referred to as "Kleinman's Nine Questions." These questions were developed by Arthur Kleinman, M.D., M.A., a physician, anthropologist, and the Esther and Sidney Rabb professor and chair of the Department of Anthropology at Harvard University. He and his colleagues L. Eisenberg and B. Good listed the questions in an article, "Culture, Illness and Care: Clinical Lessons from Anthropologic and Cross-Cultural Research," in the *Annals of Internal Medicine* in 1978. The nine questions comprise an assessment designed to yield a patient's cultural perspective on his or her illness. They are:

1. What do you think has caused your problem?
2. Why do you think it started when it did?
3. What does your sickness do to you; how does it work?
4. How severe is your sickness?

5. Will it have a short or long duration?
6. What kind of treatment should you receive?
7. What are the most important results you hope to receive from this treatment?
8. What are the chief problems your sickness has caused you?
9. What you do you fear about your sickness?

At some point, any effort involved in developing the content for a cultural and linguistic competency curriculum will address the need to work effectively with interpreters in providing care to patients with limited English proficiency by using the following tools (see Appendix A, The Toolbox, for more information):

- TRANSLATE is a mnemonic for working with health care interpreters and stands for Trust, Roles, Advocacy, Non-judgmental, Attitude, Setting, Language, Accuracy, Time, and Ethical issues

- INTERPRET is used when working with interpreters to obtaining a history from a patient with limited English proficiency. Of particular importance regarding INTERPRET is that this tool was developed by a COE. It stands for Introduction, Negotiation, Trust, Engagement, Room set-up, Patient-centered, Respect of cultural beliefs, Ethical considerations, and Time management. (See Appendix A, The Toolbox, Section III, for more information.).

Chapter 7: Assessment and Evaluation

Cultural and linguistic competence education is a relatively new and evolving field. Evaluation will determine whether the COEs have achieved their mandated goals. The results become a guidepost and support for continuous improvement. The COEs are charged with developing innovative methods to teach cultural and linguistic competence more effectively and efficiently. It has been suggested that cultural and linguistic competence education programs that are exposed to rigorous evaluation are more credible to peers and policymakers. This enhanced credibility could then improve the programs' acceptance and replication by other health professions schools.

Health professional education is organized so that students learn in a wide spectrum of settings, including classrooms, laboratories, health care delivery locations, such as hospitals, health centers, clinics, and in extracurricular activities, such as those in the community. Cultural attitudes and information can be woven into the operations of each of these settings. COEs face the difficult challenge of assessing and supporting cultural and linguistic competence across the educational spectrum.

When undertaking cultural and linguistic competence initiatives, it is critical that COEs make an initial assessment (establish a baseline) and then continuously assess the organization and the educational programming against this baseline. The role of evaluation in a change effort is to increase the likelihood that significant and sustainable change will occur by drawing attention to existing gaps and accomplishments.

To assist the COEs in considering evaluation strategies, in this chapter we highlight information related to educational and organizational assessment and evaluation, as well as a number of methods of evaluation. This chapter includes a discussion of educational assessments and evaluations, three examples of curriculum evaluation, organizational assessments and evaluations, the HRSA domains as a framework for organizational assessment, and integrated and stand alone evaluation processes.

In particular, the Expert Team believes strongly that organizational assessments and evaluations should be considered core components of all cultural and linguistic competence programming. The organization plays a significant role in the development of students' cultural and linguistic competence, and is a major component of the implicit curriculum.

Building assessments and evaluations into educational programming will also:

- Improve the effectiveness of the cultural education for health professionals

- Provide regular adjustments to the curriculum in response to the dynamic and multifaceted nature of culture

- Provide a basis for the COE to determine which methods are effective in developing culturally and linguistically competent clinicians

- Support the COEs in achieving their mandated goals

To accomplish these goals, a variety of evaluations should be conducted, including those that are formative and summative. Formative evaluations may be considered a pro forma assessment in that it might be done with a small group of people to test various aspects of instructional materials. A summative evaluation would evaluate whether students learned what they were supposed to learn.

Such evaluations can be used to track the effect of changes made in the explicit (formal) and implicit (hidden) curricula. Pre- and post-training assessments of student learning, using both quantitative and qualitative methods, are strongly recommended, along with tailoring of cross-cultural content to fit individual and group needs and capabilities. As defined earlier, some educators say the explicit curriculum is the formal program of learning, and the implicit curriculum is "hidden" or unspoken component. (Chapter 10, Resources, Section III, provides a list of evaluations at the individual, organizational, and curricular levels.)

I. Educational Assessments and Evaluations

In evaluating cultural and linguistic competence education, COEs should analyze four key aspects of educational programming.

  A. The content of the program as defined by expert knowledge and standards in the field
  B. The effect of the programming on student learning and performance
  C. The effect on clinician learning, patient care, and health outcomes
  D. The effect of the curriculum as a whole on students, faculty, administrators, and the organization.

A. Content of the Program

When evaluating the content of a program, COEs should ensure that the program is comprehensive. The Expert Team believes that COEs should use all three of the following frameworks for a comprehensive cultural evaluation: The Tool for Assessing cultural Competence Training (TACCT) developed by the American Association of Medical Colleges and scheduled to be published in 2005. TACCT provides a framework that can be used across the entire curriculum (see reference in Chapter 10, Resources), The Principles and Recommended Standards For Cultural Competence Education (www.calendow.org), and the ASKED framework, which is described in Chapter 4.

B. The Effect of the Programming on Student Learning and Performance

"Curricular evaluation hinges on measuring whether the goals and objectives of a course have been met by determining whether the desired change in the learner's attitudes, knowledge, or skills has been achieved." (Weissman, J. and Betancourt, J.R., N.D.) Therefore, the standard means of evaluating curriculum is by answering key questions involving student performance. COEs must evaluate three critical questions across their entire cultural and linguistic competence educational programming:

  1. Are students learning what is taught?
  2. Are they using what they learn?
  3. How well are students using what is taught?

1. Are students learning what is taught?

Nora et al, using multiple-choice questions, showed that students had a greater knowledge of Hispanic health and cultural issues after completing a 'Spanish Language and Cultural Competence Curriculum.' These students were also "less ethnocentric and more comfortable with others." (Nora et al., 1994) Another study reported that "family practice residents exposed to a three-year, multi-method cross-cultural curriculum had more cultural knowledge and cross-cultural skills, via self-report and faculty corroboration." (Gonzalez-Lee and Simon, 1987; as cited in Betancourt 2003). Thus, attitudes, knowledge, and skills were changed.

As discussed, there are a variety of techniques that allow COEs to measure student learning in the dimensions of attitudes, skills, knowledge, encounter, and desire. Combining techniques will allow COEs to determine how much students have learned from their experiences beyond what they knew when entering the health professions school.

2. Do students use what is taught?

Health professions students are often assessed on their interactions with actual and standardized patients. These encounters, when observed and analyzed, can show whether students are able to apply what they have learned. As Betancourt notes, however, it is often difficult to "consistently assess clinical encounters in real time to assure that the behavior exhibited truly reflects the skills demonstrated in a controlled setting" (2003). A critical question can be whether the student under time pressure, in a pediatric clinic with 10 families waiting for his or her services, is able to perform the culturally sensitive history he/she conducted with a standardized patient in a structured setting?

3. How *well* do students use what is taught?

The question "how well" implies an evaluation of the quality of a clinician's judgment. Betancourt suggests that qualitative physician and patient interviews can elicit whether cross-cultural skills have been used effectively. The challenge arises on how one can employ these skills in a real clinical setting. For example, trained reviewers can evaluate video- and audio-taped clinical encounters to judge the quality of student actions in a clinical setting. The checklist for assessment should contain items that relate to attitudes and behaviors that reflect students' attitudes.

Like et al. (1996) noted that culturally competent clinicians require a variety of skills in diagnosis (e.g. eliciting the patient's perspective about health and illness), education (e.g. providing culturally sensitive patient education and counseling), and treatment (e.g. prescribing or negotiating a culturally sensitive treatment plan). In testing students for these skills, COEs and other schools have the opportunity to measure and improve the curriculum itself, as well as train clinicians who will apply its principles more effectively. Testing for skills also has a symbolic effect in that it tells students and faculty that cultural and linguistic competence skills are important to the school.

A useful tool for evaluation may be the LEARN mnemonic (Berlin and Fowkes, 1983), which offers a framework to consider how students may learn, practice, and be evaluated on skills. While this mnemonic is included, it is simply an example of how mnemonics can be used in evaluation.

C. The Effect on Clinician Learning, Patient Care, and Health Outcomes

Does what is taught affect patient care, and ultimately health outcomes? Because of the three-year cycle of COE operations and the newness of the COE programs, there is not yet enough alumni data available from COEs to answer this question. Furthermore, COEs have not traditionally been asked this question. Even if such data were available, it is not necessarily a question a single COE could address. Answering the question may require a collaboration of multiple COEs and a careful and rigorous evaluation design.

As Betancourt calls it, "connecting the dots" presents a set of challenges. Does what is included in a curriculum affect health outcomes? He also notes the difficulty in evaluation, even with skilled, unbiased evaluators. As Betancourt notes, "It is important that we not hold cross-cultural curricula to unfair evaluation standards; detractors have asked for a direct link between curricula and the improvement of hard clinical outcomes." (2003)

Health professions students graduating from COEs will be practicing clinicians for many years. Their undergraduate and graduate education should serve as a foundation for lifelong learning in cultural and linguistic competence. If the ideal goal is to measure the effect of cultural and linguistic competence education on clinicians' behavior in patient care settings, and that behavior's effect on patient outcomes, COEs need to begin collecting quantitative and qualitative data that will lay the foundation for future evaluation of such performance. This form of evaluation becomes ever more challenging over time as students move further from the classroom experience. One possibility may be longitudinal studies of students from varied programs to observe how their practice patterns and patient outcomes vary. The methodological challenges related to intervening variables and comparable patient populations are substantial. Again, such research would likely be beyond the scope of any single COE, but could be an attractive opportunity for a collaborative effort.

D. Evaluating the Curriculum as a Whole

While COEs should evaluate their students' development as culturally competent clinicians based on the curricula's effect on student performance, the entire curricula (explicit, implicit, and null) should be evaluated in an on-going manner. Student evaluations will determine whether *individual students* have learned enough "baseline competencies" to proceed or graduate. Such evaluations also will be useful in helping students learn more effectively. However, a formative evaluation of the entire program or, in other words, the curriculum can highlight successes and identify opportunities for improvement.

A comprehensive evaluation may also include the curriculum development and implementation processes by attempting to determine if the curriculum is inclusive and culturally competent, and how the faculty creators might evaluate and improve their own cultural and linguistic competence. This formative approach is parallel to the developmental and continuous-improvement approach recommended for student evaluation.

II. Three Examples of Curriculum Evaluation

A. Evaluating Students in Cross-cultural Education

Regardless of the manner in which cultural and linguistic competence is taught or transmitted, the outcomes should have one common theme. As Gilbert notes, "consistent high-level expectations should be obtained." Evaluation of students' mastery of cultural and linguistic competence attitudes, skill, knowledge, encounter-based learning and desire should rely on a variety of techniques, both qualitative and quantitative, including oral and written examination, self-assessment and, where possible, evaluation of the application of attitudes, knowledge and skills in the actual practice setting. Given that there are a variety of cultural and linguistic competence training and educational venues and modalities, assessment strategies need to be flexible and adaptable to the training circumstances. When doing this, *The Standards for Evaluating Cultural and linguistic competence Learning, Principles and Recommended Standards for Cultural Competence Education of Health Care Professionals* (2003) from the California Endowment (at www.calendow.org) in Woodland Hills, CA, may be a helpful tool.

COEs may use multiple methods of evaluation to measure changes in students' attitudes, knowledge, and skills as shown in the table, Evaluation Tools, on the next page. The specific combination of methods will depend on each COE's resources and needs.

Table: Evaluation Tools

Tool	Areas Evaluated	Description/Uses
Written and Fact-Based Examinations		
Pre-post questionnaires and multiple-choice exams	Awareness, skills, knowledge	These could be designed to assess students' knowledge, attitudes, and skills through incorporation of clinical cases. COEs and others may wish to develop examinations based on *Nora LM, et al; Improving cross-cultural skills of medical students through medical school-community partnerships*, West. J Med. 1994; 161:144-7 and *Nunez, AE,* Transforming cultural and linguistic competence into cross-cultural efficacy in women's health education. Acad Med. 2000;75:1071-80.
Cultural Competence Health Practitioner Assessment: National Center for Cultural Competence	Awareness, skills, knowledge	20-minute questionnaire includes six sub scales. Developed for practicing clinicians; may be useful for students as well. Completing survey online provides assessment results and referral to appropriate resources based on results. *http://gucchd.georgetown.edu/nccc/pa.html*
Latino Cultural Competence Self-Assessment: Nilda Chong, Kaiser Permanente	Knowledge, skills	20 item, self-administered questionnaire assessing cultural knowledge and patient interaction skills. Developed for practicing clinicians; may be useful for students as well. <u>*The Latino Patient: A Cultural Guide for Health Care Providers, p. 85-87*</u>
"The Provider's Guide to Quality & Culture" Management Sciences for Health (MSH); U.S. Department of Health and Human Services; Health Resources and Services Administration. Bureau of Primary Health Care	Awareness, knowledge	23-item, self-administered online questionnaire. http://erc.msh.org/mainpage.cfm?file=2.0.htm&module=provider&language=English
A Family Physician's Practical Guide to Culturally Competent Care, http://cccm.thinkculturalhealth.org	Knowledge, skills, awareness/attitudes	HHS OMH-developed online/DVD course. Includes assessments leading to CME credits. COEs are encouraged to develop their own interactive online or DVD/CD-Rom tools for assessment.
Real and Simulated Clinical Encounters		
Objective Standardized Clinical Examinations (OSCEs)-(See Appendix A for sample)	Knowledge, skills, awareness	Students examine standardized patients (actors) from diverse backgrounds presenting cross-cultural issues. It is important to integrate cross-cultural issues seamlessly into the encounter or stations. COE's should develop OSCEs that assess knowledge, skills, as well as the behaviors/attitudes important for cross-cultural communication.
Videotaped/audio taped clinical encounter	Knowledge, skills, awareness	Students are recorded examining actual patients as part of their clinical experience. COEs developing and using this method are encouraged to publish their research and tools to advance the field.
Curriculum Assessment		
Tool for Assessing Cultural Competence Training (TACCT)—AAMC	Knowledge, skills, awareness	Provides an opportunity to identify and monitor cultural competence education across the basic science and clinical curriculum. COEs are encouraged to assess the overall effect of the curriculum as a whole on student's knowledge, attitudes, and skills.

B. Assessing Clinical Skills

The National Asian American Pacific Islander Mental Health Association (NAAPIMHA) has developed a curriculum to address the mental health needs of Asian Americans and Pacific Islanders. Using a workforce training grant from the U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, the association sought to help reduce disparities in mental health care for diverse populations by building a workforce capacity. As mentioned in Chapter 5, the *Growing Our Own* curriculum is based on the *DSM IV TR* Outline for Cultural Formulation.

In addition to the curriculum, NAAPIMHA has developed an evaluation design that uses Standardized Patient (SP) protocols to assess the clinical skills of interns. Often used in medical school training, these protocols may be an effective tool in assessing cultural competency for therapists in training. The SP evaluation protocol uses trained actors and scripted vignettes involving Asian-American patients to assess the effectiveness of the training program. The evaluation of trainees from all sites has been done at the UCSF Clinical Skills Center, which is used primarily to assess UCSF medical students through SP protocols. Each trainee interviews a total of two SPs and then writes a brief *DSM-IV TR* Outline for Cultural Formulation. Trainee evaluations are based on the written outline, review of the videotaped interviews, and written feedback from the SP as to the quality of the clinician-consumer interaction.

C. Using the CLAS Standards as a Framework for Assessment

The Center for Healthy Families and Cultural Diversity at the University of Medicine and Dentistry of New Jersey-Robert Wood Johnson Medical School has been actively involved in providing training about cultural competency and racial and ethnic health disparities, and employing quality improvement methods to evaluate the impact of practice interventions. The work they have done suggests some potential evaluation strategies that could be adapted by the COEs in assessing their programs. Both qualitative and quantitative assessment approaches were used.

In 200l, the center was awarded a two-year grant from the Aetna Foundation's Quality Care Research Fund to assess, along with other quality improvement issues, whether integrating a cultural competency training program into ongoing quality improvement activities at two large urban family practices would result in improved physician knowledge, skills, attitudes, and comfort levels relating to the care of patients from diverse backgrounds. Another goal related to cultural competency issues was to learn more from physicians, staff, and patients about the challenges involved in meeting the DHHS Office of Minority Health's Culturally and Linguistically Appropriated Services (CLAS) Standards.

- **Assessing Gains in Clinical Cultural Competency:** An assessment tool, a *Clinical Cultural Competency Questionnaire* (CCCQ), was administered to 17 faculty physicians both before and after A Cultural Competency for Health Care Providers Training Program was presented to faculty, residents, and medical students. The training program consisted of five 1.5-hour interactive seminars and workshops over an eight-month period.

Findings: Pre-post- training assessments showed that physician's self-perceived cultural competence knowledge, skills, and comfort levels increased significantly.

- **Addressing the CLAS Standards:** Four in-depth interviews were held with the Medical Directors and Practice Managers at the two study sites. In addition, six focus groups were conducted with physicians, staff, and patients at the two sites. Patients, staff, and physicians, while not initially fully familiar with the CLAS Standards, were highly interested in learning about ways to infuse cultural competency into patient care delivery systems. Significant challenges to implementation were also noted and discussed.

The research suggests that Quality Improvement (QI) teams can positively impact the provision of culturally responsive care in a clinical setting, The project staff found that practice-based evaluation research, while challenging, can be successfully carried out in busy primary care settings if attention is paid to 1) obtaining the support and buy-in of leadership and champions, 2) identifying the appropriate personnel, technological, and financial resources, and 3) carefully planning and executing the study. Quantitative and qualitative tools that can help measure physician's self-perceived cultural competence do exist (e.g. sample of CCCQ is included in Appendix A). The results of the project also indicated that multi-method assessment strategies are useful in providing a richer and deeper understanding of cultural competence in a practice setting.

III. Organizational Assessments and Evaluations

Organizational assessments and evaluations should be considered core components of all cultural and linguistic competence programming. Typically, an initial assessment involves articulating the desired outcomes or goals and establishing the methods of measurement and evaluation. A cultural and linguistic competence evaluation is a means of charting and measuring change and progress and a means of developing and clarifying organizational self-awareness. In addition, the organization plays a significant role in the development of students' cultural and linguistic competence and is a major component of the implicit curriculum. As has been demonstrated, the context in which education takes place is equally as important as the content. An organization that does not practice cultural and linguistic competence will have difficulty teaching cultural and linguistic competence. It is therefore necessary that each COE continually assess its organizational cultural awareness in order to teach cultural and linguistic competence (see Section IIIB in the Resources chapter for a listing of organizational assessments).

As the COE begins to address specific issues related to cultural and linguistic competence, it may encounter challenges from those who represent the structures and processes of the university, the health delivery system or public policy. As a result, those leading the effort to develop such competence will need to adapt and adjust to accommodate these challenges. It is critical that each COE maintain an awareness of its own internal development. For example, a COE seeking to understand and address issues of URM faculty advancement may need to engage in conversations or even negotiations with an individual or group that does not value cultural and linguistic competence. When addressing these, the COE may influence or be influenced by curriculum, other health professions schools, and public policy.

Cultures—and our understanding of them—are constantly changing, requiring continuous assessments and dynamic program evaluations. The absence of organizational assessments, or evaluations performed to inflexible pre-established goals, risk the possibility that cultural and linguistic competence education becoming irrelevant, or even stereotypical and harmful.

We propose an approach in which the evaluators are partners with the COE in developing and promoting organizational cultural and linguistic competence. Systemic change is difficult in any environment, particularly in academia. COEs are relatively small, distinct entities within large universities and in larger health care delivery and training networks. The role of the evaluator is to support the COE in developing awareness of its cultural and linguistic competence and to better understand its own strengths and challenges in the various cultural and linguistic competence dimensions. The initial evaluation helps the COE to understand where it is in comparison with others and in comparison with the ideal vision. Program staff and evaluators then work in partnership to design, implement, and evaluate its cultural and linguistic competence efforts. Evaluators in this context provide real time information to enable the COE to make informed decisions and provide program leaders with information they would not otherwise be able to gather. This permits a seamless and more participatory integration of cultural and linguistic competence programming across the entire organization.

For COEs seeking to use CLAS standards, they can be made applicable to COEs by:

- Replacing the term "*Health Care Organizations"* with *COEs*

- Including "faculty" and "students" when the standards say "staff"

- Adding "education" and "research" to the patient care element when the standards say "services."

Here are some specific examples of adapting the CLAS standards for COE use.

[COEs] should implement strategies to recruit, retain, and promote at all levels of the organization a diverse [faculty, student body,] staff, and leadership that are representative of the demographic characteristics of the service area.

Many COEs choose to focus on specific populations while others work across populations. To adapt this CLAS standard, all COEs will need to describe the characteristics of a "diverse faculty, student body, staff, and leadership." This description is essential to develop and implement the diverse strategies needed to achieve this standard. Doing so will provide a basis for evaluation. For COEs with a focused population, the concept of "service area" does not apply. Therefore, COEs could consider their unique stakeholders' needs and develop an appropriate definition of COE participants.

[COEs] should ensure that [students]/patients/consumers receive from all staff members effective, understandable, and respectful [education] care that is provided in a manner compatible with their cultural health beliefs and practices and preferred language.

COEs could examine themselves for cultural barriers that make it more difficult for some students to succeed and respond accordingly. Such barriers could involve different learning styles, issues of direct versus indirect communication, and the challenges in leaving behind family support. This standard is complementary with COEs' mandate to assess and improve the performance of students from underrepresented minorities.

[COEs] 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.

In addition to teaching students how to work with interpreter services, this standard also suggests the need to address those patients or consumers with limited English proficiency and who interact with the COE and its students. These patients or consumers may include community members, extended family of students, and patients.

Health care organizations should maintain a current demographic, cultural, and epidemiological profile of the community [student, staff, faculty and patient populations] 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.

COEs define their service populations in terms of demographic groups and conditions rather than geographic service areas. COEs will therefore develop and maintain needs assessments and population profiles that reflect the communities they serve.

IV. HRSA Domains as a Framework for Organizational Assessment

While the CLAS standards offer substantial guidance in developing culturally and linguistically competent organizations and programs, the HRSA domains offer specific areas that permit quantitative as well as qualitative analysis.

The following adaptation of the HRSA Organizational Cultural Competence Profile may be used as an organizing framework. (It was developed by Husbands/Stubblefield-Tave in the cultural proficiency assessment of the University of Texas College of Pharmacy).

Communication: This area involves the exchange of information between the college (the faculty and the staff), and the students and the broader community; and internally among the faculty and the staff, in ways that promote cultural and linguistic competency. The areas to address in this realm include:

- Understanding the communication needs of the students

- Offering culturally competent communication

- Communicating within the college

Services: The college's delivery of educational programming in a culturally competent manner. These include:

- Student/faculty/community input into educational activities

- Assessment and educational planning

- Educational guidelines and framework that address differences related to culture

Organizational infrastructure: The organizational resources required to deliver or facilitate delivery of culturally competent education, which include:

- Financial and budgetary infrastructure

- Faculty and staff development

- Providing physical facilities that support culturally competent education

Organizational values: The college's perspective and attitudes with respect to the worth and importance of cultural competency and its commitment to provide culturally competent education.

Governance: The goal-setting, policy-making, and other oversight vehicles the college uses to help ensure the delivery of culturally competent education.

Planning and monitoring and evaluation: The mechanisms and processes used for long- and short-term policy, programmatic, and operational cultural competency planning that is informed by external and internal consumers; and the systems and activities needed to actively track and assess the college's level of cultural competency.

Faculty and staff development: The college's efforts to ensure faculty, staff, and other service providers have the requisite attitudes, knowledge, and skills for delivering culturally competent education.

The HRSA Domains as a Framework for Organizational Assessment have proven useful at the University of Medicine and Dentistry of New Jersey-New Jersey Medical School. The NJMS-HCOE has partnered with the UMDNJ Bildner Project to translate its experiences and practices into the attainment of cultural competency at the organizational, school, and health care levels throughout the university. Students, faculty and administrators will benefit from this approach. For two years, the UMDNJ Bildner Project Team conducted interviews and focus groups to identify information concerning strategies those in the university community believed were integral to the successful incorporation of cultural and linguistic competence at all levels. The information has been analyzed and will be used as the framework for the development of cultural and linguistic competency training, curricula, and other educational services and products. Using

this framework, the HCOE can leverage university-wide expertise and programs that already exist, thus avoiding duplication and extending its capacity to achieve organizational change.

V. Integrated and Stand Alone Evaluation Processes

Evaluation of cultural and linguistic competence can be integrated into other evaluation processes, conducted as a stand alone activity, or both. Making this decision involves evaluating the unique resources and needs present in each COE.

The University of Pennsylvania, for example, has integrated cultural and linguistic competence curriculum evaluation into its campus-wide curriculum evaluation process, and supplemented it with evaluation methods recognizing the unusual nature of cultural and linguistic competence education (Jerry Johnson, University of Pennsylvania, comments during HRSA COE focus group, March, 2004.).

The University of Texas, College of Pharmacy and the University of Colorado School of Pharmacy have employed stand-alone evaluations of their schools' cultural and linguistic competence. These evaluations were developed and facilitated by an outside consulting group, The Cultural Imperative. The University of Texas, College of Pharmacy used the evaluation report as part of its accreditation process and created an ongoing committee to evaluate and implement findings of the assessment.

Ultimately, evaluation will determine whether the COEs have achieved their mandated goals.

Chapter 8: Dissemination

Cultural and linguistic competence is a matter of urgent importance not only for Centers of Excellence, but for health care professionals across the Nation. While the first priority for COEs is to provide culturally and linguistically competent education and training for students and faculty, there is an additional responsibility to export lessons learned to the broader health professions community. COEs may be able to reach this community at large by integrating dissemination into the outreach work they are already doing. The COEs can disseminate to other academic departments at the COE host institution. For example, they can work with other COEs, the health care community with which they interact, health professional organizations, students associations, graduate school programs, "donor" schools (such as community colleges and of feeder institutions affiliated with major universities), public and private organizations such as the government health department, patients, patients' family members, and consumers. This chapter serves as a guide for developing and implementing a plan to disseminate cultural and linguistic competence to these and other audiences as appropriate. It discusses the reasons a COE would disseminate, the mechanisms for dissemination, and offers examples of an effective dissemination plan.

The first issue to address in any discussion about dissemination of a culturally competent curriculum involves defining the term "dissemination." Kropf Design and Communication Services, Inc. (2003) defines dissemination as the aggressive sharing of expertise and as teaching others about best practices and new models of care. Not only do we want to teach others about what Huberman (1992) calls the "conceptual use" of cultural and linguistic competence, which involves the "changes in levels of knowledge, understanding, or attitude," but also we want to encourage instrumental use of cultural and linguistic competence, or "changes in behavior and practice."

There are numerous models for dissemination including those from the U.S. Department of Health and Human Services agencies, such as Health Research Services Administration (HRSA), the Office of Minority Health (OMH), and the Substance Abuse Mental Health Administration (SAMSHA)'s Center for Substance Abuse Prevention (CSAP). In addition to these models from governmental agencies, there are a number of models available from universities and private organizations, such as those that can be found by doing an Internet search. Among all of these models, the basic premises of dissemination are similar. Each one recommends that any organization disseminating information about cultural and linguistic competence needs to understand the scope of the project and the target group fully to ensure that the dissemination plan is achieved. When planning for dissemination, it is important to ask: Why disseminate?

I. Why Disseminate?

The organization that is able to develop and disseminate new and promising practices will automatically be seen as a leader in the arena of practice. In fact, COEs should aspire to be models for others in the area of cultural and linguistic competence by reporting their findings through educational scholarship such as in peer-reviewed academic journals and publications. Although COEs currently have varying levels of leadership in the area of cultural and linguistic

competency, there is an expectation that the COEs will continue to accept such a leadership role. Furthermore, COEs must follow the same principles set by academic institutions by contributing to the evidence-based fund of knowledge and practices.

Additionally, Kropf Design and Communication Services, Inc. (2003) emphasizes that dissemination must be a priority not only for those organizations seeking to replicate the program in question but also for promoting promising practices. These promising practices, such as the COE's cultural and linguistic competency curriculum, can improve the quality of health care, make positive social contributions, and "improve the excellence of our own services if we know others are watching." The goal of any dissemination plan is utilization of the information, which in this case is the curriculum. Another reason for dissemination is that it is a requirement for recipients of most funds from HRSA and other organizations.

A simple dissemination model, such as the one adapted from the National Center for Dissemination of Disability Research NCDDR (2001), Developing an Effective Dissemination Plan, can be useful in planning ways to share successful programs and strategies.

II. Elements of an Effective Dissemination Plan

In Developing an Effective Dissemination Plan, the NCDDR says there are a number of elements making up an effective dissemination plan.

a.) **Goals and objectives:** Determine and document the goals of the dissemination effort for the proposed project. Associate each goal with one or more objectives of the dissemination activities.
b.) **Users and audiences:** For each of the objectives, describe the scope and characteristics of the "potential users" that the dissemination activities are designed to reach. The first users would be the staff, students, and faculty at the institution. Other audiences would be comprised of other nursing, pharmacy, or medical schools, or practice associations.
c.) **Content:** Identify the basic elements of the projected content to disseminate to each of the potential user groups identified.
d.) **Sources:** Identify the primary source or sources that each potential user group already uses or respects as an information source. Consider ways to partner with these sources in the dissemination efforts.
e.) **Medium:** Describe the medium or media through which the content of the message can best be delivered to the potential users and describe the capabilities and resources that will be required of potential users to access the content for each medium to be used.

Table: Dissemination Methods and Channels	
Methods	**Channels**
Brochures	Targeted audiences, such as prospective students, university faculty, and community leaders
Press release	The press, local and National
Articles on the project	Professional and health care

	journals
Presentations	Papers and panels at professional and health care conferences
Posters	Poster sessions at seminars and conferences
Web-pages and listserves	Internet and Intranet, specialized listserves, such as Diversity RX
Packaged product	Training
Training videos, case studies	Present at seminars and conferences

f.) **Success:** Describe how to determine if the dissemination activities have been successful. If data are to be gathered, describe how, when, and who will gather it.

g.) **Access and availability:** Describe how to promote access to the information and how information that may be requested later will be archived. Consider that most people will use the project-related information when needed, not necessarily when one has completed the project.

h.) **Identify strategies**: Promote awareness of availability of the information and availability of alternate formats.

i.) **Barriers:** Identify potential barriers that may interfere with the targeted users' access or use of the information and develop actions to reduce these barriers.

COEs should seek to develop or customize existing products for specific target audiences, such as students, faculty, or the organization. Additional methods of dissemination suggested by members of the Expert Team for dissemination of the COE curricula are:

- Use the HRSA Website

- Develop small modules for training of faculty and publish information about them or illustrate their use at conferences, meetings, and seminars

- Send material to medical and other health professions schools and residency programs through such organizations as the Association of American Medical Colleges (AAMC), osteopathic associations, and the Accreditation Council for Graduate Medical Education (ACGME), among others

- "Package" curriculum using diversity symbols and artwork to create a mini booklet that contains the consolidated curriculum in a nutshell

- Conduct informational workshops for local, regional, and National health profession conferences

- Create a "Strategies for Integrating Cultural and Linguistic Competency Education" listserve just for COEs. Listserves are easy and inexpensive to put in place and are excellent for dialogue and sharing

III. The Importance of Internal Dissemination

It is essential to include strategic planning as part of the internal dissemination plan. In this case, strategic planning means developing a way to share the information and knowledge in effective and well-planned ways, steps that will keep the promising practices developed as part of the cultural and linguistic competence curriculum from becoming lost. Too often, programs that have proved successful are lost after the funding ends. Faculty and students should be encouraged to share their successful strategies and models at faculty meetings and departmental workshops. A well-planned and executed internal dissemination plan will not only sustain the successful program within the COE institution, but also will provide motivation for making it available to other educational institutions as well. In ensuring that it is available to other institutions, the COE will be helping to make sure that service providers have the skills, knowledge, and attitudes to provide competent cultural services.

Chapter 9: Next Steps

This curriculum guide was developed for the use of HRSA Centers of Excellence grantees and other educational programs that may find it helpful. The purpose of the guide is to provide the COEs with material that will assist them in meeting the mandated program requirements related to cultural and linguistic competence and to enhance the training programs for students to better prepare them for meeting the health care needs of diverse populations. For these reasons, it may be best to publish this curriculum guide on the Web so that it will be available to a wide audience, and so that the materials cited in this guide will be easily accessible.

This chapter will provide a brief summary of the curriculum guide and discuss potential challenges and issues COEs may face in implementing the contents of the guide. While this guide provides a *starting point* for COEs to address cultural and linguistic competence education, much can be done to build on this foundation. The Expert Team has identified and will share in this chapter a number of recommendations for next steps, both in using this curriculum guide and in encouraging wide recognition of the importance of cultural and linguistic competence training.

I. Summary of the Project and the Curriculum Guide

This curriculum guide was the result of a diligent effort over 18 months by members of an Expert Team who participated in numerous conference calls and face-to-face meetings, and debated the benefits of using various approaches to arrive at a collective consensus on the content of the curriculum guide. The guide took several turns in its development from the beginning of the process to its completion as a final document. The initial plan was to involve an Expert Team with significant expertise in the field of cultural and linguistic competency. However, one of the first principles the group unanimously agreed upon was to involve representatives of the COEs as much as possible throughout this process. Although the Expert Team is fortunate to include two COE grantee directors and several members who have worked closely with COEs, numerous COE directors have contributed significantly by participating in

focus groups and in meetings. Their opinions were invaluable in directing the project to improve its focus to benefit COE grantees and students.

In its present form, the outline of chapters for the curriculum guide has been designed to inform readers systematically. Chapters 1 through 3 provide an overview of the history of COE cultural and linguistic competency issues and clearly identify a case for cultural and linguistic competence education in COEs. Models of cultural and linguistic competence are presented along with principles and goals. Chapters 4 through 6 address designing a cultural and linguistic competence curriculum, provides guidance on its content, and strategies to incorporate content into curricula. Chapters 7 and 8 focus on assessment and evaluation of cultural and linguistic competency education activities and dissemination strategies that can be used when sharing lessons learned in the community. Chapter 10 summarizes an extensive amount of resources available for COEs in fields related to cultural and linguistic competence education. The appendices contain examples of implementation strategies, a glossary of terms related to cultural and linguistic competency, and the *Centers of Excellence Assessment and Promising Practices Report,* which includes descriptions of cultural and linguistic competence activities of HRSA COE grantees.

II. The Need for Collaboration and Potential Challenges

When using this curriculum guide, COEs will find that as they add to or develop a curriculum in cultural and linguistic competency, it will be advantageous to work together with other COEs so that they can share information and ideas about strategies that have worked and those that have failed. There are, however, barriers to such collaboration in four specific areas:

a.) **Collaboration.** Among the constraints is the competitiveness among COEs, which tends to inhibit collaboration, the sharing of ideas, and assisting each other in developing programs in cultural and linguistic competency. Ways of fostering collegial collaboration should be seriously considered by HRSA including funding specific pilot programs.

b.) **Funding Cycle.** A three-year COE funding cycle is too short for institutions seeking to implement long-term changes such as the addition of cultural and linguistic competency elements to their curricula and subsequent assessment and evaluation of the curricular model. The directors said that they found it to be a challenge to address all the expectations of HRSA in terms of institutionalizing cultural competency, addressing appropriate outcomes, and conducting assessments and evaluations, while facing the risk of not having COE funding continued. In addition, pressure for support of activities that promote cultural and linguistic competence is increasing from the public, practice associations, and accrediting bodies, but implementation of curricula is labor-intensive and COE staff need time to make such changes.

c.) **Communication:** There is a need for more structured and dedicated communication on the topic of cultural and linguistic competence between the HRSA's Bureau of Health Professions and the individuals COEs. This approach would allow both the COE grantee and

HRSA to benefit from an exchange of ideas, strategies, and promising or best practices. Furthermore, it allows both to understand and set realistic expectations.

d.) **Need for institutional support.** For a curriculum in cultural and linguistic competency to be successful, there is a great need for understanding and support from the larger university institutions and their leaders. Each institution has its own culture, and therefore various approaches are needed to match the various institutional cultures. Also, changes in the curriculum will need support from a critical mass of faculty who can be instrumental in obtaining the buy-in from the institution to support the effort.

III. Recommendations and Next Steps

There is still much work to be accomplished in the area of developing cultural and linguistic competency in health care. Due to their unique positions, COEs have the opportunity to provide leadership among their institutions, community partners, and in the larger society in the movement of cultural and linguistic competence education. The following are some recommendations the Expert Team identified as possible next steps for the COEs to consider:

- Designing very specific pilot cultural competence elements in the curriculum and evaluating them empirically to assess the degree of change in knowledge, skills, and attitudes relevant to diversity, cultural competence, and health care disparities. These results should be shared with colleagues and other institutions though publications and presentations

- Working collaboratively with one another whenever possible to implement the curriculum. Doing so would particularly benefit COEs focused on specific ethnic minority groups or particular disciplines

- Fostering faculty and student efforts to conduct cross-cultural research and share findings

- Developing public-private partnerships to fund and develop cultural and linguistic competency curricula and educational materials related to specific health and illness conditions (both physical and mental health issues) in diverse populations

- Availing themselves of opportunities to develop transnational partnerships with health professions educational institutions in other countries that are developing cultural and linguistic competency curricula, programs, and materials

- Expending resources to explore methods of increasing the diversity of the workforce and ways to take advantage of a diverse workforce

- Encouraging projects and funding opportunities from agencies such as Federal Office of Mental Health and the National Institutes of Health

- Partnering with communities and community-based organizations to support efforts to address cultural competence

Other suggestions for COEs and HRSA to consider include:

- Conducting practical workshops and training for COE faculty on such topics as how to select a video and do a debriefing on it; how to integrate cultural and linguistic competency into lectures, case management, history-taking, and patient assessment; and how to insert just-in-time training on various aspects of cultural and linguistic competency into a curriculum

- Facilitating Web-based training

- Initiating efforts to promote sharing best practices and resources among COEs by developing a Website, for example, and a moderated listserve. The Website would include such resources as this curriculum guide and links to other useful publications and Websites, provide updates on resources that are available to COEs, and showcase successful models developed by COEs

- Collaborating closely with other Federal agencies on COE requirements and progress

- Providing feedback on next steps that would be helpful to COEs by making the sharing of resources and best practices among COEs a grant review criteria, for example

Cultural and linguistic competence is not an end point, but a process. As suggested earlier, this curriculum guide was written as a starting point for COEs to fulfill the mandate for teaching cultural and linguistic competency. It is a foundation on which they can build by engaging in a collaborative process within their communities and with other institutions. It is, however, just a beginning, and the COEs and other readers have the opportunity to use the content of this curriculum to educate future leaders in providing culturally and linguistically competent, and ultimately better quality, health care for all.

Chapter 10: Resources

The field of cultural and linguistic competence in health care has undergone extensive development in the last decade and a half. As a result, a number of curricular approaches and models have been tried, many with excellent success, as pedagogical strategies. Additionally, the number of tools available to curriculum designers, such as video case studies, Web-based training modules, and culturally sensitive patient assessments, has greatly expanded. Websites and training centers are devoted to cultural and linguistic competence in health care, and extensive bibliographies have been compiled to aid in the integration of cultural factors into course content. In this chapter is a list of what the Expert Team considers the best of these materials and tools.

Section I looks at the tremendous amount of public and professional support that has been given to the issues surrounding cultural and linguistic competencies in health care. Section II provides

a wealth of information on the types of approaches that have been used in creating courses and curricula on the topic, including specific courses and curricular offerings, Web-based modules, and patient assessments. Section III provides assessment tools and criteria for personal, organizational, and curricula evaluation. Section IV lists excellent audiovisual resources that have been designed to enhance cultural and linguistic competency curricula. Section V directs the curriculum designer to specific Websites providing tools, discussion materials, and ongoing and current topics on related issues. Section VI lists a number of educational and training centers that devote attention to cultural and linguistic competency subject matter and training programs. Finally, Section VII is a compilation of bibliographies that address both broad and specialized epidemiological, diagnostic, and treatment issues in diverse populations. This section is useful in integrating culture-specific information into course material.

Since the resources are extensive, curriculum and course designers may wish to first browse these sections, noting entries that appear to best suit their specific educational purposes before delving more deeply during subsequent readings.

I. Professional and Public Support for Cultural Competence Education in the Health Professions

In this section, the reader is directed to specific statements and materials from the health professions and public policy-making bodies that endorse the need for cultural and linguistic competence education and culturally and linguistically competent health care practice. Statements such as these help make the case for cultural and linguistic competence education as an accepted aspect of quality health care that are useful for discussing these issues with administrators, those in charge of curriculum content or resource allocation, and any other professionals who have not been persuaded as to the importance of cultural and linguistic competence education in the health professions. It is recommended that curriculum designers first become familiar with these key materials before embarking on a program to implement cultural and linguistic competence education. In many cases, links to Websites are provided.

A. Standards and Policies of Accreditation Agencies and Professional Organizations.

1. *Accreditation Council for Graduate Medical Education Outcome Project: General Competencies.* www.Outcomes@acgme.org

Professionalism is made up of the following: 1) A commitment to carrying out professional responsibilities, adherence to ethical principles and sensitivity to a diverse population; and 2) Sensitivity and responsiveness to patients' culture, age, gender, and disabilities.

2. 1998 Association of American Medical Colleges. *Teaching and Learning of Cultural Competence in Medical School*. Contemporary Issues in Medical Education, Feb.; Vol. 1(5). Division of Medical Education, AAMC, Washington, D.C. www.aamc.org

3. Liaison Committee on Medical Education. *Standard on Cultural Diversity*. Full text of LCME Accreditation Standards (from <u>Functions & Structure of a Medical School, Part 2</u>). www.lcme.org

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.

4. 2001 American Academy of Family Physicians (AAFP). *Cultural Proficiency Guidelines*. The guidelines were approved by the AAFP Board of Directors in March 2001. For more information, contact AAFP at 11400 Tomahawk Creek Parkway, Leawood, KS 66211 or call (913) 906-6000. Website: www.aafp.org.

The AAFP believes in working to address the health and educational needs of our many diverse populations. A list of issues to consider in preparing informational or continuing medical education material and programs has been developed to ensure cultural proficiency and to address specific health related issues as they relate to special populations of patients and providers.

5. 2001 American College of Emergency Physicians. *Cultural Competence and Emergency Care*. Approved by the ACEP Board of Directors, October. For more information, contact ACEP at 1125 Executive Circle, Irving, TX 75038-2522 or call (800) 798-1822. www.acep.org

The American College of Emergency Physicians believes that quality health care depends on the cultural competence as well as the scientific competence of physicians. It also believes that cultural competence is an essential element of the training of health care professionals.

6. 1998 The American College of Obstetricians and Gynecologists (ACOG) Committee on Health Care for Underserved Women. *Committee Opinion,* No. 201, March. Copyright Clearance Center, Danvers, MA 01923. Call (978) 750-8400. For more information, contact ACOG at 409 12th Street, SW, PO Box 96920, Washington, D.C. 20090-6920. www.acog.org

Culture and Health Care

During every health care encounter, the culture of the patient, the culture of the provider, and the culture of medicine converge and affect the patterns of health care utilization, compliance with recommended medical interventions, and health outcomes.

7. The American Dentistry Association. http://www.ada.org

The ADA is "committed to reducing health disparities by supporting initiatives that broaden access to dental care for people who otherwise cannot afford it and encourages more dentists to practice in designated underserved areas."

As part of its core values, or Guiding Lights, the ADA Foundation "…embraces diversity and cultural competency as essential components in its programs, partnerships, and coalition activities."

8. The American Association of Pediatric Dentists

"AAPD values the diversity of children, their families, and their communities and respects the contribution of culture to the attainment of oral health and use of dental services."

9. 1999 The American Medical Association. Cultural Competence Initiative: *Cultural Competence Compendium*. Guide and resources for cultural competence in medicine. www.ama-assn.org

10. The American Medical Student Association. www.amsa.org

Cultural competency is "a set of academic and personal skills that allow us to increase our understanding and appreciation of cultural differences between groups." Becoming culturally competent is a developmental process.

11. American Nurses Association. *Position Statements: Cultural Diversity in Nursing Practice.* http://www.nursingworld.org/readroom/position/ethics/etcldv.htm

Knowledge of cultural diversity is vital at all levels of nursing practice. Ethnocentric approaches to nursing practice are ineffective in meeting health and nursing needs of diverse cultural groups of clients. Knowledge about cultures and their impact on interactions with health care is essential for nurses, whether they are practicing in a clinical setting, education, research or administration.

12. 1990 American Psychological Association. *Guidelines for Culturally Diverse Populations: APA Guidelines Approved by the APA Council of Representatives* in August. For more information, write to 750 First Street, NE, Washington, DC 20002. Tel. (202) 336-5500. www.apa.org/pi/guide

13. 2002 American Psychological Association. *Guidelines on Multicultural Education, Training, Research, Practice, and Organizational Change for Psychology*. www.apa.org/pi/multiculturalguidelines/pdf

14. 1999 Committee on Pediatric Workforce and the American Medical Association Advisory Committee on Minority Physicians. *Culturally Effective Pediatric Care: Education and Training Issues*. American Academy of Pediatrics, Jan; Vol. 103 (1): 167-170.

This policy statement defines culturally effective health care and describes its importance for pediatrics. The statement also defines cultural effectiveness, cultural sensitivity, and cultural

competence and describes the importance of these concepts for training in medical school, residency and continuing medical education curricula.

15. Society for the Teachers of Family Medicine. Core curriculum guidelines on culturally sensitive and competent health care. These are recommendations that can be used to help train family physicians to provide culturally sensitive and competent health care. http://www.stfm.org/corep.html

16. Society for Public Health Education (SOPHE). *Code of Ethics for the Health Education Profession.* http://www.sophe.org/ (click on "About SOPHE" and then click "Ethics."

By acknowledging the value of diversity in society and embracing a cross-cultural approach, the Society for Public Health Educators supports the worth, dignity, potential, and uniqueness of all people.

B. Standards, Policies, and Related Reports of Public and Private Policy-making Agencies and Organizations.

1. Culturally and Linguistically Appropriate Services in Health Care (CLAS Standards). U.S. Department of Health and Human Services, Office of Minority Health. www.omhrc.gov/clas/finalcultural1a.htm

This policy statement provides Federal guidance to health care organizations on providing culturally and linguistically appropriate patient care.

2. State of New Jersey Senate bill 144; Assembly Bill 492, signed into law on March 23, 2005. This law requires cultural competence training for licensure and relicensure to practice medicine in New Jersey. Additional information about the bill can be obtained at the New Jersey Legislature Website: http://www.njleg.state.nj.us.

   "Cultural awareness and cultural competence are essential skills for providing quality health care to a diverse patient population…. The public interest in providing health care to all segments of society dictates the need for a formal requirement that medical professionals be trained in the provision of culturally competence health care as a condition of licensure to practice medicine in New Jersey."

3. 2000 Guidance on the Mandated Provision of Language Service in Health Care. Department of Health and Human Services Office of Civil Rights www.hhs.gov/ocr/lep/revisedlep.html

4. 2000. White House. Executive Order: Improving Access to Services for Persons with Limited English Proficiency. Federal Register, 65 (159): 50121-50122.

5. 2003 Ensuring Linguistic Access in Health Care Settings: Legal Rights and Responsibilities. National Health Law Program (NheLP). www.healthlaw.org

6. 2002. <u>Principles and Recommended Standards for the Cultural Competence Education of Health Care Professionals</u> The California Endowment. Guidelines for curricular content, pedagogy, evaluation. www.calendow.org

7. 1998 <u>Cultural Competence Standards in Managed Care Mental Health Services: Four Underserved/Underrepresented Racial/Ethnic Groups.</u> Western Interstate Commission for Higher Education (WICHE). Center for Mental Health Services, Substance Abuse and Mental Health Services Administration; U.S. Department of Health and Human Services. www.wiche.edu/MentalHealth?Cultural_Comp/ccslist.htm

8. 2002 <u>Unequal Treatment. Confronting Racial and Ethnic Disparities in Health care.</u> Institute of Medicine. Washington, D.C. National Academy Press. www.nap.edu

"Sociocultural factors are critical to the medical encounter, yet cross-cultural curricula have been incorporated into undergraduate, graduate, and continued health professions only to a limited degree…" in Chapter 6, *Interventions: cross-cultural education in the health professions.*

9. 2004 <u>Missing Persons: Minorities in the Health Professions. A Report of the Sullivan Commission on Diversity in the Health care Workforce.</u> www.sullivancommission.org

"There is an unbalance in the makeup of the Nation's physicians, dentists, and nurses. This imbalance contributes to the gap in health status and impaired access to health care experienced by a significant portion of our population."

II. Curricular Strategies and Approaches Used in the Teaching of Cultural and Linguistic Competencies to Health care Professionals

Work in the area of cultural competence curriculum design for health professionals has been ongoing for several years at various medical, nursing, and pharmacy schools, and residency programs. Lessons have been learned and innovative techniques have proven to be successful. This section provides specific information on different types of curricular activities used in educating health care professionals about cultural competency. **Section A** contains articles and books in which health care professionals, professors, and trainers discuss different approaches, techniques, and curricular content that they have used in cultural and linguistic competency education. Also included are seminal works on cultural competency. **Section B** contains Web-based curricular programs and modules.

A. Articles and Books

(Note: There are now thousands of articles on cultural competency as it relates to *treatment* modalities and the needs of specific populations. The references below are focused mainly on the *pedagogy* of cultural competence training for the health care professions.)

1. 1995 Alexander, M. *Cinemeducation: An Innovative Approach to Teaching Multi-Cultural Diversity in Medicine.* <u>Annals of Behavioral Science and Medical Education.</u> Vol. 2 (1):

23-8. Department of Family Practice, Area Health Education Center, Carolinas Medical Center, Charlotte, North Carolina.

2. 2004 <u>American Journal of Managed Care</u>, 10(SP), September. Theme Issue – Health care Disparities.

3. 2003 <u>American Journal of Public Health</u>, 93(2). Theme-Issue – Racial/Ethnic Bias in Health Care.

4. 2003 Andrews, M. & Boyle, J.R. <u>Transcultural Concepts in Nursing Care</u>. Philadelphia: Lippincott Williams & Wilkins (includes ethnic pharmacology).

5. 2004 Assemi, M., Cullander, C. & Henderson, K. *Implementation and Evaluation of Training for Pharmacy Students.* <u>The Annals of Pharmacotherapy, 38</u> (5): 781-786.

6. 2005 Barr, D.A. and Wanat, S.F. *Listening to Patients: Cultural and Linguistic Barriers to Health Care Access*. <u>Family Medicine</u>, 37(3): 199-204.

7. 1983 Berlin, E.A., & Fowkes, W.S. *A Teaching Framework for Cross-Cultural Health Care.* <u>Western Journal of Medicine,</u> 139: 934-938.

8. 1998 Berger, J. T. *Culture and Ethnicity in Clinical Care.* <u>Archives of Internal Medicine, 158</u>: 2085-2090.

9. 2003 Betancourt, J. R. *Cross-Cultural Medical Education: Conceptual Approaches and Frameworks for Evaluators.* <u>Academic Medicine,</u> 78(6): 560-569. Note that this entire issue of <u>Academic Medicine</u> is devoted to cultural competence in health care professional education.

10. 2003 Bigby, J.A. (Ed.) <u>Cross-Cultural Medicine</u>. Philadelphia: American College of Physicians.

11. 1991 Borkan, J. and Neher, J. *A Development Model for Ethnosensitivity in Family Practice Training*. <u>Family Medicine</u>, 23(3): 212-7.

12. 2002 Brach, C. & Fraser, I. *Can Cultural Competency Reduce Racial and Ethnic Health Disparities? A Review and Conceptual Model.* <u>Medical Care Research and Review, 57</u> (Supplement 1): 181-217.

13. 2002 Brach, C. & Fraser, I. *Reducing Disparities through Culturally Competent Health Care: An Analysis of the Business Case.* <u>Quarterly Management in Health Care, 10 </u>(4): 15-28.

14. 2002 Burroughs, V., Maxey, R. & Levy, R. *Racial and ethnic differences in response to medications: Towards individualized treatment*. <u>Journal of the National Medical Association, 94</u> (1): 1-26.

15. 2003 Byrne, M.M., Weddle, C., Davis, E., & McGinnis, P. *The Byrne Guide for Inclusionary Cultural Content.* Journal of Nursing Education, 42(6): 249-257.

16. 1999 Carrillo, J.E., Green, A.R., & Betancourt, J.R. *Cross-Cultural Primary Care: A Patient-Based Approach.* Annals of Internal Medicine, 130:829-34.

17. 1999 Campinha-Bacote, J. *A Model and Instrument for Addressing Cultural Competence in Health Care.* Journal of Nursing Education, 38 (5): 203-7. Primarily for Nursing Education.

18. 2003 Campinha-Bacote, J. *The Process of Cultural Competency in the Delivery of Health care Services: A Model of Care.* Journal of Transcultural Nursing 13(3): 181-184.

19. 2005 Campinha-Bacote, J. A Biblically Based Model of Cultural Competence in the Delivery of Health care Services. Cincinnati: Transcultural C.A.R.E. Associates.

20. 1997 Castillo, R.J. Culture and Mental Illness. A Client-Centered Approach. Pacific Grove, CA: Brooks/Cole Publishing Company.

21. 2005 Circulation, 111(10). Theme Issue – Cardiovascular Health Disparities.

22. 2001 Christensen, M. *Diagnostic Criteria in Clinical Settings: DSM-IV and Cultural Competence.* American Indian and Alaska Native Mental Health Research, 10(2): 52-66.

23. 1989 Cross, T., Bazron, B., Dennis K., and Isaacs, M. Towards a Culturally Competent System of Care. Volume I. Washington, DC: CASSP Technical Assistance Center, Center for Child Health and Mental Health Policy, Georgetown University Child Development Center. March 1989, pp.v-viii.

24. 2000 Clark, L., Zuk, J., & Baramee, J. *A Literary Approach to Teaching Cultural Competence.* Journal of Transcultural Nursing, 11(3): 199-203.

25. 1984 Collins, J.L., Mathura, C.B., Risher, D.L. *Training Psychiatric Staff to Treat a Multicultural Patient Population.* Hospital and Community Psychiatry, 35(4): 372-6.

26. 2004 Champaneria, M.C. & Axtell, S. *Cultural Competence Training in U.S. Medical Schools.* Journal of the American Medical Association, 291:2141.

27. 1982 Chrisman, N. & Maretzki, T., Eds. Clinically Applied Anthropology. Boston: D. Reidel Publishing Company. Contains articles about how to teach cultural competence to clinicians by Kleinman, Ness, and Chrisman. Out of print, but some copies available at www.amazon.com

28. 1991 Comas-Diaz, L. and Jacobsen, F.M. *Ethnocultural Transference and Countertransference in the Therapeutic Dyad.* American Journal of Orthopsychiatry, 61(3): 392-402.

29. 2000 Connolly, I.M., Darby, M.L., Tolle-Watts, L., & Thomson-Lakey, E. *The Cultural Adaptability of Health Sciences Faculty.* Journal of Dental Hygiene, 74(2): 102-109.

30. 1997 Culhane-Pera, K.A., Reif, C., Egli, E., Baker, N.J., & Kassekert, R. *A Curriculum for Multicultural Education in Family Medicine.* Family Medicine, 29(10): 719-23. Department of Family and Community Medicine, Regions Hospital, St. Paul Ramsey Family Practice Residency, St. Paul.

31. 2000 Culhane-Pera, K.A., Like, R.C., Lebensohn-Chialvo, P., & Loewe, R. *Multicultural Curricula in Family Practice Residencies.* Family Medicine, 32(3):167-73.

32. 2003. Culhane-Pera, K.A., Vawter, D.E., Xiong, P., & Babbitt, M.M. (Eds). Healing by Heart. Clinical and Ethical Case Stories of Hmong Families and Western Providers. Nashville: Vanderbilt University Press: Chapter 16: A Model for Culturally Responsive Care.

33. 2001 DeSantis, Lydia. *Health-Culture Reorientation of Registered Nurse Students.* Journal of Transcultural Nursing, 12(4): 310-18.

34. 2003 Dobbie, A., Medrano, M., Tysinger, J. & Olney, C. *The BELIEF Instrument: A Preclinical Teaching Tool to Elicit Patients' Health Beliefs*. Family Medicine, 35(5): 316-319. Standardized patient cases.

35. 2000 Einbinder, L.C. and Schulman, K.A. *The Effect of Race on the Referral Process for Invasive Cardiac Procedures*. Medical Care Research and Review, 1:162-177.

36. 2003 Ferguson, W.J., Keller, D.M., Haley, H.L., & Quirk, M. *Developing Culturally Competent Community Faculty: A Model Program.* Academic Medicine, 78:1221-1228.

37. 2003 Formicola, A.J., Klyvert, M., McIntosh, J., Thompson, A., Davis, M., & Cangialosi, T. *Creating an Environment for Diversity in Dental Schools: One School's Approach.* Journal of Dental Education, 67(5): 491-9.

38. 2003 Formicola, A.J., Stavisky, J. & Levy, R. *Cultural Competency: Dentistry and Medicine Learning from One Another.* Journal of Dental Education, 67(8): 869-75.

39. 2004 Fortier, J.P. and Bishop, D. (eds.). Setting the Agenda for Research on Cultural Competence in Health Care: Final Report. Resources for Cross Cultural health Care. U.S. Department of Health and Human Services Office of Minority Health and Agency for Health care Research and Quality, August 2004. Rockville, MD (http://www.ajhrq.gov/research/cultura.htm).

40. 1980 Foulks, Edward. *The Concept of Culture in Psychiatric Residency Education.* The American Journal of Psychiatry, 137(7): 811-6.

41. 2002 Fuller, K. *Eradicating Essentialism from Cultural Competency Education.* <u>Academic Medicine,</u> 77: 198-121.

42. 2001 Gaw, A. <u>Concise Guide to Cross-Cultural Psychiatry</u>. Washington, D.C.: American Psychiatric Publishers, Inc.

43. 2004 Galanti, G. <u>Caring for Patients from Different Cultures, 3rd edition.</u> Philadelphia: University of Pennsylvania Press. Case-based material

44. 1986 Galazka, S.S. & Eckert, K.J. *Clinically Applied Anthropology: Concepts for the Family Physician.* <u>The Journal of Family Practice,</u> 22(2): 59-65.

45. 2003 Giger, J. & Davidhizar, R. <u>Transcultural Nursing, 4th edition</u>. St. Louis: Mosby Year Book.

46. 2000 Glanville, C. & Porche, D. *Graduate Nursing Faculty: Ensuring Cultural and Racial Diversity Through Faculty Development.* <u>Journal of Multicultural Nursing and Health,</u> 6 (1): 6-13.

47. 2001 Godkin, M.A. & Savageau, J.A. *The Effect of a Global Multiculturalism Track on Cultural Competence of Preclinical Medical Students.* <u>Family Medicine,</u> 33(3): 178-86.

48. 2002 Gilbert, M.J. <u>A Manager's Guide to Cultural Competence Education for Health Care Professionals.</u> www.calendow.org

49. 1996 Goldman, R.E., Monroe, A.D. & Dube, C.E. *Cultural Self-Awareness: A Component of Culturally Responsive Care.* <u>Annals of Behavioral Science and Medical Education,</u> 3: 37-46.

50. 2003 Grant, L. & Letzring, T. *Status of Cultural Competence in Nursing Education: A Literature Review.* <u>Journal of Multicultural Nursing & Health,</u> 9(2): 6-13.

51. ND Green, A.R., Betancourt, J.R., & Carrillo, J.E.. *Cross-Cultural Curriculum Syllabus.* Weill Medical College of Cornell University; New York Presbyterian Hospital Internal Medicine Residency Program. Contact: alexgreen@pol.net.

52. 2002 Green, A.R., Betancourt, J.R., & Carrillo, J.E. *Integrating Social Factors into Cross-cultural Medical Education.* <u>Academic Medicine,</u> 77(3): 193-7.

53. 1997 Gupta, A.R, Duffy, T.P., & Johnston, M.C. *Incorporating Multiculturalism into a Doctor-Patient Course.* <u>Academic Medicine,</u> 72(5): 428.

54. 2003 Haden, N.K., Catalanotto, F.A., Alexander, D.J., Bailit, H., Battrell, A., Broussard, J. Jr., Buchanan, J., Douglass, C.W., Fox, C.E. 3rd., Glassman, P., Lugo, R.I., George, M., Meyerowitz, C., Scott, E.R. 2nd., Yaple, N., Bresch, J., Gutman-Betts, Z., Luke, G.G., Moss, M., Sinkford, J.C., Weaver, R.G., & Valachovic, R.W. *Improving the Oral Health*

Status of All Americans: Roles and Responsibilities of Academic Dental Institutions. Journal of Dental Education, 67(5): 563-583.

55. 1999 Hadwiger, S.C. *Cultural Competence Case Scenarios for Critical Care Nursing Education.* Nurse Educator, 24(5): 47-51.

56. ND Haq, C., Grow, M., Adler, K., Appelbaum, D., Hawkin, G., Hewson, M. *Creating a Longitudinal Multicultural Medical School Curriculum.* Department of Family Medicine, University of Wisconsin Medical School.

57. 2001 Hays, P. Addressing Cultural Complexities in Practice. Washington, DC: American Psychological Association Press.

58. 2005 Health Affairs, 24(2). This thematic issue is a collection of articles regarding racial and ethnic disparities in health care. Online at www.healthaffairs.org/Thematic.php

59. 2003 Journal of Nursing Education, 42(6). This June issue is devoted to cultural competence in nursing education. Online at www.journalofnursingeducation.com

60. 2002 Journal of Transcultural Nursing, 13(3) presents several theoretical and conceptual models as well as frameworks to organize knowledge about transcultural nursing.

61. 1998 Journal of Nursing Education, 37(1). This January issue focuses on cultural diversity in nursing education.

62. 2003 Kagawa-Singer, M. and Kassim-Lakha S. *A Strategy to Reduce Cross-Cultural Miscommunication and Increase the Likelihood of Improving Health Outcomes.* Academic Medicine, 78: 577-587.

63. 1982 Kleinman, A. *The Teaching of Clinically Applied Medical Anthropology on a Psychiatric Consultation-Liaison Service*. In Chrisman and Maretaki, Eds. Clinically Applied Anthropology. Boston: D. Reidel Publishing Company. This book is out of print but can still be obtained at www.amazon.com. It is one of the best on teaching clinicians.

64. 2003 Kehoe, K., Melkus, G. & Newlin, K. *Culture Within the Context of Care: An Integrative Review.* Ethnicity and Disease, 13 (3): 344-353.

65. 2001 Kim-Godwin, Y. Clarke, P., & Baron, L. *A Model of Delivery of Culturally Competent Community Care.* Journal of Advance Nursing Practice, 35 (6): 918-925.

66. 1999 Kudzma, E.C. *Culturally Competent Drug Administration.* American Journal of Nursing, 99 (8): 46-51.

67. 1996 Lavizzo-Mourey, R. & MacKenzie, B. *Cultural Competence: Essential Measures of Quality for Managed Care Organizations.* Annals of Internal Medicine, 124 (10): 919-921.

68. 2002 Leininger, M., McFarland, M. Transcultural Nursing: Concepts, Theories, Research & Practice, 3rd ed. NY: McGraw-Hill Medical Publishing Division.

69. 2002 Levin, S.J., Like, R.C. & Gottlieb, J. E. *ETHNIC: A Framework for Culturally Competent Clinical Practice.* Patient Care, 34(9): 188-189.

70. 1996 Like, R.C., Steiner, P., & Rubel, A.J. *Recommended Core Curriculum Guidelines on Culturally Sensitive and Competent Health Care.* STFM Core Curriculum Guidelines. Family Medicine, 28(4): 291-7.

71. 2000 Like, R.C. *TRANSLATE: for Working With Medical Interpretation.* Patient Care, 34(9): 188.

72. 1997 Lockhart, J.S. & Resick, L.K. *Teaching Cultural Competence: The Value of Experimental Learning and Community Resources.* Nurse Educator, 22(3): 27, 29, 31, 44.

73. 1999 Loudon, R.F., Anderson, P.M., Gill, P.S., & Greenfield, S.M. *Educating Medical Students for Work in Culturally Diverse Societies.* Journal of American Medical Association, 282 (9): 875-80.

74. 1994 Lum, C.K. & Korenman, S.G. *Cultural-sensitivity Training in U.S. Medical Schools.* Academic Medicine, 69(3): 239-41.

75. 2003 Luquis, R. & Perez, M. *Achieving Cultural Competence: The Challenges for Health Educators.* American Journal of Health Education, 34 (3): 131-139.

76. 1990 Lurie, N. & Yergan, J. *Teaching Residents to Care for Vulnerable Populations in the Outpatient Setting.* Journal of General Internal Medicine, 5:S26-34.

77. 2004 Lu, F. *Program Requirements for Residency Training in Psychiatry on Cultural Issues,* Jan. University of California, San Francisco. Contact: Francis.Lu@sfdph.org

78. 1989 MacIntosh, P. *White Privilege: Unpacking the Invisible Knapsack.* Peace and Freedom, July/August: 10-12.

79. 1988 Mao, C., Bullock, C.S., Harway, E.C., & Khalsa, S.K. *A Workshop on Ethnic and Cultural Awareness For Second-Year Students.* Journal of Medical Education, 63: 624-8.

80. 1993 Marvel, M.K., Grow, M., & Morphew, P. *Integrating Family and Culture Into Medicine: A Family Systems Block Rotation.* Family Medicine, 25 (7): 441-2.

81. 1998 Masters, D. *Teaching and Learning of Cultural Competence in Medical School.* Contemporary Issues in Medical Education, 1(5).

82. 2000 McCarty, L.J., Enslein, J.C., Kelley, L.S., Choi, E., & Tripp-Reimer, T. *Cross-Cultural Health Education Materials on the World Wide Web.* Journal of Transcultural Nursing, 13(1): 54-60.

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84. 1996 Mezzich, J.E., Kleinman, A., Fabrega, H., & Parron, D.L. Culture and Psychiatric Diagnosis. A DSM-IV Perspective. Washington, DC: American Psychiatric Press, Inc.

85. 2003 Mouradian, W., Berg, J., & Somerman, M. *The Role of Cultural Competency in Health Disparities: Training Primary Care Medical Practitioners in Children's Oral Health.* Journal of Dental Education, 67: 860-868.

86. Neighbors, H. *The (mis) Diagnosis of African Americans Implementing DSM Criteria in the Hospital and the Community.* Martin Luther King, Jr. Day Grand Rounds, University of Michigan Department of Psychiatry, January 22, 2003. Online at http://www.med.umich.edu/psych/mlk2003.htm.

87. 1982 Ness, R.C. *Medical Anthropology in a Preclinical Curriculum.* In Chrisman and Maretzki, Eds. Clinically Applied Anthropology. Boston: D. Reidel Publishing Company.

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90. 2000 Nunez, A.E. *Transforming Cultural Competence into Cross-cultural Efficacy in Women's Health.* Academic Medicine, 75: 1071-1080.

91. 2002 Office of Minority Health, U.S. Department of Health and Human Services in association with Rebecca Rios and Jacquelyn Graham of the American Institutes for Research. Teaching Cultural Competence in Health Care: A Review of Current Concepts, Policies and Practices. www.cultureandhealth.org/cccm/Resources/scanfinal.pdf

92. 1999. Oz, M. Healing from the Heart: A Leading Surgeon Combines Eastern and Western Traditions to Create the Medicine of the Future. New York: Plume Books.

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94. 2000 Paniagua, F.A. *Culture-bound Syndromes, Cultural Variations, and Psychopathology*, In Cuellar, I. and Paniagua, F.A. (eds.) Handbook of Multicultural Mental Health, San Diego, Ca: Academic Press, Inc., 139-169.

95. 1989 Pedersen, P. A Handbook for Multicultural Awareness. VA: American Association for Counseling and Development.

96. 1992 Pico, E., Wimbley, M., & Wells, K.B. *First-year Students' Expectations of Interacting with Minority Patients and Colleagues.* Academic Medicine, 67:411-2.

97. 2003. Physicians for Human Rights. The Right to Equal Treatment: An Annotated Bibliography on Racial and Ethnic Disparities in Health care, Their Causes and Related Issues. www.phrusa.org/research/domestic/race/race_report/bibliography.html Discusses disparities by specialty.

98. 1986 Poulton, J., Rylance, G.W., & Johnson, M.R.D. *Medical Teaching of the Cultural Aspects of Ethnic Minorities: Does It Exist?* Medical Education, 20:492-7.

99. 2000 Purnell, L. *A Description of the Purnell Model for Cultural Competence.* Journal of Transcultural Nursing, 11(1): 40-6.

100. 2003 Purnell, E.C. & Paulanka, B. Transcultural Health: A Culturally Competent Approach. Philadelphia: Davis Publishers.

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103. 2002 Ryan, M. & Twibell, R.S. *Outcomes of a Transcultural Nursing Immersion Experience: Confirmation of a Dimensional Matrix.* Journal of Transcultural Nursing, 13(1): 30-39.

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106. 1996 Shapiro, J. & Lenahan, P. *Family Medicine in a Culturally Diverse World: A Solution-oriented Approach to Common Cross-cultural Problems in Medical Encounters.* Family Medicine, 28 (4): 249-55.

107. 2002 Smedley, B.D., Stith, A.Y., & Nelson, A.R. (Eds.). Unequal Treatment. Confronting Racial and Ethnic Disparities in Health care. Institute of Medicine. Washington, D.C.: National Academy Press (at www.nap.edu or www.amazon.com.) This critical book is accompanied by a CD-ROM with several useful articles.

108. 1994 Stein, T.S. *A Curriculum for Learning in Psychiatric Residencies About Homosexuality, Gay Men, and Lesbians.* Academic Psychiatry, 18(2): 59-68.

109. ND Streeter, R., Campa, D., & McDiarmid, J. *Second Year Residents on Community Medicine Rotation – Culture Clinic at Golden Valley*. Email: mcdiarj@chw.edu.

110. 2000 Takeuchi, J. *Treatment of Biracial Child with Schizophreniform Disorder: Cultural Formulation*. Cultural Diversity and Ethnic Minority Psychology, 6(1): 93-101.

111. 2003 Taylor, J.S. *Confronting "Culture" in Medicine's "Culture of No Culture."* Academic Medicine, 78(6): 555-559.

112. 1998 Tervalon, M., & Murray-Garcia, J. *Cultural Humility Versus Cultural Competence: A Critical Distinction in Defining Physician Training Outcomes in Multicultural Education.* Journal of Health Care for the Poor and Underserved, 9(2): 117-25.

113. 2003 Tervalon, M. *Components of Culture in Health for Medical Students' Education.* Academic Medicine, 78(6): 570-6.

114. 2002 Turbes, S., Krebs, E., & Axtell, S. *The Hidden Curriculum in Multicultural Medical Education.* Academic Medicine, 77: 209-216.

115. 2004 Weinick, R.M., Jacobs, E.A., Stone, L.C., Ortega, A.N., and Burstin, H. *Hispanic Health care Disparities: Challenging the Myth of Monolithic Hispanic Population*. Medical Care, 42(4): 313-20.

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117. 2000 Wells, M.I. *Beyond Cultural Competence: A Model for Individual and Institutional Development*. Journal of Community Health Nursing, 17(4): 189-199.

118. 1998 Wenger, F. *Cultural Openness, Social Justice, Global Awareness: Promoting Transcultural Nursing with Unity in a Diverse World*. in Merilainen, P. and Vehvilainen-Julkunen, K. (Eds.), The 23rd Annual Nursing Research Conference 1997: Transcultural Nursing – Global Unifier of Care Facing Diversity with Unity, Kuopio, Finland: Kuopio University Publications, pg. 162-8.

119. 1998 Whaley, A.L. *Cross-cultural Perspective on Paranoia: A Focus on the Black American Experience*. Psychiatry Quarterly, 69(9): 325-43.

120. 2002 Whitcomb, M.E. *Assisting Medical Educators to Foster Cultural Competence.* Academic Medicine, 77:191-192.

121. 2000 Yeo, G. Ed. Core Curriculum in Ethnogeriatrics. Developed by the Members of the Collaborative on Ethnogeriatric Education, supported by the Bureau of Health Professions, Health Resources and Services Administration, USDHHS, October 2000. http://www.stanford.edu/group/ethnoger

122. 1998 Zweifler, J. & Gonzalez, A.M. *Teaching Residents to Care for Culturally Diverse Populations.* Academic Medicine, 73(10): 1056-61.

B. Web Accessible Cultural Competence Curricular Modules for Health Care Professionals

These easily accessible teaching modules and curricula designed by health care professionals can be used to augment curriculum or in "blended" (such as face-to-face and distance learning) training programs. Curriculum designers should familiarize themselves with the approaches used in these modules to determine how they might best be integrated into the overall curriculum.

1. American Medical Student Association. *Promoting, Reinforcing and Improving Medical Education Culture and Diversity Curriculum, One Year Model Curriculum, Topics and Core Competencies.* Can be downloaded. Contains useful resource material. www.amsa.org/programs/diversitycurriculum.cfm

2. 2004 Betancourt, J.R, Green, A.R., & Carrillo, J.E. *Quality Interactions: A Patient-Based Approach to Cross-Cultural Care.* This is an e-learning, case-based, interactive course, carrying CME credits. Cost per student depends on number of students. www.criticalmeasures.net/mccg/

3. The Center for the Health Professions at University of California, San Francisco offers several learning modules based on Toward Culturally Competent Care: A Toolbox for Teaching Communication Strategies, a 170-page curriculum focused on teaching clinicians to recognize cultural differences in patient interactions and use specific skills to improve patient care. The toolbox costs $75. Included among the learning modules in the toolbox are:

   - *Cultural Competence in Pharmaceutical Care Delivery*
   - *Cultural Competence Training Template*
   - *An Outline for a Half Day Cultural Competency Training Program*

   This manual can be ordered at http://www.futurehealth.ucsf.edu/cnetwork/resources/curricula/diversity.html.

4. The Office of Minority Health offers The Cultural Competency Curriculum Modules for Physicians within "A Family Physician's Practical Guide to Culturally Competent Care." These modules carry nine hours of CME credit with AMA/AAFP. www.cultureandhealth.org.

5. Cultural Positivity: Cultural Competence in Health care. <u>A Diversity and Cross-Cultural Teaching Module for the Internet.</u> Detailed teaching guide for family practice residents and preceptors. www.gvhc.org/cultural/pod's_online.htm

6. Provider's Guide to Quality and Culture. A web-based training on health care quality and culture, developed by the Health Resources and Services Administration. http://erc.msh.org/quality&culture

7. Virtual Lecture Hall. CME web-based course by Randa Kutob, MD, Department of Family Medicine, University of Arizona. *Culturally Effective Care.* Diabetes/Cultural Competency with patient education materials and references. Case-based skill building. www.vlh.com/shared/courses/course_info.cfm?courseno=1786

C. Cross-Cultural Patient Assessment

These resources discuss and model how to conduct a variety of patient assessments while taking cultural factors into consideration.

1. 1995 Campinha-Bacote, J. *The Quest for Cultural Competence in Nursing.* <u>Nursing Forum</u>, 30(4): 19-25.

2. 2002 Committee on Cultural Psychiatry. <u>Cultural Assessment in Clinical Psychiatry</u>. Group for the Advancement of Psychiatry, Report No. 145. Washington, DC: American Psychiatric Publishing, Inc.

3. 1998 Davidhizar, R. & Giger, J. N. *Transcultural Patient Assessment: A Method of Advancing Dental Care.* <u>The Dental Assistant,</u> 67(6): 34-43.

4. 1991 Giger, J. & Davidhizer, R. <u>Transcultural Nursing Assessment and Intervention.</u> St. Louis: CV Moseby.

5. 2002 Group for the Advancement of Psychiatry. <u>Cultural Assesesment in Clinical Psychiatry</u>, Washington, D.C.: American Psychiatric Press.

6. 1999 Huff, R.M. & Kline, M.V. *The Cultural Assessment Framework.* In R.M. Huff and M.V. Kline, Eds. <u>Promoting Health in Multicultural Populations: A Handbook for Practitioners.</u> Thousand Oaks, Calif.: Sage.

7. 1995 Leininger, M. *Culture Care Assessment to Guide Nursing Practices.* In M. Leininger, Ed., <u>Transcultural Nursing: Concepts, Theories, Research, and Practices (2nd edition).</u> New York: McGraw-Hill.

8. 1988 Like, R.C., Rogers, J., and McGoldrick, M. *Reading and Interpreting Genograms: A Systematic Approach.* <u>Journal of Family Practice</u>, 26: 407-12.

9. 1995 Lu, F.G., Lim, R.F., Mezzich, J.E. *Issues in the Assessment and Diagnosis of Culturally Divers Individuals*. In Oldham, J. and Riba, M. (eds.) <u>Review of Psychiatry</u>, 14: 477-510

III. Tools for Assessing Cultural Competence

Cultural competence assessment tools fall into three categories: evaluation of the individual clinician's cultural competencies, evaluation of a health care organization or service delivery program, and evaluation of training programs. Curriculum planners can examine the criteria for clinician cultural competence in **Section A** below to determine the hoped-for characteristics of a culturally competent clinician. **Section B** looks at how the cultural competence of health care organizations, such as hospitals or clinics, might be assessed. **Section C** contains tools for assessing training programs. See above for culturally sensitive patient assessments.

A. Clinical or Personal Assessments

1. 2002 Campinha-Bacote, J. *Inventory for Assessing the Process of Cultural Competence Among Health care Professionals-Revised (IAPCC-R).* Transcultural C.A.R.E. Associates: Cincinatti, OH. Contact Dr. J. Campinha-Bacote at www.transcultural.net

2. 2004 *Clinical Cultural Competency Questionnaire* in Like, R.C., Fulcomer, M.C., Kairys, J.A., Wathington, K.D., & Crosson, J. <u>Final Report Assessing the Impact of Cultural Competency Training Using Participatory Quality Improvement Methods</u>, Aetna 2001 Quality Care Research Fund/Aetna Foundation, April 30, 2004 (additional information available from the Center for Healthy Families and Cultural Diversity, Department of Family Medicine, University of Medicine and Dentistry at New Jersey – Robert Wood Johnson Medical School, New Brunswick, New Jersey, http://www2.umdnj.edu/fmedweb/chfcd/index.htm).

3. 1992 Bhawuk, D.P.S., Brislin, R. *The Measurement of Intercultural Sensitivity Using the Concepts of Individualism and Collectivism.* <u>InterNational Journal of Intercultural Relations,</u> 16:413-36. For more information, contact Dr. R. Brislin at 808-944-7111.

4. 1993 Child Welfare League of America. <u>Cultural Competence Self-Assessment Instrument.</u> Washington, D.C. For more information, contact Jean Tucker Mann at the National Task Force on Cultural Competency of the CWLA, Inc. at 440 First Street, NW, Suite 310, Washington, DC 20001 or call 202-638-2952.

5. 1996 Culhane-Pera, K.A. *Ethnosensitivity in Medicine Questionnaire with Key.* Department of Family and Community Medicine, St. Paul Ramsey Medical Center. For more information, contact K. Culhane-Pera at kathiecp@yahoo.com or 651-602-7565.

6. ND Culhane-Pera, K.A. *Five Levels of Cultural Competency in Medicine* and *Self-Evaluation of Five Levels of Cultural Competence.* Ramsey Family and Community Medicine Residency,

St. Paul Ramsey Medical Center. For more information, contact K. Culhane-Pera at kathiecp@yahoo.com or 651-602-7565.

7. 1991 D'Andrea, M., Daniels, J., Heck, R. *Multicultural Awareness-Knowledge-and-Skills Survey (MAKSS).* Journal of Counseling and Development, 70:143-50.

8. 2004 Duffy, F.D., Gordon, G.H., Whelan, G., Cole-Kelly, K., Frankel, R., Buffone, N., Lofton, S., Wallace, M., Goode, L., Langdon, L., and Participants in the American Academy of Physician and Patient's Conference on Education and Evaluation of Competence in Communication and Interpersonal Skills. *Assessing Competence in Communication and Interpersonal Skills: the Kalamazoo II Report*. Academic Medicine, 79(6): 495-507.

9. 2002 Epstein, R.M. and Hundert, E.M. *Defining and Assessing Professional Competence*. Journal of the American medical Association, 287: 226-35.

10. 1994 Family and Youth Services Bureau, U.S. Department of Health and Human Services. *Cultural Competency Administration Self-Assessment.* For more information, write to the Administration for Children and Families, 370 L'Enfant Promenade, SW, Washington, DC, 20201.

11. 2000 Goode, T. *Promoting Cultural and Linguistic Competency.* Self-Assessment Checklist for Personnel Providing Primary Health Care Services. National Center for Cultural Competence, Georgetown University, Washington, D.C. www.gucdc.georgetown.edu/nccc/ncc11.html

12. N.D. Harvard University. Implicit Association Test. Deals with unconscious bias and categorization. www.implicit.harvard.edu/implicit/demo/index.jsp

13. 1991 Ho, M.K. *Use of Ethnic-Sensitive Inventory (ESI) to Enhance Practitioner Skills with Minorities.* Journal of Multicultural Social Work, 1(1): 57-67.

14. 1999 Jeffreys, M.R. *Construct Validation of the Transcultural Self-Efficacy Tool.* Journal of Nursing Education, 38(5): 222-7.

15. 1991 LaFromboise, T.D, Coleman, H.L.K, & Hernandez, A. *Development and Factor Structure of the Cross-Cultural Counseling Inventory-Revised.* Professional Psychology: Research and Practice, Vol. 22:380-8. For further information, contact T. LaFromboise at Stanford University, Counseling and Psychological Services at 606 Campus Drive, Stanford, CA 94305 or call 415-723-1202. Email: lafrom@leland.stanford.edu.

16. 1995 Mason, JL. Cultural Competence Self-Assessment Questionnaire: A Manual for Users. Portland, OR: Research and Training Center on Family Support and Children's Mental Health, Portland State University. For more information, contact J. Mason at Portland State University, Graduate School of Social Work, 5914 N. Commercial Avenue, Portland, OR 97217 or call (503) 287-7260.

17. 1997 National Public Health & Hospital Institute. <u>Self-Assessment of Cultural Competence.</u> Washington, D.C. For more information, contact D. Andrulis at NPHHI at 1212 New York Avenue, NW, Suite 800, Washington, DC 20005 or call 202-408-0229.

18. 1997 Ponterotto, J.G. <u>Multicultural Counseling Knowledge and Awareness Scale (MCKAS).</u> New York, NY. For further information, contact J. Ponterotto of the Division of Psychological & Educational Services at Fordham University at Lincoln Center, 113 W 60th Street, New York, NY 10023 or call 212-636-6480.

19. N.D. Ponterotto, J.G. <u>Quick DiscrimiNation Index (QDI).</u> New York, NY. For further information, contact Joseph Ponterotto of the Division of Psychological & Educational Services at Fordham University at Lincoln Center, 113 W 60th Street, New York, NY 10023 or call 212-636-6480.

20. 1992 Ramer, L. *Nursing Issues for the 21st Century-Module 1: Culturally Sensitive Caregiving and Childbearing Families.* Further information can be obtained from: Education & Health Promotion Department, March of Dimes Birth Defects Foundation, 1275 Mamaroneck Avenue, White Plains, NY 10605.

21. 2003 Rew, L., Becker, H., Cookston, J., Khosropour, S., & Martinez, S. *Measuring Cultural Awareness in Nursing Students.* <u>Journal of Nursing Education,</u> 42(6): 249-257.

22. 1998 Robins, L.S., Alexander, G.L.,Wolf, F.M., Fantone, J.C., & Davis, W.K. *Development and Evaluation of an Instrument to Assess Medical Students' Cultural Attitudes.* <u>Journal of American Medical Women's Association,</u> 53(3, Supplement): 124-7.

23. 2001 Robins, L.S., White, C.B., Alexander, G.L., Gruppen, L.D., & Grum, C.M. *Assessing Medical Students' Awareness of and Sensitivity to Diverse Health Beliefs Using a Standardized Patient Station.* <u>Academic Medicine,</u> 76: 76-80.

24. 2005 Schirmer, J.M., Mauksch, L., Lang, F., Marvel, M.K., Zoppi, K., Epstein, R.M., Brock, D., and Pryzbylski, M. *Assessing Communication Competence: A Review of Current Tools.* <u>Family Medicine</u>, 37(3): 184-92.

25. 1994 Sodowsky, G.R., Taffe, R.C., Gutkin, T.B., & Wise, S.L. *Development of the Multicultural Counseling Inventory: A Self-Report Measure of Multicultural Competencies.* <u>Journal of Counseling Psychology,</u> 41(2): 137-8.

26. 1998 Tirado, M. *Tools for Monitoring Cultural Competence in Health Care; The Health Plan Audit; Health Plan Administrator Survey.* Monitoring the Managed Care of Culturally and Linguistically Diverse Populations. Health Resources and Services Administration, Center for Managed Care. Contact: National Clearinghouse for Primary Care Information at primarycare@circsol.com or call 800-400-2742.

B. Assessing the Cultural Competence of Organizations That Deliver Health care Services

1. 2000 Abernethy, A., Baars, L., Luu, Q., Hong, J., Olivares, T., & Ruiz, L. <u>Culturally Competent Assessment and Treatment Planning Curriculum</u>. Monroe County, Rochester, N.Y.

2. 2002 Anderson, C.C. (Mike) & Anderson, M.P.A. *Linguistically Appropriate Access and Services: An Evaluation and Review for Health care Organizations.* Working Paper Series, Vol. 6, The National Council on Interpreting in Health Care. http://www.ncihc.org.

3. 1999 Andrulis, D., Delbanco, T., Avakian, L., & Shaw-Taylor, Y. *The Cultural Competence Self-Assessment Protocol.* February; A Publication of the National Public Health and Hospital Institute, Washington, D.C. Project Support: The Robert Wood Johnson Foundation. Contact: Gartrell Wright at 718-270-7727 or email gartrell.wright@downstate.edu.

4. 1999 Aponte, C. *Cultural Competence: Self-Assessment Survey.* Western Region of New York State, New York State Office of Mental Health.

5. 2004 Beach, M.C., Lead Investigator. <u>Strategies for Improving Minority Health care Quality.</u> Summary, Evidence Report/Technology Assessment No. 90 (Prepared by the Johns Hopkins University Evidence-Based Practice Center, Baltimore, MD) AHRQ Publication No. 04-E008-01. Rockville, Md. Call AHRQ Clearninghouse: 800-358-9295. http://www.ahrq.gov/clinic/epcsums/minqusum.pdf.

6. 2001 California Pan-Ethnic Health Network. *Diverse Patients, Disparate Experience: The Use of Standardized Patient Satisfaction Surveys in Assessing the Cultural Competence of Health Care Organizations.* California Health care Foundation, Oakland, CA. www.chcf.org.

7. 1993 The Child Welfare League of America, Inc. <u>Cultural Competence Self-Assessment Instrument.</u> For more information, contact the CWLA Publications Department at: 440 First Street, NW, Suite 310, Washington, D.C. 20001-2085.

8. 1991 Cross, T. The Northwest Indian Child Welfare Association, Inc. <u>Organizational Self-Study on Cultural Competence.</u> Portland, OR. For more information, contact T. Cross at The National Indian Child Welfare Association located at 3611 SW Hood Street, Portland, OR 97201 or call 503-222-4040.

9. 1994 Family and Youth Services Bureau, U.S. Department of Health and Human Services. *Cultural Competence Self-Assessment: Staff Survey.*

10. 1991 Isaacs, M.R. & Benjamin, M.P. *Screening Survey for Culturally Competent Agency/Program.* <u>Towards a Culturally Competent System of Care Volume II: Programs Which Utilize Culturally Competent Principles.</u> Washington, DC: CASSP Technical Assistance Center. For more information, contact the National Center for Cultural Competence, Georgetown University Medical Center, Child Development Center at: 3307 M Street, NW Suite 401, Washington, DC 20007 or call 202-687-5387.

11. 2002 The Lewin Group, Inc. *Indicators of Cultural Competence in Health Care Delivery Organizations: An Organizational Cultural Competence Assessment Profile.* Washington, D.C. Prepared for The Health Resources and Services Administration, U.S. Department of Health and Human Services. To view this report, visit the HRSA Website, under Minority Health at www.hrsa.gov/omh.

12. 1995 Mason, J. & Williams-Murphy, T. *Cultural Competence Self-Assessment Questionnaire: A Manual for Users.* Research and Training Center on Family Support and Children's Mental Health; Regional Research Institute for Human Services; Graduate School of Social Work, Portland State University, P.O. Box 751, Portland, OR 97207-0751 or call 503-725-4040.

13. 1998 Missouri Department of Mental Health and the Missouri Institute of Mental Health. *Cultural Competence Self-Assessment Tool.* For further information, contact James Topolski, Ph.D., at University of Missouri–Columbia, School of Medicine, 5400 Arsenal Street, St. Louis, MO 63139; or call 314-644-8657 or email: mimhjt@showme.missouri.edu.

14. 1995 Myers, L.J. Culturally Competent Service Outcomes Assessment Tools: Guidelines for Upgrading Quality Assurance. Ohio Department of Mental Health, Consumer Services Department.

15. ND National Maternal and Child Health Resource Center on Cultural Competency, Texas Department of Health. *Journey Towards Cultural Competency: Lessons Learned*. Contact: Don Lawson 512-458-7111.

16. 1998 The New York State Office of Mental Health; The Research Foundation of New York State; The Center for the Study of Issues in Public Mental Health; Substance Abuse and Mental Health Services Administration, Center for Mental Health Services. Cultural Competence Performance Measures for Managed Behavioral Health care Programs.

17. 2002 Siegel, C., Haugland, G., & Chambers, E. Cultural Competency in Mental Health Systems of Care: Selection and Benchmarking of Performance Measures. The New York State Office of Mental Health, Nathan S. Kline Institute for Psychiatric Research, Center for the Study of Issues in Public Mental Health.

18. 1996 Roizner, M. *A Practical Guide for the Assessment of Cultural Competence in Children's Mental Health Organizations.* The Technical Assistance Center for the Evaluation of Children's Mental Health Systems at Judge Baker Children's Center at 295 Longwood Ave., Boston, MA 02115 or call 617-232-8390.

19. 1997 Saldaña, D. *Cultural Competency Scorecard for Mental Health Facilities (Pilot Instrument).* Development of a Cultural Competency Scorecard for Mental Health Facilities: Paper presented at the Seventh Annual National Conference on State Mental Health Agency Services Research and Program Evaluation. For further information, contact Dr. Delia Saldaña with the Department of Psychiatry at the University of Texas Health Science Center

at 7703 Floyd Curl Drive, San Antonio, TX 78284 or call 210-531-7918. Email: saldana@uthscsa.com

20. 1998 Tirado, M. *Tools for Monitoring Cultural Competence in Health Care; The Health Plan Audit; Health Plan Administrator Survey.* Monitoring the Managed Care of Culturally and Linguistically Diverse Populations. Health Resources and Services Administration, Center for Managed Care. Contact: National Clearinghouse for Primary Care Information at primarycare@circsol.com or call 800-400-2742.

21. 1996 Weiss, Carol; Minsky, Shula. *Program Self-Assessment Survey for Cultural Competence: A Manual.* New Jersey Division of Mental Health and Hospitals. Trenton, NJ. For more information, contact Carol Weiss with the Department of Human Services, Division of Mental Health Services, 50 East State Street, P.O. Box 727, Trenton, NJ 08625-0727 or call 609-777-0821. Email: cweiss@dhs.state.nj.us.

20. 1998 Western Interstate Commission on Higher Education (WICHE). Cultural Competence Report Card Items, Jan. Boulder, CO. For further information, contact WICHE Mental Health Program at P.O. Box 9752, Boulder, CO 80301 or call 303-541-0258. Website: www.wiche.edu.

C. Tools to Evaluate Cultural Competence Curricula

1. 2004 American Association of Medical Colleges a Tool for the Development of Cultural Competence Training (TACCT). This document should be available after March 2005 (contact ddanoff@aamc.org).

2. 2003 Pena-Dolhun, E., Munoz, C., & Grumback, K. *Cross-Cultural Education in U.S. Medical Schools: Development of an Assessment Tool.* Academic Medicine, 78 (6): 615-622.

3. 2003 Crandall, S.J., George, G., Marion, G.S. & Davis, S. *Applying Theory to the Design of Cultural Competency Training for Medical Students: A Case Study.* Academic Medicine, 78: 588-594. Contains evaluation material.

IV. Audio-Visual Resources

Next to an actual in-person clinical encounter, well-constructed video case studies can promote many teachable moments and foster in-depth discussion. Fortunately, several organizations have developed a number of high quality case-based videos that can richly augment curricula focused on cultural competence education. The videos deal with subject matter that is clinically relevant to different practice specialties and specific issues encountered in patient care. The videos are accompanied by training manuals and resource materials that make it easy for the educator to adapt them to specific training situations. For about $2,000, an educational institution can create a good library of these excellent training tools. The following is a list of easily accessed video and training material.

1. Videos from Fanlight Productions. fanlight@fanlight.com Telephone 800-937-4113. Fanlight is distributing a series of videos, excellent for use in teaching cultural competency to health care professionals. Most are clinically accurate and case-based. All have cultural competence themes. The Fanlight Website offers a list and detailed descriptions. All may be rented or purchased. Here's a sample:

   "*The Angry Heart: The Impact of Racism on Heart Disease Among African Americans*" By Jay Fedigan. The cost to buy the video is $199 and it is 57 minutes long.

   "*Community Voices Exploring Cross-Cultural Care through Cancer*" By Jennie Greene, MS, and Kim Newell, MD, for the Harvard Center for Cancer Prevention, Produced at the Harvard School for Public Health. The cost to buy it is $249, and it is 69 minutes long.

   "The Culture of Emotions. A Cultural Competence and Diversity Training Program." Scientific advisors: Francis G. Lu, M.D., and Juan E. Mezzich, M.D., Ph.D.; Producer: Harriet Koskoff. The cost to buy it is $249, and it is 58 minutes long.

   "Worlds Apart" By Maren Grainger-Monsen, M.D. Trigger tapes raise awareness of cultural barriers that affect patient/provider communication. The cost to buy it is $369, and it is 48 minutes long.

   "Grief in America" By Bert Atkinson, with narration by Anthony Edwards. The cost to buy it is $245, and it is 55 minutes long.

2. *"The Bilingual Medical Interview."* Boston City Hospital. Prepared by The Faculty and Staff of the Primary Care Training Programs in Internal Medicine and Pediatrics at Boston City Hospital. The Boston University School of Medicine and Office of Interpreter Services, Department of Health and Hospitals, Boston, MA and The Boston Area Health Education Center. Written and directed by Eric J. Hardt, M.D. Video Post Production: CF Video/Watertown © 1987. The length of video is 31:15. It is designed to improve the skills of the viewer in the bilingual medical interview. Vignettes and case studies richly illustrate many aspects of clinician-patient interpreter interaction and the dos and don'ts involved.

3. *"Communicating Effectively Through An Interpreter: Barriers to Communication."* CCHCP – The Cross Cultural Health Care Program. www.xcultural.org

4. *"Female Circumcision/Female Genital Mutilation: Clinical Management of Circumcised Women."* The American College of Obstetricians and Gynecologists, 1999. You can order this video from the ACOG Bookstore at: http://sales.acog.com/acb23/showdetl.cfm?&DID=6&Product_ID=540&CATID=17. The cost of video is $125 ($95 for ACOG members) and it is 69 minutes long.

5. Kaiser Permanente CARE Actors' award-winning cultural competency and medicine videos and DVD. Many were created with funding from The California Endowment. Professional actors and screenwriters. Contact Gus Gaona (323-259-4776) at Kaiser Permanente MultiMedia Communication, 825 Colorado Boulevard, Suite 301, Los Angeles, CA 90041

for order forms. The total cost for 20 vignettes is $105. The brief but dramatic vignettes are accompanied by support materials for facilitators and participants. The length of each trigger video is 8 to 12 minutes. Series A is Cultural Issues in the Clinical Setting and contains 5 vignettes. Series B is Beyond OB and contains 5 vignettes. The Multicultural Health Series, Part 1, contains four vignettes and the Multicultural Health Series, Part 2 contains six vignettes. The Multicultural Health Series 1 & 2 are available on DVD.

Kaiser Permanente also makes five provider's handbooks on culturally competent care for the following populations: Latino; African American; Asian and Pacific Islanders; Gay, Lesbian, Bisexual, and Transgender; and Individuals with Disabilities. These books provide background on demographics, epidemiology, risk factors, health beliefs and behaviors, and treatment issues. Call 510-271-6653 to obtain these handbooks.

6. M*ental Health Interpreting: a Mentored Curriculum."* Pollard, Robert. Accompanied by a workbook. Contact: Robert Pollard, Ph.D. (716) 275-3544 or Robert_Pollard@urmc.rochester.edu. The University of Rochester, School of Medical and Dentistry. The video was produced in association with the Monroe County Office of Mental Health and the Department of Psychiatry at the University of Rochester Medical Center © 1997-2000 University of Rochester. The length of the video in minutes is 32:02.

7. *"Quality Care for Diverse Populations."* The American Academy of Family Physicians. This program is available in two formats to suit group training and self-learning needs. Both formats can be ordered either online (www.aafp.org/catalog/) or over the telephone (at 800-944-0000). The item number is Cs 723 and the title is Cultural Competency Videotape.

8. *"Through the Eyes of Others" Tape 1: General Sessions.* ROWAY Productions – 7317 Cahill Road #229, Edina, MN 55439 or call 612-941-9337. Jointly sponsored by the Hennepin County Medical Society, United Way of Minneapolis Area, Hennepin County Medical Center Staff, and the University of Minnesota. The length of the video is 2:00:35.

9. *"Training for Cultural Competence in the HIV Epidemic."* Presented by the Hawaii Area AIDS Education and Training Center, University of Hawaii, John A. Burns School of Medicine. Funded in part by grant No. 5-T01 MH19263-02 from the National Institute of Mental Health. The length of the video is 45:45.

10. CD-ROM: 2000 Ohio Department of Health and Medical college of Ohio. *Cultural Competence in Breast Cancer Care.* Vertigo Productions LTD, 3634 Denise Drive, Toledo, OH 43614. Phone 877-385-6211, fax 419-385-7170.

V. Useful Websites

The following Websites, particularly those run by foundations and the Centers of Excellence, are a source of current information on issues related to cultural competence and diversity. Many have on-going newsletters and alerts. They consistently produce new statistical and educational

material that will be useful in keeping curricula current and focused on emerging and important issues in patient care and public policy. Many have bibliographies or are linked to bibliographies.

1. The California Endowment
   http://www.calendow.org

2. California Health care Foundation
   http://www.chcf.org

3. The Commonwealth Fund
   One East 75th Street, New York, NY, 10021
   Phone 212-606-3800; fax 212-606-3500
   http://www.cmwf.org/

4. Chinese American Medical Society Home Page
   www.camsociety.org

5. Cultural Competence Activities in the Bureau of Primary Health Care
   http://www.bphc.hrsa.dhhs.gov/cc/cc-activities.htm

6. The Cross Cultural Health Care Program. Language issues, training, interpretation.
   www.xculture.org

7. New York State Citizens' Coalition for Children, Inc.
   http://www.nysccc.org/T-Rarts/CultCompCont.html

8. Directory of Resources in Cultural Diversity and Cultural Competence
   www.aucd.org

9. Diversity Rx Home Page
   www.diversityrx.org

10. EatEthnic Home Page
    www.eatethnic.com

11. EthnoMed – Ethnic Medicine Guide
    http://www.ethnomed.org

12. The Henry J. Kaiser Family Foundation
    http://www.kff.org

13. Hablamos Juntos Resource Center: Models, Approaches, and Tools
    www.hablamosjuntos.org/resourcecenter/default.asp

14. Kaiser Permanente National Linguistic & Cultural Programs
    www.kphci.org

15. Institute for Diversity in Health Management
www.institutefordiversity

16. Manhattan Cross-Cultural Group. Physician educators in cross-cultural medicine. Contact: Tessa Misiaszek by email gmisiaszek@adelphia.net

17. McGill University Department of Psychiatry, Division of Transcultural Psychiatry
www.mcgill/ca/tcpsych

18. The National Alliance for Hispanic Health
www.hispanichealth.org

19. National Council on Interpreting in Health Care (NCIHC)
http://www.ncihc.org/index.html

20. National Hispanic Medical Association Home Page
www.home.earthlink.net/~nhma

21. National Asian Women's Health Organization
www.nawho.org

22. National Center for Cultural Competence/Georgetown University
http://gucchd.georgetown.edu/nccc

23. North East Consortium on Cross-Cultural Medical Education and Practice
Contact: Ed Poliandro by email e.poliandro@att.net

24. Office of Minority Health - *Cultural Competence Works.*
http://www.haa.omhrc.gov/HAASidebar/cultural3.htm

25. Office of Minority Health Resource Center
The Health Resources and Services Administration (HRSA) provides publications and resources on minority health issues. www.omhrc.gov or email lmosby@omhrc.gov.

26. Office of Minority Health. Culture and Health Website provides tools, teaching modules, and concept papers.
www.cultureandhealth.org

27. The Park Ridge Center for the Study of Health, Faith and Ethics
www.parkridgecenter.org/cgi-bin/showpage.dll?id=1880

28. Perspectives of Difference. Teaching Diversity and Cross-Cultural Competence in Health care: A Trainer's Guide
www.mwelchatpodsdt.org

29. Society for Medical Anthropology
http://www.medanthro.net

30. Stanford Geriatric Education Center Cross-Cultural Geriatric Medicine
c/o VAPAHCS, 3801 Miranda Avenue, Room A-236, (182B-SGEC), Palo Alto, CA 94304, or call (650) 494-3986.
http://www.stanford.edu/group/ethnoger/target.html

31. Transcultural Nursing Society Home Page
www.tcns.org

VI. Selected Centers of Excellence

Many of the following Centers of Excellence have developed training and evaluation tools, materials on interpretation and other useful material that could be incorporated into curricula for health care professionals.

1. Center for Cross-Cultural Health (CCCH)
   http://www.crosshealth.com/index.html

2. Center for Healthy Families and Cultural Diversity
   Located at: Department of Family Medicine, University of Medicine and Dentistry of New Jersey- Robert Wood Johnson Medical School, 1 Robert Wood Johnson Place, New Brunswick, NJ 08903
   http://www2.umdnj.edu/fmedweb/chfed/index.htm

3. Center for Research on Ethnicity, Culture and Health (CRECH)
   University of Michigan, School of Public Health
   www.sph.umich.edu/crech/about/

4. Center for Immigrant Health/New York University School of Medicine
   http://www.med.nyu.edu/cih Training and evaluation materials.

5. Center for Multicultural and Community Affairs/Mount Sinai School of Medicine
   http://www.mssm.edu/cmca

6. Center for Multicultural and Minority Health/New York Weill Cornell Medical Center
   http://www.nycornell.org/dept/medicine/residency/multicultural.html

7. Center for Multicultural Health, University of New South Wales, Sydney, Australia
   http://cch.med.unsw.edu.au/cch.nsf

8. Multicultural Training and Research Institute, Temple Department of Social Work
   http://www.temple.edu/socialwork/centers_inst/multiculture.html

9. University of Michigan Health System Program for Multicultural Health
   http://www.med.umich.edu/multicultural

10. University of Wisconsin Center for the Study of Race & Ethnicity in Medicine
    http://wiscinfo.doit.wisc.edu/crem

VII. Bibliographies

The number of bibliographies focused on cultural competence in the health professions and cross-cultural medicine has expanded exponentially, and is too numerous to capture here. However, these excellent bibliographies should be a good start and will lead to others. Many are broken down by medical specialty, specific medical issues, or population groups. When seeking to integrate cross-cultural information into lecture materials on specific subject matter, appropriate materials can often be found in these resources.

1. 1999 Andrews, M.M. *How to Search for Information on Transcultural Nursing and Health Subjects: Internet and CD-ROM Resources.* Journal of Transcultural Nursing, 10(1): 69-74.

2. CultureMed www.sunyit.edu/library/html/culturemed/index.html

3. Lu, F.G. *Annotated Bibliography on Cultural Psychiatry and Related Topics.* Contact Francis G. Lu, M.D., at francis.lu@sfdph.org.

4. 2002 McCarty, L.J. et al. *Cross-Cultural Health Education: Materials on the World Wide Web.* Journal of Transcultural Nursing, 13(1): 54-60.

5. Physicians for Human Rights. *The Right to Equal Treatment: An Annotated Bibliography on Studies on Racial and Ethnic Disparities in Health care, Their Causes and Related Issues.* An excellent resource on health disparities by specialty. www.phrusa.org/research/domestic/race/race_report/bibliography.html

6. Transcultural and Multicultural Health Links. http://www.sunyit.edu/library/html/culturemed/index.html

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Appendix A: The Toolbox

I. Building Cultural Awareness

The tools included in this section can be used by a provider to build cultural awareness, particularly for self-awareness. They include: Cultural Genogram Exercise, Exploring One's Community Map, Context Grid, the Iceberg Analogy, the Diversity Wheel, and the Cox Pie Charts.

A. Cultural Genogram Exercise

Cultural Genogram –The cultural genogram is a tool developed by Hardy and Laszloffy (1995) to increase providers' cultural awareness and sensitivity through the use of the family genogram or family tree. Family genograms are used widely for training and for clinical purposes to explore a variety of family structures, relationships and legacies, e.g. legacies of loss. They also can be used to explore spirituality (Wiggins Frame, 2001). It also can be used to explore socio-cultural variables within the family and the meanings that are attributed to these variables.

The goal of exercises using cultural genogram is to increase awareness of the provider's cultural background, the significant socio-cultural differences that emerge in the family of origin and the meaning attributed to these differences (valences).

Cultural Genogram Exercise

Sketch your genogram (at least a three-generation family tree) in the traditional manner, using squares for males and circles for females. Honor the diversity in family forms: i.e. single, blended, adopted, same sex, etc. Be as extensive as you can, assured that the genogram is for your use and will be shared with others only as you wish. Note any differences in your family tree that are of significance to you. Refer to the following guidelines.

Preparing the Cultural Genogram:

1. **Defining one's culture of origin:** The culture of origin is comprised by our simultaneous membership and participation in a variety of contexts such as language; rural, urban, suburban setting; race, ethnicity and socioeconomic status; age, gender, religion, Nationality; employment, education and occupation, political ideology, stage of acculturation." (Falicov, 1998)

   Use different colors or symbols to identify each influence in your family tree, i.e. color the squares or circles a certain color for a specific ethnic group or more than one color denoting the mixtures.

2. **For each family member representing a group or subgroup that is part of your culture consider the following:**

a. How is family defined in the group? (nuclear, extended, blended, same sex, etc.)
b. For ethnic groups: Note the migration patterns of the group and the historical context of immigration. If other than Native American, under what conditions did your family (or their descendants) enter the United States? (i.e. immigrant, political refugee, slave, etc.)?
c. Race: What significance does race, skin color, and hair play in each group represented?
d. Geographical region: What role does region and geography play for each group/sub-group group?
e. Gender: How are gender roles defined within the group/each generation?
f. Religion and spirituality: What is the religious affiliation of members of the family? Note meanings associated with religious affiliation, practice, non-practice, conversion or intermarriage.
g. Health and mental health: note illnesses and the meanings associated to health and illness.
h. Social class: What occupational roles are valued and devalued by the group?
i. Age: What is the relationship between age and the values of the group?

3. **Note intercultural marriages:** Explore how divergent cultural issues were negotiated in these unions and the influence in had on the children. How does this group view outsiders or is viewed by them?

4. **Note how group values have shaped your family and its members? How have they shaped you?**

5. **Meaning of the differences:**

- What significant differences emerge in your family of origin?

- What was the meaning associated with those differences? i.e. better than, less than; pride and shame issues; where was the power and what was its effect ?

- Note and discuss in your small group the emotional and/or behavioral effects of: pride-shame.

- What are the rules for talking about differences in your family?

Adapted from Hardy, K.V. and Laszloffy, T.A. (1995) for ECCP course at Harvard Medical School (Contact for ECCP Course: Roxana_llerena-quinn@hms.harvard.edu)

References:

Hardy, K.V. and Laszloffy, T.A. (1995) *The Cultural Genogram: Key to Training Culturally Competent Family Therapists*. Journal of Marital and Family Therapy. 21(3): 227-37

Wiggins Frame, M. (2001) *The Spiritual Genogram in Training and Supervision*. The Family Journal- Counseling and Therapy for Couples and Families. 9(2): 109-115

B. Exploring One's Community Map

The goal of this exercise is to increase our awareness of the communities we have been and are a part of and, what they tell us about our preferences and comfort zones. It also aims to raise awareness about the communities we don't know very well and what they might tell us about our blind spots.

Capturing Our Social Network: then and now

1. How do you define community? What does "community" mean to you?
2. Make a list of the communities of which you are a part.
3. Who makes up those communities? Who is not there? Is it different from the communities in which you grew up? How so?
4. Where did you grow up? Who else lived there? Who wasn't there? (Pinderhughes, 1989)
5. How did you or your family feel about "them" and how do you think they felt about you?
6. What does your *map of communities* say about your comfort zone? Others' comfort zone with you?
7. What is your *position or location* in the communities you described?

Adapted from Pinderhughes (1989) for ECCP course at Harvard Medical School (Contact for ECCP course: Roxana_llerena-quinn@hms.harvard.edu)

Reference:

Pinderhughes, E. (1989) Understanding Race, Ethnicity, & Power: The Key to Efficacy in Clinical Practice. New York: Free Press; 109-146.

C. Context Grid

This context grid can be use to facilitate understanding of the differences that exist between and within members from different ethnic groups. It addition to differences, it helps highlight points of connection or similarities that exist across different ethnic groups. It can be used by providers or for patients, or to explore similarities and differences between the two.

CONTEXTUAL FACTORS FOR CASE PRESENTATION or SELF-EXPLORATION*	Black or African American	Asian	Hispanic/Latino	American Indian or Alaskan Native	Native Hawaiian & other Pacific Islander	White	Other
Gender							
Race							
Country of Origin							
Socio-economic Status							
Immigration							
Language(s)							
Sexual Orientation							
Religion/ Spirituality							
Other: Age, Disability, etc.							

*Use GRID to map the clinician, family members, provider team or a patient.

Gender: Inquire about culturally ascribed gender roles, current gender role, changes in gender roles, degree of conflict within the family/society due to roles.

Race: Distinguish race from ethnicity; different ethnic groups include different racial groups. What is the historical and current power dynamics associated to the construction of skin color for this group? If multiracial, what groups?

Country of Origin: Distinguish country of birth, ethnic background/s, country of citizenship. What socio-political issues in the global /local contexts are associated to membership in this group?

SES: Includes education, occupation, income, status, level of power/life control over resources, note SES pre/post migration.

Immigration/Refugee Status/Acculturation: Country of birth, reason for migration, migration history, historical context of immigration, immigration status, length of stay in the U.S., moves within the U.S.; opportunities for involvement with culture of origin, and/or with host culture, ethnic identity, perception of discrimination/racism, note if trauma/violence related to migration or reason for migration. Note if family was left behind, plans to reunite, generation level, intergenerational conflicts, cultural factors and development. How does society mirror this group? Is there a refugee history associated with immigration? Are there any health and mental health issues? Is this a transnational family? Who is the family (here and there)? Note acculturation patterns, stresses.

Language(s): Primary language spoken at home, language of instruction at school, current use of primary language, other languages spoken, level of literacy/fluency of each-[understand, speak, reads, writes].

Sexual Orientation: Experiences of discrimination and disclosure, in family and culture of origin vs. host culture. Are there any significant intersections between sexual orientation and other group dimensions?

Religion: Dominant/marginalized religious affiliation in country of origin, in host culture. Is religion a primary source of identity? How is the individual or family religious affiliation mirrored by society?

Prepared by Roxana Llerena-Quinn, Ph.D and Fabiana Wallis, Ph.D. (Harvard Medical School-reprint permission can be requested to roxana_llerena-quinn@hms.harvard.edu)

D. Iceberg Analogy

This tool can assist in discussing the immediately apparent and not so immediately apparent characteristics of one's culture. Discussion questions follow the diagram.

Primarily in Awareness

Cultural Artifacts

Folk Dancing

Cooking

Fine Arts

Dress

Popular Music

Literature

Classical Music

Games

Drama

Theory of Disease

Preference for Competition or Cooperation

Social Interaction Rate

Nature of Friendship

Rules of Descent

Facial Expressions

Ideals Governing Childraising

Notions of Adolescence

Definition of Sin

Notions of Modesty

Notions About Logic and Validity

Relationship to Animals

Conception of Beauty

Patterns of Superior/Subordinate Relations

Courtship Practices

Conception of Justice

Arrangement of Physical Space

Notions of Leadership

Tempo of Work

Incentives to Work

Cultural Assumptions

Attitudes Toward the Dependent

Eye Behavior

Patterns of Group Decision-Making

Conception of Cleanliness

Body Language

Approaches to Problem-Solving

Roles in Relation to Status by Age, Sex, Class Occupation, Kinship, and so forth

Conception of Status Mobility

Conversational Patterns in Various Social Contexts

Conception of Past and Future

Patterns of Handling Emotions

Definition of Insanity

Ordering of Time

Arrangement of Physical Space

Conception of "Self"

Patterns of Visual Perception

AND MUCH MUCH MORE...

Primarily Not in Awareness

Discussion Questions for Iceberg Analogy

- Where are the most of the differences between people?
- Are they immediately apparent?
- What does this analogy suggest?
- What attributes do we have most control over?
- What attributes do we react to?

E. Diversity Wheel

This tool can be used to discuss what constitutes "diversity." Diversity can be defined as all the ways in which people are different. It affects how people see the world, how they behave, and what values they hold, among others.
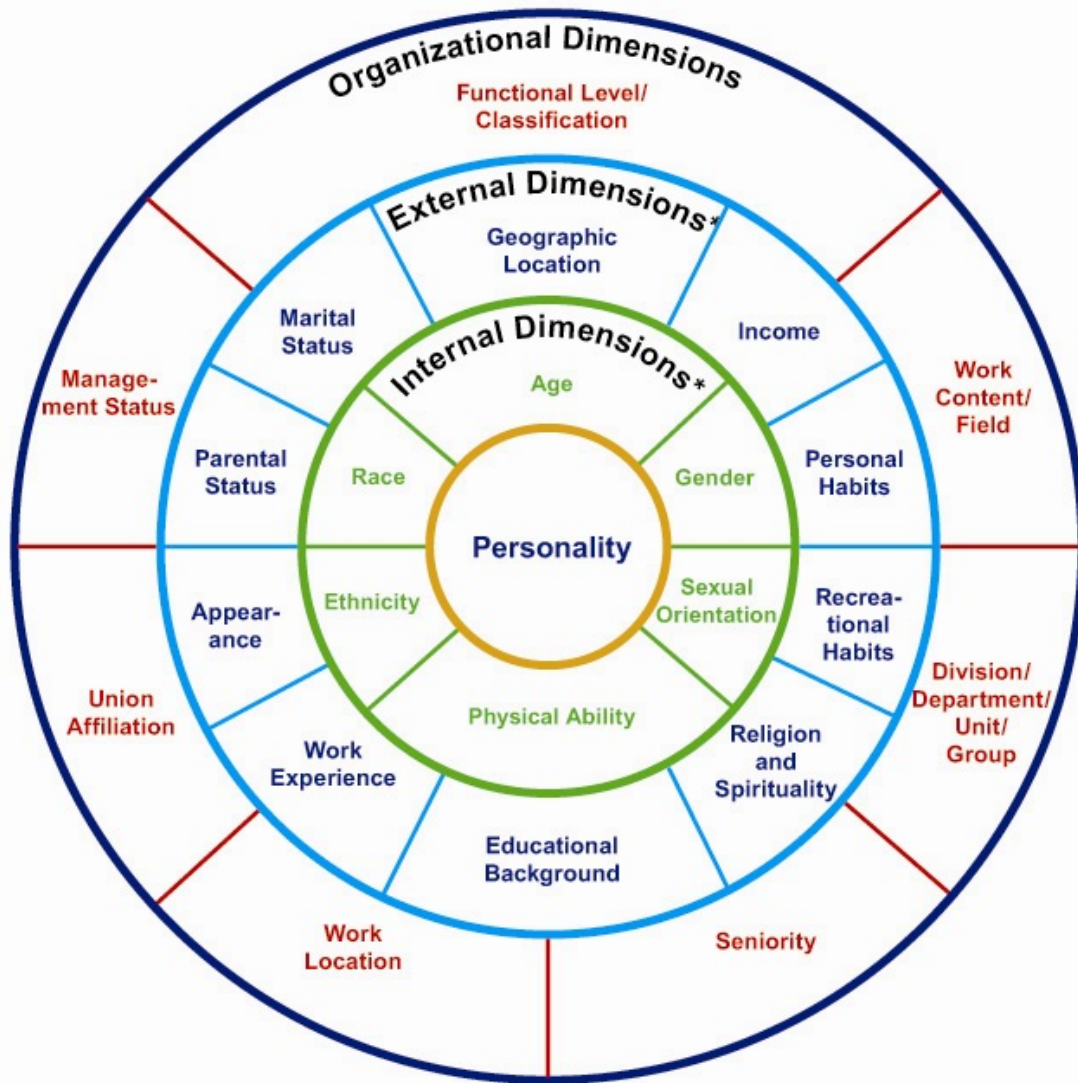
Source: <u>Diverse Team</u>. Lee, Gardenswartz, and Rowe. Burr Ridge, IL: Irwin Professionals, 1994. Used with permission. Note: Internal Dimensions and External Dimensions are adapted from Marilyn Loden and Judy Rosener, <u>Workforce America!</u> Burr Ridge, IL: Irwin Professionals, 1991

Adapted by Kaiser Permanente (2003).

F. Cox Pie Charts

Please see grid in Chapter 7 for description of tool.

Culture is Like Genetics: Group Definition, Individual Expression

Examples of Culture Identity Structure

Example 1

Example 2

Example 3

Examples 4
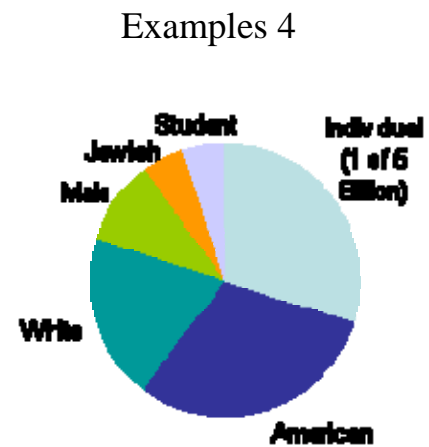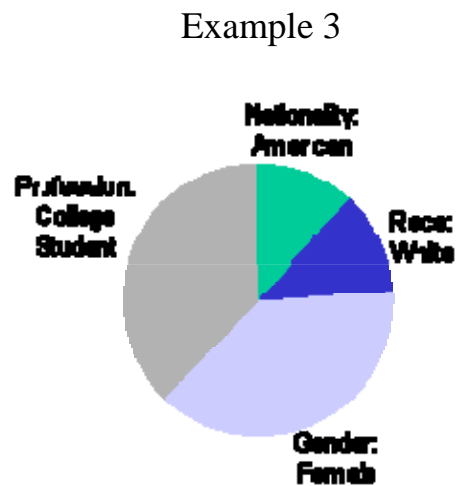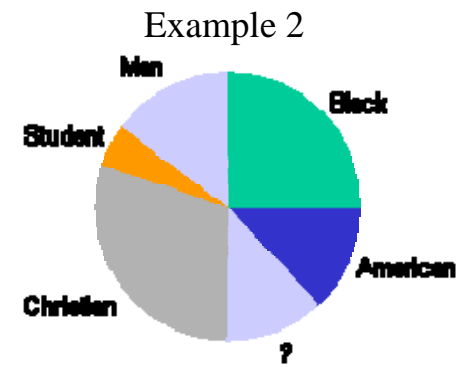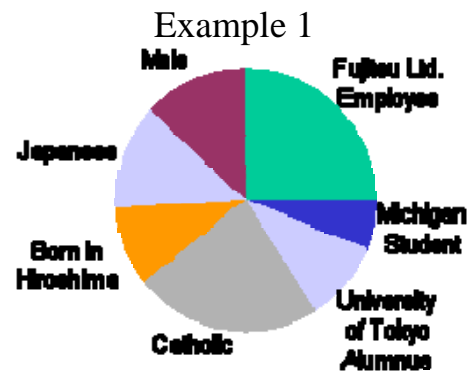
Define *Your* Cultural Identity Structure (Cox, 1994)
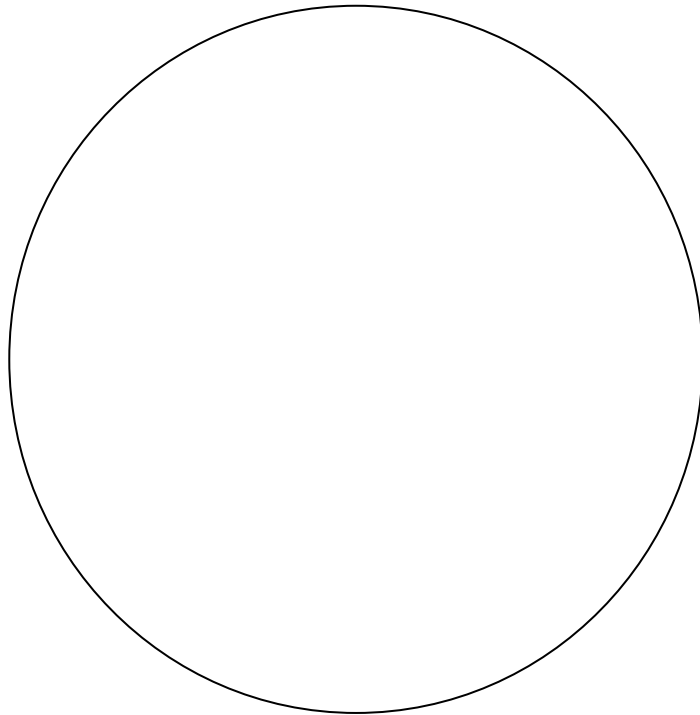
A. List Your Cultural Identity Elements

1.

2.

3.

4.

5.

6.

7.

8.

9.

10.

B. Create a pie chart with these elements. Size of slices reflects strength (importance to you) of each element.

4-10 cultural groups with which you personally identify with, e.g. gender, race/ethnicity, occupation, etc.

Source: *Cox Self-Identity Exercise (Pie Chart)* as it appears in: Cox, Taylor Jr. (1994) Cultural Diversity in Organization: Theory, Research, and Practice. San Francisco, CA: Berrett-Koehler Publishers, Inc., Pg. 49.
Adapted by The Cultural Imperative

II. Mnemonics

Mnemonics are devices, such as a formula or rhyme, used as an aid in remembering. The mnemonics listed here are primarily used in interacting with patients. Refer to the original citation for more detailed explanation for each of the mnemonics.

LEARN

L   **Listen** with sympathy and understanding to the patient's perception of the problem.

E   **Explain** your perceptions of the problem.

A   **Acknowledge** and discuss the differences and similarities.

R   **Recommend** treatment.

N   **Negotiate** agreement.

From: Berlin E.A. and Fowkes, W.C. Jr: *A Teaching Framework for Cross-Cultural Health Care*, <u>Western Journal of Medicine</u> 1983, 139:934-938

ESFT

E   Explanatory Model of Health and Illness

S   Social and Environmental Factors

F   Fears and Concerns

T   Therapeutic Contracting

Adapted from Betancourt J.R., Carrillo J.E., Green A.R. (1999). *Hypertension in Multicultural and Minority Populations: Linking Communication to Compliance*. <u>Current Hypertension Reports,</u> 1:482-488

ETHNIC: A Framework for Culturally Competent Clinical

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 or who has 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?

N: Negotiate   Negotiate options that will be <u>mutually acceptable</u> to you and your patient and that do not contradict, but rather incorporate your patient's beliefs.

Ask what are the most important results your patient hopes to achieve from this intervention.

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.

Levin, S.J., Like, R.C., and Gottlieb, J.E. (2000) *ETHNIC: A framework for culturally competent clinical practice. In Appendix: Useful clinical interviewing mnemonics.* <u>Patient Care</u>, 34(9): 188-189

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.

From: Stuart, M.R. and Lieberman, J.A III. <u>The Fifteen Minute Hour: Practical Therapeutic Interventions in Primary Care</u>, 3rd Edition. Philadelphia, PA: Saunders, 2002

ADHERE: A Mnemonic for Improving Patient Adherence with Therapeutic Regimens

A: **Acknowledge** the need for treatment with the patient, and ask about previous treatments utilized. Together determine mutual goals and desired outcomes.

D: **Discuss** potential treatment strategies and options, as well as consequences of non-treatment with the patient (consider issues such as treatment effectiveness, prognosis, use of complementary/ alternative medicine, brand name vs. generics, off-label uses, prescription plans, formularies, etc.).

H: **Handle** any questions or concerns the patient may have about treatment (e.g., fears or worries, side effects, costs, dosage, frequency, timing, sequence, duration of treatment, drug or food interactions, proper storage techniques).

E: **Evaluate** the patient's functional health literacy and understanding of the purpose/rationale for treatment, and assess barriers and facilitators to adherence (e.g., environmental, economic, occupational, and sociocultural factors, family situation and supports)

R: **Recommend** treatment, and **review** the therapeutic regimen with the patient.

E: **Empower** by eliciting the patient's commitment and willingness to follow-through with the therapeutic regimen.

From: The Provider's Guide to Quality and Culture (http://erc.msh.org/quality&culture)

Published in Soto-Greene, M., Salas-Lopez, D., Sanchez, J., and Like, R.C. (2004) *Antecedents to Effective Treatment of Hypertension in Hispanic Populations*. **Clinical Cornerstone, 6(3): 30-36**

RESPECT

R espect - A demonstrable attitude involving both verbal and nonverbal communications

E xplanatory Model - What is the patient's point of view about his or her illness? How does it relate to the physician's point of view? All points of view must be elicited and reconciled.

S ociocultural context - How class, race, ethnicity, gender, education, sexual orientation, immigrant status, and family and gender roles, for example, affect care

P ower - Acknowledging the power differential between patients and physicians

E mpathy - Putting into words the significance of the patient's concerns so that he or she feels understood by the physician

C oncerns and fears - Eliciting the patient's emotions and concerns

T herapeutic alliance/Trust - A measurable outcome that enhances adherence to, and engagement in, health care

RESPECT model developed by the Boston University Residency Training Program in Internal Medicine, Diversity Curriculum Taskforce

Published in Bigby J.A., ed. Cross-Cultural Medicine, Philadelphia, PA, American College of Physicians, 2003, page 20

BELIEF

B: Health **beliefs** (What caused your illness/problem?)

E: **Explanation** (Why did it happen at this time?)

L: **Learn** (Help me understand your belief/opinion)

I: **Impact** (How is this illness/problem impacting your life?)

E: **Empathy** (This must be very difficult for you)

F: **Feelings** (How are you feeling about it?)

Dobbie, A., Medrano, M., Tysinger, J., and Olney, C. (2003) *The BELIEF Instrument: A Preclinical Teaching Tool to Elicit Patients' Health Beliefs.* Family Medicine, 35(5): 316-19

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III.   Communication and Language

This section includes tools to be used in aiding with communication and language issues that arise when interacting with patients. Several items relate to interacting with limited English proficient patients, particularly in using interpreters: General Guidelines for Effective Use of Interpreters in a Health Care Settings, Tips for Successful Interpretation, and the mnemonics, TRANSLATE and INTERPRET. The last item in this section describes tools that can be used to measure the health literacy of patients who may be fluent in English, but still lack language skills for full understanding in a health care setting.

A. General Guidelines for Effective Use of Interpreters in a Health care Setting
Developed by M. Jean Gilbert, Ph.D.

Legal Considerations

When do you need to use an interpreter?

- When your patient is a Limited English Speaker (LEP) and you don't speak his/her language: You can't understand fully when they speak to you, and they can't understand when you speak to them

- When any part of the patient's care is funded by a Federal program (e.g. Medicare, MediCaid)

- When the quality of care of a patient would be affected if you didn't understand each other

Unless you are <u>thoroughly</u> fluent in the patient's language, it is strongly recommended that you work with an interpreter. In this way, you know that your patient fully understands your diagnosis, treatment and advice and you know that you understand the patient's description of his/her illness clearly. <u>When you have a limited ability to speak and understand another language, but do not use the correct forms of verbs or the right genders and nouns, your information is unintelligible at worst and confusing at best to your patient</u>. Whether they understand you or not, patients may not risk questioning you or asking you to explain more thoroughly because:

- They do not wish to appear ignorant or uneducated

- They fear insulting you by seeming to call into question your expertise

- They may be afraid of losing face by showing ignorance of medical terminology or unfamiliarity with the way health care is structured in the U.S.

Make sure that you are using a competent *health care* interpreter. Just because a person is bilingual doesn't mean that they have the language or interpretation skills to accurately interpret medical information. Research has shown that untrained interpreters and family or friends used as interpreters results in about 50 percent of the messages being miscommunicated and is a

significant source of medical errors. It is better to use a telephonic interpretation service that does train and certify the proficiency of its interpreters than to use a bilingual medical assistant of whose language skills you are uncertain. If you use a telephonic interpreter, it is best to use a speaker phone.

It is required that you note the language and the type of interpreter services used. This is easily done by having adhesive labels printed with space for the interpreter's name and the date, then just attaching them to the record of the patient's visit. If you use a telephone interpreter, record the name, time and date of the telephonic interpretation. The company who provides the interpretation also keeps track of this information.

Legally, you must always offer the patient the use of an interpreter first. If a trained interpreter is not used, record who you *do* use to interpret in the patient's chart (e.g. patient's family member or friend). If the patient refuses your offer of an interpreter and insists you use someone they brought with them, record that also.

Techniques for Effectively Using Interpreters

Read over these proven strategies for efficiently getting the most out of an interpreted patient visit. It takes awhile to become truly adept, but you'll find that these techniques really work, and you'll soon be able to implement them quickly and automatically.

Have a Quick Pre-Encounter Discussion with Interpreter

Tell the interpreter what you hope to accomplish, what the encounter is about. As you and your interpreters consistently work together and develop a mutually workable style, this "discussion" may simply be a sentence or two.

- Ask interpreter if he/she is familiar with the concepts involved in the visit that is about to occur

- Agree with interpreter on interpretation techniques, e.g., how to signal you to pause, signal that they need to explain something the patient has said

- When working with non-staff interpreters, point out importance of accuracy, completeness, impartiality and confidentiality

- Agree with interpreter on interpretation techniques, e.g., how to signal you to pause, signal that they need to explain something the patient has said

- Encourage interpreters to ask questions when they are uncertain

- Encourage interpreters to make pertinent comments when they notice there is a conceptual, cultural or linguistic misunderstanding. Frequently either clinician or patient assumes background information, which is actually lacking

- In many cases, patients will prefer an interpreter of their same gender, particularly if a physical examination is to take place

In the Encounter

- Be sure to introduce the interpreter to the patient. Emphasize that the interpreter is bound to confidentiality, just as you are

- Place the interpreter slightly to one side and behind the patient, so that it is easy to look directly at the patient when the interpreter is speaking

- Look at patient just as if you were conversing with an English-speaking person. The interpreter is only a conduit. Observe non-verbal signs that will give you an indication of their emotional effect; this will provide you with important information as to what your response to the individual patient should be

- Use the first person when talking to the patient: "Mr. Quesada, I am wondering if..." Encourage the interpreter to use the first person as well instead of "The doctor says she is wondering if…"

- Express one concept at a time

- Pace your speech so interpreter and patient can understand and follow

- Make sure the complexity of the language is not beyond the interpreter's medical knowledge and familiarity with institutional protocols and procedures

- When the interpreter finishes explaining a point to the patient, occasionally ask the interpreter to tell you in English exactly what she just told the patient. This "re-telling" will give you the feedback you need to feel confident about the quality of the translation or to identify and catch mistakes

- Give complete information on diagnosis, tests and treatment. Then ask for feedback if there is any doubt that the patient understands. For example, if the question "How do you feel about that?" elicits a nervous and bewildered reaction, you will conclude that the patient doesn't entirely understand and needs you to elaborate more fully

- Patients of varied ethnic backgrounds will not follow your orders unless they made to feel that you really care enough to provide a full explanation and are therefore trustworthy. They have a need to clearly understand why it is in their best interest to comply

- Encourage interpreters to make pertinent comments when they notice there is a conceptual, cultural or linguistic misunderstanding

After The Visit

Ask for feedback from the interpreter. If possible after the interview, speak privately with the interpreter. Be open to comments. Interpreters may perceive cultural and emotional subtleties more clearly than you. Take advantage of their unique bi-cultural perspective.

Non-verbal Communication in the Interpreted Encounter

Body language and non-verbal behavior are important links. They can make an important difference in those situations where you have no language and no cultural background in common with your international patient. Sixty percent of rapport is the result of non-verbal language. It is therefore important to be aware of signs, which may be misunderstood.

  For example:
- Eye contact and a calm, intent attitude will take you a long way with Latin American patients

- Lack of eye contact while listening by Asian patients can mean respect and concentration and not disrespect, as it does in Western cultures

- When Asian patients are preoccupied, they may seem tense and concentrated. The impenetrable features should prompt the clinician to ask the patient for more detail about their concerns

- When Limited English Proficiency (LEP) patients repeatedly nod with a subtle nervousness it sometimes means they are listening intently but don't understand

- A warm empathetic smile at the right time creates a link with Asian as well as Latin American patients. However, a smile while a patient is talking or acting out his/her problem is considered sarcastic by both these cultures and is often misunderstood

- Warm and polite physical touch is considered a sign of empathy by most international patients. However some Muslim and Orthodox Jews do not want any male/female physical contact, no matter how friendly

Using the Patient's Family Members and Friends as Interpreters

When using family members as interpreters, proceed cautiously. Family members will often give incomplete and edited translations of what you say! Relatives will sometimes substitute their own opinion rather than tell you the patient's point of view. It is useful to have your own interpreter in the room even when the patient or family insists on providing theirs.

Why would a friend or family member misinterpret? The reasons can be many:

- Sometimes they are reluctant to ask questions when they don't really understand or are embarrassed. They may lack medical vocabulary in English or their own language. They may be too embarrassed to ask for an interpreter when the conversation gets beyond their linguistic abilities

- Relatives will sometimes not give the patient your full and complete explanations. They may be embarrassed to admit they do not understand, or embarrassed by the nature of the conversation

- Relatives' emotional involvement often results in a tendency to protect the patient from bad news; therefore they edit or change information. Also, relatives will sometimes not share with you the full explanation the patient has told them, again because they are embarrassed, do not have what they judge to be the proper vocabulary, or because THEY make a decision that you don't need to know "all this extra information."

- Finally, confidentiality is also a problem when relatives serve as the interpreters. Often, the patient does not want to disclose upsetting private information or secret issues in front of a relative. A relative may convey information as he/she perceives it and not as the patient does

Child interpreters pose unique problems. Several negative consequences have resulted from the use of children interpreters and this practice is highly discouraged. The Office of Civil Rights expressly discourages the use of minors in health care interpreting. Why is this?

- Role reversal: Child ends up having to process information and provide support to parents

- Editing: Child may present information to suit his personal view of what is "convenient" to say to spare parents from suffering. This will isolate the child and create a burden for him or her

- Mistakes: There is no guarantee that children understand the intended message, even when they say they do. They may "think" they do

- Guilt: If a child does not convey the information correctly; If a child feels he/she is the source of suffering because he/she said something painful. Children may feel they should carry the burden alone

- Resentment: Parents have shown resentment of providers because they do not feel they can express their adult concerns when their child is interpreting. Parents do not feel they have the benefit of a one to one relationship with provider. Confidentiality is at stake. Parents usually choose to communicate sensitive information to their children in a particular way and they resent losing all control in respect to communication

B. Tips for Successful Interpretations

The following tips were developed by Kaiser Permanente, National Diversity, National Linguistic & Cultural Programs to aid health care providers in utilizing interpreter services.

(Note: Sometimes patients/family may insist on not using an interpreter for variety of reasons. If that is the case, it is recommended that a trained and qualified interpreter is in the room to ensure that the information is conveyed accurately and completely. It helps for the clinician to explain that the interpreter is there to assist himself/herself in case there is misunderstanding. Remember, the best person to interpret is the one who can facilitate understanding and communication in sensitive situations between speakers with different languages and/or from different cultures, while maintaining neutrality and confidentiality. The clinician is ultimately responsible for effective communication.)

- Don't depend on children or other relatives and friends to interpret

- Ensure that the interpreter is appropriate for the encounter, e.g., language/dialect, gender, religion, etc.

- Address yourself to the interviewee, not the interpreter

- Watch the patient during the interpretation. Observe the patient's body language for cues

- Don't say anything that you don't want the other party to hear

- Speak in a normal voice, clearly, and not too fast

- Avoid jargon and technical terms

- Keep your statements short, pausing to permit the interpretation. Ask only one question at a time

- Permit the interpreter to interrupt when clarification is necessary

- Be prepared to repeat yourself in different words if your message is not understood

- Check to see if the message is understood by having the interpreter ask the patient to repeat important instructions or directions

- Ask the interpreter to speak to you and the patient, using the first person pronoun to refer to the patient

- Instruct the interpreter not to add or delete anything, especially not to add his/her own comments or offer advice, or suggest questions or answers to your questions

Tips To Share *with* Untrained Interpreters

From the Provider:

- Please let me know if you are familiar with this patient so that the patient's confidentiality would not be breached if you provided interpreting services

- Advise me if there are diversity and/or cultural reasons that would make it inappropriate for you to serve as an interpreter, such as, language, age, gender, and religious beliefs

- Please interpret accurately and convey the meaning of what I say and what the patient says. Do not paraphrase or rephrase the patient's or my words

- I will be facing the patient. Please sit or stand next to the patient. When the patient enters the room, I will introduce myself directly to the patient and wait for you to interpret, then I will introduce you

- I will speak in short units and ask short questions. Please let me know if I need to slow down or rephrase something in easier-to-understand terms. If you need to ask the patient to clarify, be sure to inform me that you are getting more clarification. Avoid answering for the patient

- At the end of the interview I will ask the patient to repeat the instructions to confirm that they have been understood.

C. Useful Mnemonics for Working with Interpreters

TRANSLATE

T: TRUST	How will trust be developed in the patient-clinician-interpreter triadic relationship? In relationships with the patient's family and other health care professionals?
R: ROLES	What role(s) will the interpreter play in the clinical care process (e.g., language translator, culture broker/informant, culture broker/interpreter of biomedical culture, advocate)?
A: ADVOCACY	How will advocacy and support for patient- and family-centered care occur? How will power and loyalty issues be handled?
N: NON-JUDGMENTAL ATTITUDE	How can a non-judgmental attitude be maintained during health care encounters? How will personal, beliefs, values, opinions, biases, and stereotypes be dealt with?
S: SETTING	Where and how will medical interpretation occur during health care encounters (e.g., use of salaried interpreters, contract interpreters, volunteers, AT&T Language Line)?
L: LANGUAGE	What methods of communication will be employed? How will linguistic appropriateness and competence be assessed?
A: ACCURACY	How will knowledge and information be exchanged in an accurate, thorough, and complete manner during health care encounters?
T: TIME	How will time be appropriately managed during health care encounters?
E: ETHICAL ISSUES	How will potential ethical conflicts be handled during health care encounters? How will confidentiality of clinical information be maintained?

Like RC. TRANSLATE: A mnemonic for working with medical interpreters. In "Appendix: Useful clinical interviewing mnemonics," Patient Care 2000; 34(9):188

[Adapted from and based on the work of Kaufert J.M. and Putsch R.W. (1997). *Communication through Interpreters in Health care: Ethical Dilemmas Arising from Differences in Class, Culture, Language, and Power*, The Journal of Clinical Ethics, 8(1):71-87]

INTERPRET: To Use in Obtaining a History From a Limited English Proficient Patient

The following mnemonic can be used by physicians to interview a patient through an interpreter. This can help the physician obtain the history in an appropriate manner.

I   Introduction; Introduce and identify all participants.

N   Negotiation; Negotiate clear role for interpreter, especially if staff member, family member or other lay person. Agree on mode of interpretation (simultaneous vs. interval) if professional interpreter. Clarify if interpreter will also act as "culture broker."

T   Trust; Establish atmosphere of mutual trust, e.g. attempt to greet patient in his/her own language.

E   Engagement; Speak directly to patient. Use short, simple sentences. Allow time for patient to speak and interpreter to interpret before proceeding.

R   Room Set-up; Place interpreter's chair slightly behind patient. Sit directly facing patient.

P   Patient-centered; Make an effort to ensure the history is complete and accurate. Take action to establish and address patient's agenda. Ensure patient agrees to and understands treatment plan and follow up. Ask if patient has any questions or concerns.

R   Respect of Cultural Beliefs; Elicit and acknowledge patient's cultural beliefs without necessarily agreeing with them.

E   Ethical Considerations; Address ethnical issues, e.g. confidentiality, gender issues, use of children as interpreters.

T   Time Management; Manage the interview in a time efficient manner without rushing the patient.

D. Tools for Measuring Health Literacy in Patients

The following three tools can be used by health care professionals to identify patients with limited or low health literacy skills.

Ask Me 3

Ask Me 3 is a solution-based initiative developed by the Partnership for Clear Health Communication to quickly and effectively improve health communication between patients and providers.

Through patient and provider education materials developed by leading health literacy experts, Ask Me 3 promotes three simple but essential questions that patients should ask their providers in every health care interaction. The program encourages providers to help their patients understand the answers to the following questions:

- What is my main problem?

- What do I need to do?

- Why is it important for me to do this?

For more information or to download free materials online, please visit www.askme3.org.

Rapid Estimate of Adult Literacy in Medicine (REALM)

The Rapid Estimate of Adult Literacy in Medicine (REALM) is a screening instrument used to determine a patient's literacy, or ability to read and pronounce common medical terminology and lay terms for body parts and illnesses. It does not measure understanding. It is meant to help medical professionals determine a patient's literacy so that the appropriate educational materials and instructions may be used. The REALM was specifically designed to identify patients who read at levels below ninth grade.

The REALM was developed by researchers at the Department of Family Medicine and Comprehensive Care at the Louisiana State University Medical Center. To receive a sample kit (instruction manual, laminated patient word lists, scoring sheets), write to: Terry C. David, Ph.D., LSU Medical Center, 1501 Kings Highway, Shreveport, LA 71130-3932. Please contact the developer at tdavis2@lsuhsc.edu for updated price.

Test of Functional Health Literacy in Adults (TOFHLA)

The Test of Functional Health Literacy in Adults (TOFHLA) is used to measure functional health literacy—both numeracy and reading comprehension—using actual health-related

materials such as prescription bottle labels and appointment slips. It is designed to assess adult literacy in the health care setting:

- By health care providers, to determine the adequacy of their patients' reading and understanding of health care materials needed for their health care or health education

- By researchers, to assess patient health literacy as a variable in their research

TOFHLA was developed at Georgia State University under a grant to Emory University from the Robert Wood Johnson Foundation and was first published in 1995.

A TOFHLA package includes:

- Full versions in English and Spanish, in regular (12 pt.) and large font (14 pt)

- A short version in English and Spanish in large font (14 pt)

- Directions for administration and scoring and the technical manual for each

- A bibliography of published articles concerning the development and validation of the instrument and research studies for using it

For sample pages of the package and/or to purchase the package, please visit www.peppercornbooks.com.

IV.   Culturally Sensitive Patient Assessment and Treatment

This section includes tools that can be used for culturally sensitive patient assessment and treatment that can be used to measure student proficiency as well as in clinical settings. They include: Harvard Medical School Objective Structure Clinical Examination (HMS OSCE), the Guide to Clinical and Public Health Practices, and the Patient/Family/Community Assessment Form.

A. Harvard Medical School Objective Structured Clinical Examinations (HMS OSCE): Cultural Competency/Oral Presentation Station

Objective Structured Clinical Examination (OSCE) is a multi-stationed clinical examination using standardized/simulated patients in a focused history and physical clinical task exercise within a limited time period. The following are sample instructions and evaluation forms for the "Cultural Competency/Oral Presentation Station."

Cultural Competency/Oral Presentation Station

[Authors: Margaret M. Hinrichs, M.Ed., Program Coordinator, Program in Medical Education, Office of Educational Development, Harvard Medical School; David A. Hirsh, M.D., Instructor in Medicine, Department of Medicine, Cambridge Hospital, Cambridge, M.A.; Developed by Janet Palmer Hafler, Ed.D., Director Faculty Development, Harvard Medical School. Please contact Dr. Hafler at Janet_Hafler@hms.harvard.edu to obtain permission to use.]

Goals: The goals of the station are to allow participants:

- to become familiar with the process of developing a cross-cultural OSCE ; and

- to begin thinking about one they may initiate at their home institutions.

Activities: The activities at this station will include:

- Overview of the process

- Observation and evaluation of an HMS student participating in the OSCE

- Discussion of the interaction, history checklist and exploration of main challenges in case development

Student Learning Objectives:

- To be able to elicit complete and concise history in a patient presenting for a blood pressure check

- Identify a non-adherence as a central problem which can affect clinical outcomes

- Demonstrate a framework for approaching non-adherence with a particular focus on key cross-cultural issues

- To be able to present orally effectively

- To communicate effectively with the patient

References:

Betancourt, J.R., Carrillo, J.E., and Green, A.R. (1999) *Hypertension in Multicultural and Minority Populations: Linking Communicating to Compliance.* Current Hypertension Reports, 1: 482-488

Carrillo, J.E., Green, A.R., and Betancourt, J.R. (1999) *Cross-Cultural Primary Care: A Patient-Based Approach*. Annals of Internal Medicine, 130: 829-834

Student Instructions:

Setting: you are a second year student working in a primary care clinic with your preceptor. Patient is a 58-year-old woman who comes into her primary care clinic for a routine follow-up.

You learn from a quick review of the record that the patient's blood pressure has been difficult to control despite multiple medications. She's had a full medical work-up for secondary causes of hypertension and all tests were completely negative. Today she presents without major complaints, and has a blood pressure of 54/96 on right and 150/94 on left with a heart rate of 84.

You will:

- Take a concise but relevant history of all the details important to understanding why the patient's blood pressure is not controlled (8 minutes)

- Prepare oral presentation (2 minutes)

- Perform an oral presentation based on your findings from the history (4 minutes). The presentation is as if you were informing your preceptor of a patient you just saw in the clinic

- Answer the question on the case (1 minute)

- Receive feedback (5 minutes)

HISTORY CHECKLIST (DO THIS WHILE STUDENT IS TAKING HISTORY)

	HPI:	Did	Did Not
*	Timing – difficult to control blood pressure for 5 years	○	○
	Several medications failed to control the pressure	○	○
	Asks about salt restriction	○	○
*	Has anxiety related to family issues	○	○
*	Takes HTN meds irregularly	○	○
*	Probes more deeply to understand pattern of medication use (uses as needed for anxiety)	○	○
*	Explanatory model (what the patient thinks is causing the problem)	○	○
	Pertinent Negatives		
	No headache	○	○
	No dizziness or lightheadedness **(check the box for EITHER)**	○	○
	No chest pain	○	○
	No vision changes	○	○
	Medicines		
	Names unknown	○	○
*	Uses herbs from botanica	○	○
	Social History		
*	From Dominican Republic and native Spanish speaker (credit for either)	○	○
	Lives alone since death of husband	○	○
*	Doesn't read	○	○
	Doesn't smoke	○	○
	Doesn't use ETOH	○	○
	Asked about affordability of medications	○	○

After 8 minutes or when student completes history, show the student handout #1, in the 3 ring binder.

After the student prepares Oral Presentation for 2 minutes, tell them it's time to present.

HMS PDII OSCE Communication Skills Checklist – For Standardized Patient - CULTURAL COMPETENCY

A. Build a Relationship (includes the following):

	1 Poor	2 Fair	3 Good	4 Very Good	5 Excellent
Greets and shows interest in patient as a person	○	○	○	○	○
Uses words that show care and concern	○	○	○	○	○
Uses tone, pace, eye contact, and posture that show care and concern	○	○	○	○	○
Build a Relationship:	○	○	○	○	○

B. Open the Discussion (includes the following):

	1 Poor	2 Fair	3 Good	4 Very Good	5 Excellent
Allows patient to complete opening statement without interruption	○	○	○	○	○
Asks "is there anything else" to elicit full set of symptoms and concerns	○	○	○	○	○
Open the Discussion:	○	○	○	○	○

C. Gather Information (includes the following):

	1 Poor	2 Fair	3 Good	4 Very Good	5 Excellent
Begins with open ended questions ("tell me about…")	○	○	○	○	○
Clarifies details as necessary with more specific or "yes/no" questions	○	○	○	○	○
Summarizes and gives patient opportunity to confirm information	○	○	○	○	○
Transitions effectively between questions/topics	○	○	○	○	○
Uses words that are easy for patient to understand	○	○	○	○	○
Gather Information:	○	○	○	○	○

D. Understand the Patient's Perspective (includes the following):

	1 Poor	2 Fair	3 Good	4 Very Good	5 Excellent
Elicits patient's beliefs (explanatory model), concerns, and expectations about hypertension (that is caused by stress and medications are to be taken "as needed"	○	○	○	○	○
Responds explicitly to patient's ideas and feelings about stress and hypertension in an understanding and empathic way while explaining need for patient to take medication daily.	○	○	○	○	○
Understand the Patient's Perspective:	○	○	○	○	○

D1. Explore other potential reasons for patient's poorly controlled blood pressure (includes the following:)

	1 Poor	2 Fair	3 Good	4 Very Good	5 Excellent
Asks respectfully about difficulty affording the medications	○	○	○	○	○
Asks respectfully about difficulty reading and understanding the instructions for taking the medications	○	○	○	○	○
Asks respectfully about use of other treatments for blood pressure besides medicines (herbals remedies from botanica)	○	○	○	○	○
Explore other potential reasons for patient's poorly controlled blood pressure	○	○	○	○	○

E. Share Information (includes the following)

	1 Poor	2 Fair	3 Good	4 Very Good	5 Excellent
Explains using words that are easy for patient to understand	○	○	○	○	○
Checks for mutual understanding	○	○	○	○	○
Share Information:	○	○	○	○	○

F. Provide Closure (includes the following):

	1 Poor	2 Fair	3 Good	4 Very Good	5 Excellent
Ask if patient has questions or concerns	○	○	○	○	○
Avoids premature advice	○	○	○	○	○
Acknowledges patient and transitions to next task	○	○	○	○	○
Provide Closure:	○	○	○	○	○

B. A Guide to Clinical and Public Health Practices[1-3]

	INDIVIDUAL	FAMILY	INSTITUTION	COMMUNITY
SUBJECTIVE				
Qualitative data	The medical history Interviewing	The medical history Family genogram Family interview	The institutional history Institutional charts Interviews with management/ staff	Written and oral history of community Interviews with citizens
Profile of symptoms	Patient symptoms	Family symptoms	Institutional symptoms	Community symptoms
Explanation of problem(s)	Patient's explanation(s) of problem(s)	Family's explanation(s) of problem(s)	Institution's explanation(s) of problem(s)	Community's explanation(s) of problem(s)
Perception of resources	Patient's perception of Personal resources	Family's perception of family resources	Institution's perception of institutional resources	Community's perception of community resources
OBJECTIVE				
Direct & Indirect Observations	Physical exam findings (signs)	Family observations Home visits Household assessment	Institutional observations and assessment of... - human resources - financial resources - capital resources - building and space Site visits	Community's observations of... - geology and geography - natural and man-made resources, barriers, and hazards - institutional resources
Quantitative Data	Results of laboratory tests, imaging studies, and other ancillary investigations	Tests for familial diseases (hereditary) Family demographics and epidemiological data list	Institutional documents, reports, files, and records Administrative data sets	Findings from... - photographs and maps - demographic, epidemiologic, economic, and sociologic data sets
ASSESSMENT				
The Diagnostic Process	Individual problem and resource list	Family problems and resource list	Institutional problem and resource list	Community problem and resource list
PROGNOSIS				
Knowledge of the natural history	- of individuals in health and disease ("individual life cycle")	- of families that are functional or dysfunctional ("family life cycle")	- of institutions that are thriving or failing ("institutional life cycle")	- of communities and cultures in adaptive or maladaptive states ("community life cycle")
PLAN				
Disease Prevention	Advice	Advice	Advice	Advice
Health Promotion	Patient Education	Family Education	Institutional Education	Community Education
Treatment	Medication	Family Counseling	Innovations and Change	Community-Based Programs
Rehabilitation	Counseling	Family Therapy	Strategies	and Social Services
Supportive Care			Total Quality Management	Jobs
				Advocacy

[1] Adapted and expanded from Mettee TM. Community Diagnosis - A Concept for Family Practitioners. Paper presented at Plenary Session of North American Primary Care Research Group Meeting (NAPCRG), Lake Tahoe NV, March, 1981

[2] Mettee TM. Community Diagnosis: A Tool for COPC. In PA Nutting (ed.), Community-Oriented Primary Care: From Principle to Practice. (DHHS Publication No. HRS-A-PE-86-1). Washington DC: U.S. Government Printing Office, 1987.

[3] Like RC, Breckenridge MB, Swee DE, Lieberman JA III. Family Health Science and the New Generalist Practitioner. Family Systems Medicine 1993; 11:149-161.

C. Patient/Family/Community Assessment Form

Patient Name: _____   **Date:** _____

Brief Patient Profile: Age   Gender   Race/Ethnicity   Language   Need for Interpreter (Y/N)   Insurance (Y/N)   Religion   Educational Level
Primary Clinical Issue Addressed:
Family Profile Household Structure (who lives there and relationships)   Language(s) spoken, understood/Literacy issues: Financial Situation of Household: Family Problems (e.g., domestic violence, alcohol or drug problem, marital discord, illness):   Family Supports (how does family help with clinical problem addressed):
Cultural Profile Diet (24 hour diet recall): Religious Beliefs (and degree of importance in life): "My health is controlled by"   **ME** --**GOD**

Patient's explanation of primary clinical issue addressed:

Use of alternative treatments and healers:

Community Profile
Workplace Issues (possible exposures, muscle strain, injury risk):

Neighborhood Description:

   What does patient like about neighborhood?

   What would patient like to change about neighborhood?

Accessibility to Health care (primary care, dental, vision)(consider transportation, language, availability of appointments, insurance):

Accessibility of Other Services (grocery, pharmacy, medical supplies):

Additional in-depth questions:

1. Identify a problem that this patient faces that is common to other people in the community.
2. Does [clinical care facility] address this problem on a community level? How?
3. What do other health centers or private physicians do to address this issue? Consider contacting other physicians to find out.
4. What other resources/services already exist in the community to address this issue? Contact or visit 2 or 3 of these resources to learn more about them.
5. What other health/social service professionals or "lay health/para-professional/other healers" besides physicians can be helpful with this issue?
6. What creative ideas do you have for addressing this issue on a community level? Consider performing a literature search. Consider using this issue as a starting point for your senior project.

V. Developing Culturally and Linguistically Appropriate Skills

This section describes a framework that one can consider when designing cultural and linguistic competence curriculum/training sessions. This framework is based on the notion that developing cultural and linguistic competence is a journey; as we practice more of what we have learned, we will become more fluent in understanding the different cultures and more fluid in our cross-cultural or intercultural interactions.

>**Cultural fluency** is the degree to which we are able to manage a cross-cultural encounter with *ease* and *fluidity*. The level of fluency is dependent on one's experience, knowledge and skills. Most importantly, and ultimately, it is dependent on our attitude. Our attitude can propel or impede us in achieving the highest levels of cultural fluency. Finally, our desire and ability to apply culturally and linguistically appropriate strategies can be supported by a culturally and linguistically competent system of care, or hindered by its absence.
>(G. Tang, 1997)
>
>A culturally and linguistically system of care should take into account systems, technology, environment, people, and safety – **STEPS** model (G. Tang, 2001).
>
>*Systems*: Design systems to ensure an integrative care process mindful of the patient's care experience.
>
>*Technology:* Leverage technologies that facilitate organizational knowledge of patient's cultural needs and communication requirements.
>
>*Environment:* Create an environment that is safe and welcoming, allowing ease of navigation through the facilities, and is reflective of diversity.
>
>*People:* Employ people who are skilled and knowledgeable to provide high quality care and services that are respectful to the diverse communities.
>
>*Safety:* Employ continuous quality improvement and total quality management processes to ensure patient's safety.

Cultural Fluency Crosswalk

A 5 x 6 matrix, designed to enhance levels of *cultural fluency* using Dr. Josepha Campinha-Bacote's ASKED Model (described more fully in Chapter 4) and creating a Cultural Fluency Crosswalk (CFC) illustrating how attitudes, skills, knowledge, encounter, and desire relate to oneself, one's patient, their families, one's work teams, one's organizations and the community at large. By applying various *cultural fluency tools*, such as videos, activities and/or workshops, learning outcomes and performance expectations can be plotted within the CFC dimensions creating a logic model to curriculum design.

Application Example

Use the following Cultural Fluency Tools*:

Videos - "Lost in Interpretation," Kaiser Permanente
Tips on Using Untrained Interpreters (Included in Appendix A)
Brain Teaser – pre-assessment of knowledge and attitude (10 questions or more on acculturation, language acquisition, legal and regulatory requirements).

* For more information on these specific tools, contact Gayle Tang, MSN, RN, Director of Kaiser Permanente's National Linguistic & Cultural Programs, at Gayle.Tang@kp.org.

Desired Outcomes:

At the end of this session/module, students will be able to:
1. Gain appreciation of the challenges faced by English speakers in seeking health care in a non-English environment
2. Identify the impact on patient's comfort and trust in the health care system
3. Identify the impact on quality health outcomes
4. Identify the institutional barriers to language access
5. Identify 3-5 strategies to eliminate the access and communication barriers

The following matrix shows how the Cultural Fluency Crosswalk can be used to map out the concepts illustrated in the tools used above.

Cultural Fluency Crosswalk	Attitudes	Skills Demonstrate how to…	Knowledge Gain knowledge of…	Encounter	Desire (Strategies & Application)
Self	– See self in the shoes of the LEP/NEP patient – Recognize personal views on people who are LEP	– Anticipate cultural & linguistic demands – Use appropriate resources	– Impacts on quality and cost – Impacts on personal and professional satisfaction	English speaker navigating in a non-English speaking health care environment	What can I do to ensure my understanding of the patient?
Patient	– Patient's experience with the health care system – Patient's experience with the health professionals	– Use trained & untrained interpreters – Conduct a cultural assessment, e.g., Kleinman's model	– Quality health outcomes and patient safety issues – Potential for medication errors	Vignettes showing frustrating clinical encounters	What would good care look like for the patient?
Families	– Understand family structure – Patient's role within the family	– Elicit family history – Identify roles & position in the family and the "sick role"	– Potential impacts on family – Values, beliefs and traditions	Imagine: Family member is interpreting for patient	Is there a role for the family?
Teams	– Make no assumptions – Colleagues' time may be limited	– Seek help from appropriate team member	– The importance of team competency	Vignettes showing frustrating clinical encounters	How do we know if our colleagues are C & L competent for the job?
Community	– Understand the importance of community	– Leverage community resources	– Availability of community resources	Imagine: Patient's support system is the church	Is there a role for the community?
Organization	– Leadership support – Accountabilities – Work force diversity – Rewards & recognition	– Identify existing policy & procedures – Influence organizational change	– Systems barriers to linguistic access – Legal & regulatory requirements	English speaker navigating in a non-English speaking health care environment	What is the role of the organization in ensuring access to LEP population?

Following is an additional example of the matrix that has been expanded and adapted to integrate information outlined in Like et al., 1993.

Cultural Fluency Crosswalk	Attitudes	Skills Demonstrate how to…	Knowledge Gain knowledge of…	Encounter	Desire (Strategies & Application)
Self	– See self in the shoes of the LEP/NEP patient – Attitudes toward oneself; self-esteem related to cultural or language issues; early or other experiences	– Anticipate cultural and linguistic demands – Use appropriate resources	– Impact on quality and cost – Impact on personal and professional satisfaction – Self-knowledge/ "cultural mindfulness"	- English speaker navigating in a non-English speaking health care environment	- What can I do to ensure my understanding of the patient? What can I do to ensure my understanding of myself?
Patient	- Attitudes toward working with culturally and linguistically diverse patients; individuals with LEP - Addressing ethnocentrism, racism, xenophobia, other "isms."	– Use trained and untrained interpreters – Conduct a cultural assessment, e.g. Kleinman's model – Gain skills in triadic relationship (e.g., working with trained professional interpreters, community language banks, telephonic interpreters, family members when required)	– Quality health outcomes and patient safety issue – Potential for medication errors – Published literature on cultural and linguistic issues in patient care (generic and for selected health and illness conditions)	- Vignettes showing frustrating clinical encounters - Vignettes showing "successful" clinical encounters	- What would good care look like for the patient? - Why is culturally and linguistically appropriate <u>patient-centered</u> clinical care important?
Families	- Understanding one's own family of origin and related cultural and language dynamics	- Elicit family information and construct a genogram (including information on patients' clinical conditions, cultural and language issues, literacy).	– Potential impact on family – Different types of families (e.g., nuclear, single parent, step-families, blended families, multicultural/ multigenerational families, gay and lesbian families), family life cycle, family dynamics, family functioning.	- Convening family meetings and working with the family Primary care family counseling and education Collaborating	- Is there a role for the family? - Why is working with families important? - Why is culturally and linguistically appropriate <u>family-focused</u> care important?

			– Genetics issues – Family acculturation/ adaptation issues – HIPAA requirements, confidentiality and privacy issues	with family therapists and social workers	
Teams	– No assumptions – Colleagues' time may be limited – Attitudes toward working on a culturally diverse team	- Seek help from appropriate team member – Skills needed to work in culturally diverse interdisciplinary health care teams - Skills in working with different types of interpreters on teams - Working with quality improvement teams – Working with disease management teams	– The importance of team competency - Knowledge about similarities and differences both within and across different professional cultures (medicine, nursing, pharmacy, dentistry, nutrition, social services, mental health, etc); various clinical practice styles; age, gender and ethnic cultural differences	- Vignettes showing frustrating clinical encounters - Vignettes showing "successful" interdisciplinary team encounters.	- How do we know if our colleagues are linguistically competent to do the job? - Why is culturally and linguistically appropriate interdisciplinary team care important?
Organization	- Attitudes toward working in a culturally diverse organization	- Skills in carrying out an "organizational cultural competence assessment" focusing on linguistic issues . - Accessing cultural and linguistic resources in organizations.	– Recognize systems barriers to linguistic access – Understand legal and regulatory requirements	- English speaker navigating in a non-English speaking health care environment "Organizational immersion experiences" focusing on cultural and language issues	- What is the role of the organization in ensuring access to LEP population? - Why do health care organizations need to provide more culturally and linguistically appropriate services?
Community	- Attitudes relating to working with diverse communities	- Skills in working with community language banks and other community organizations and advocacy groups; dealing with stable multicultural diversity, rapidly changing communities,	- Knowledge about demographics and diversity of communities being served, different languages, ethnic/socio-cultural groups; health and health care disparities, indigenous healers, community language banks, community assets and resources, etc.	- "Community immersion experiences" focusing on cultural and language issues	- Is there a role for the community? - Why is culturally and linguistically appropriate community-oriented care important?

		community crises/emergencies - Developing health promotion/disease prevention programs for diverse communities			

Appendix B: Glossary

This section provides definitions of terms in the context they were used in this curriculum.

Culture – a set of implicit or explicit guidelines transmitted to individuals from a particular society, group or subgroup, which tells them "how to view the world, how to experience it emotionally, and how to behave in it relation to other people, to supernatural gods, and to the natural environment." (Helman, 2000). These rules and guidelines are often learned and dropped out of awareness.

Culture can also be defined as the way of life of a people. It is the sum of their learned behavior, patterns, attitudes and materials. It is not innate but learned and it is shared and in effect defines the boundaries of different groups (Falicov, 1998).

Cultural Diversity includes factors of race, ethnicity, age, gender, language, country of origin, sexual orientation, religion/spirituality, socioeconomic class, political orientation, educational/intellectual levels, and physical/mental ability among other factors.

Cultural lens: influence

- how we see ourselves

- how we see others

- what we value and how we behave with others

- the social structures we construct for dividing people into social categories (rich/poor, men/women, upper class/lower class, normal/abnormal, etc.)

- the rules for moving people from one social category into another, with or against their will.

Cultural background play and important role in people lives' by influencing beliefs, values, behavior, attitudes to illness, pain and other important factors to health. However, *culture is never homogenous or static*. Generalizations lead to stereotyping, misunderstanding, prejudice and discrimination. Thus, *the role of culture needs to be understood in its multidimensionality* and always seen within a particular context (historical, economic, social, political and geographic).

Diversity is defined as all the ways in which people are different. It affects how people see the world, how they behave, and what values they hold.

Enculturation is the process by which the individual growing up as a member of a particular group or society acquires the "cultural lens" of that society.

Interpretation is the oral restating in one language of what has been said in another language.

Linguistic Competence – the capacity of an organization and its personnel to communicate effectively, and convey information in a manner that is easily understood by diverse audiences including persons of limited English proficiency, those who have low literacy skills or are not literate, and individuals with disabilities. This may include, but is not limited to, the use of:

– Bilingual/bicultural or multilingual/multicultural staff;
– Cultural brokers;
– Foreign language interpretation services including distance technologies;
– Sign language interpretation services;
– Multilingual telecommunication systems;
– TTY
– Assistive technology devices;
– Computer assisted real time translation (CART) or viable real time transcriptions (VRT);
– Print materials in easy to read, low literacy, picture and symbol formats;
– Materials in alternative formats (e.g. audiotape, Braille, enlarged print);
– Varied approaches to share information with individuals who experience cognitive disabilities;
– Materials developed and tested for specific cultural, ethnic and linguistic groups;
– Translation services including those of:

- legally binding documents (e.g. consent forms, confidentiality and patient rights statements, release of information, applications)
- signage
- health education materials
- public awareness materials and campaigns; and
- ethnic media in languages other than English (e.g. television, radio, Internet, newspapers, periodicals)

Translation typically refers to the written conversion of written materials from one language to another.

Underrepresented minority is defined as racial and ethnic populations who are under-represented in the designated health profession discipline relative to the number of individuals who are members of the population involved. This definition would include Black or African American, American Indian or Alaska Native, Native Hawaiian or Other Pacific Islander, Hispanic or Latino, and any Asian other than Chinese, Filipino, Japanese, Korean, Asian Indian or Thai.

References:
Falicov, C.J. (1998) *Latino Families in Therapy: A Guide to Multicultural Practice*. New York, NY: Guilford Press.
Helman, C.G. (2000) *Culture, Health and Illness*, Fourth Edition. England: Buttersworth-Heinnemann; pg. 2-6

Appendix C: COE Assessment and Promising Practices Report

ABSTRACT

The Assessment and Promising Practices Results describe the cultural and linguistic competence activities of HRSA Centers of Excellence (COE) grantees. This report on assessment and promising practices is a result of an assessment of COEs and a collection of "promising practices" that COEs provided in response to a questionnaire.

For the assessment, the authors collected information from the 2001-2002 Uniform Progress reports, which COE grantees complete annually. The authors examined reports from 29 COEs, and coded and cataloged activities according to an assessment matrix, developed by the Expert Team of this project. The matrix was arranged by topic: Content, Teaching Delivery/Methods, Non-Teaching Delivery/Methods, and Evaluation. Another source of assessment information came from two focus group interviews held on March 19, 2004, in Washington D.C., in conjunction with the COE directors' conference. The purpose of the focus groups was to gather the opinions of the COE directors to enable Magna Systems and the Expert Team to draft a curriculum guide for COEs.

To complement the assessment, additional findings were collected that describe the cultural and linguistic competence activities that the HRSA Centers of Excellence (COE) grantees have determined to be "Promising Practices." These practices are based on responses solicited from COEs in a questionnaire. Each COE provide its own definition of "promising practices," and using this definition, selected activities to include in its response.

The following are some of the main findings from the assessment and collection of "promising practices":

- The topic taught with the most frequency among the 29 COEs was "Different Population Groups." This topic includes the general health-related and cultural beliefs of ethnic groups, and instruction on diversity and multiculturalism.

- The teaching method the COEs employed most frequently was "classroom-directed learning." This method includes classroom-directed learning that has been incorporated into the curriculum either as a required course, elective, or unit in an established course.

- The non-teaching method most frequently used was "research pertaining to people of color." This category is included as a way to determine the COEs' activities involving academic or community-based research pertaining to people of color.

- A few COEs conducted evaluations for their programs. Three COEs conducted an evaluation of their cultural and linguistic competence curricula.

This project is being conducted by Magna Systems, Incorporated under contract with the HRSA Division of Health Careers Diversity and Development.

Introduction

The Centers of Excellence (COE) Program is a program of the Federal Health Resources and Services Administration of the Department of Health and Human Services. The goal of this program is to assist health professional schools in supporting various programs in health professions education for underrepresented minorities. The purpose of this Assessment and Promising Practices Report of the COE grantees' activities is to identify their past cultural and linguistic competency educational activities and highlight selected current activities.

Note that the term "Underrepresented Minority" (URM) is used often in this text. In this report, it is used according to HRSA's definition, which states "with respect to a health profession, racial and ethnic populations that are underrepresented in the health profession relative to their proportion of the population involved include Blacks or African Americans, American Indians or Alaska Natives, Native Hawaiians or Other Pacific Islanders, 'Hispanics or Latinos,' and certain Asian subpopulations."

Methodology: Assessment and Promising Practices

The primary source of data for the assessment was the 2001-2002 Uniform Progress Reports, which COE grantees complete annually. The data from the 2001-2002 reports are the most recent set of comprehensive data available from HRSA. Each report contains a narrative section that details the COEs' objectives and accomplishments for the past year. The Expert Team examined reports from 29 COEs. Of the 29 COEs, ten were Hispanic/Latino Centers of Excellence, three were African American, four were American Indian, one was Native Hawaiian, and eleven were Other. The activities were coded and catalogued according to an assessment matrix that the Expert Team developed.

A secondary source of assessment data came from two focus group interviews held on March 19, 2004, in Washington, D.C., in conjunction with the COE directors' conference. The purpose of the focus groups was to gather examples of current COE activities as well as solicit opinions from COE directors to enable Magna Systems and the Expert Team to develop a curriculum guide for COEs. Among the questions that were posed during the focus groups were the following:

- How can we share promising practices among the COEs?

- What kind of cultural and linguistic competency curricula are the COEs currently using?

- How can the COEs emerge as leaders in cultural and linguistic competency?

In the two focus group sessions, there were 31 participants altogether, although not all participants stayed for each full session. These participants represented COEs from medical, osteopathic medicine, pharmacy, and dental schools. The suggestions gathered during the two focus groups became the initial basis for the assessment matrix, which the Expert Team than further refined and expanded.

After the activities for the assessment matrix were identified and coded, the Project Team recorded the number of activities in the matrix and calculated the sum for each cell. The Content and Teaching Delivery/Methods matrices have two numbers in each cell. One number is the total number of activities in which the COE participated. Some COEs had multiple activities for a single category, meaning the total number would be more than 29 in some cases (There were 29 COE grantees' reports examined in the assessment). The second number in the cell represents the number of COEs that participated in the activity. The numbers in the Non-Teaching Delivery/Methods and Evaluation matrices refer to COEs; no COEs had multiple activities for each category.

After the numbers were tabulated, the Project Team chose examples to illustrate various levels of participation. Some COEs are just beginning to initiate activities in certain areas, while others have more established programs. Although two activities may teach students about similar content topics, the objectives and methods may be very different.

The *assessment tool* was developed through the previously mentioned Focus Groups with additional input from the Expert Team members. The tool consists of four matrices: Content, Teaching Delivery/Methods, Non-Teaching Delivery/Methods, and Evaluation. The matrices allow a detailed overview of the COE grantees' activities by showing activities that address cultural and linguistic competence at the patient-client level, as well as at the organizational level. In an attempt to capture a detailed view of activities, each matrix contains topics that serve as examples of more general categories. For example, some categories in the Content matrix address an individual's cultural and linguistic competence, such as "Clinical Practice Issues," while others address an organization's competence in such areas as the CLAS standards, for instance.

The audience for each matrix remains the same and ranges from the individual student to the surrounding community. The audience refers to the groups that participate in or receive the cultural and linguistic competence activity. Each of the audience fields is described below:

- Student: students in health professional schools

- Residents: residents in any year of residency

- Fellows: health professional school fellows who have completed post-graduate training and are either teaching or conducting research

- Faculty: junior or senior faculty within the health professional school

- Staff: COE staff members

- Manager: COE managers

- Deans/leader: COE deans or leaders

- COE-wide: All individuals affiliated with the COE, including all individuals listed above

- Community-wide: practitioners, service providers, or other health workers in the COE's community

In addition to audience fields, the assessment and promising practices data are disaggregated by COE type and the COEs gear their recruitment and curricula toward specific groups, including African Americans, American Indians, Latinos/Hispanics, Native Hawaiians, and Others.

The accompanying **_promising practices_** are included to complement the assessment data. The promising practices are based on solicited responses from COEs who defined their promising practices and, using their own definitions, selected activities to include in their responses. The following is a sample definition:

> _"Promising practices_ are identified strategies, approaches, and activities that are designed to enhance and underscore cultural and linguistic competency education for medical students, residents, faculty, and staff. These practices include defining cultural and linguistic competence within the context of the patient-doctor clinical encounter. As a practice, the concept of cultural and linguistic competence expands to include the recognition of culture as _dynamic societal happenings with norms, mores, and customs_ outside of the _political_ concept of race and ethnicity."

In contrast another COE defined promising practices more generally as:

> "Educational activities that utilize creative ways of implementing and assessing cultural and linguistic competence curricula."

COEs reported their activities in a free format, which allowed them to stress whichever aspects of the promising practices they believed were most important. A total of 16 COEs responded and provided more than 70 examples of promising practices. Since it is cumbersome to include descriptions of all the responses, several activities were selected to illustrate promising practices on topics that are also included in the assessment information matrices, such as "different population groups" or "curriculum development."

The report also includes a matrix of promising practices which is meant to quantify the responses received thus far from COEs for informational purposes. By clustering COEs by the populations they serve, we hope to highlight areas of focus that may be pertinent to particular communities. The quantified data on promising practices are not meant to be analyzed along with the assessment information.

In addition to being arranged by COE population-served, the matrix on promising practices is also arranged by content versus process: cultural awareness, cross-cultural communication, alternative treatments, awareness of disparities, language acquisition, workforce diversity, evaluation, cultural and linguistic competency pedagogy, community-based research, community-based practice, curriculum development, recruitment/retention, information dissemination, organizational development, and other.

While certain schools listed more than 20 activities, other schools listed only one, a factor that tends to skew the data if one looks only at the frequency at which activities were reported. Although definitions of promising practices are relatively similar among schools, they are not identical; and because reports were submitted in various formats, comparisons among schools are not included.

The difficulty in quantifying qualitative data is that there is often an element of subjectivity in the interpretation process. Thus, when coding the various activities, the greatest efforts were made to rely on the stated purpose or criteria of the promising practice in order to place the activity in the appropriate category and limit interpretation. Many schools listed a large number of promising practices but provided no descriptions of what the activities entailed. These practices, due to a lack of information, were omitted from this report.

Content Matrix

The Content Matrix catalogs the various topics that are included in cultural and linguistic competence education. The Content Matrix is closely related to the Teaching Delivery/Method Matrix. The methods the COEs use to teach the content categories are catalogued in the Teaching Delivery/Method Matrix.

The *different population groups* category refers to the general health-related and cultural beliefs of an ethnic group. This category also includes teaching diversity and multiculturalism. COEs taught this topic the most frequently among the other cultural and linguistic competence topics. There were 18 COEs that conducted 32 activities related to Different Population Groups for their students. Of the 18 COEs, six were Other, six were Hispanic/Latino, four were American Indian, one was African American, and one was Native Hawaiian.

Six of the COEs chose to teach students about different population groups through classroom-based learning. This method was the most frequently employed method of teaching about different population groups. Some COEs taught general multiculturalism and diversity issues. The objectives of one COE's cultural and linguistic competence curriculum include the following:

- Have students recognize their own attitudes, beliefs, and values and the effect of these attitudes on clinical practice

- Increase understanding of similarities in attitude, beliefs, and values across groups

- Communicate effectively

- Increase knowledge of variation.

Another COE developed a core set of cultural concepts to incorporate into their curriculum.

Other COEs used classroom-based methods to teach students about a particular ethnic group. One COE developed a course in Native Hawaiian health issues. Another COE offered two elective courses on Native American health for its students, "Seminars in Indian Health" and "Health Outside the Mainstream." An example of a "Promising Practice" on this topic is "Consulting the Family Ghost: Using Cultural Genograms to Promote Cultural Awareness." This practice has been adapted to multiple formats for first-year medical students, senior internal medicine residents, and attending faculty as a way for learners to introduce themselves, deepen group cohesion, and raise awareness about themselves and the diversity of their peers. In the activity, small groups of learners introduce themselves by drawing and narrating a personal "cultural genogram" including factors such as race/ethnicity, religion, socioeconomic status, geographical influences, formative family events (e.g. immigration, illnesses, etc.), and family medical and psychiatric histories. When appropriate, facilitators asked probing questions to promote reflection.

Other COEs taught students about different population groups through experiential clinical practice, such as through community immersion. At one COE, the Native American students take clinical rotations at sites that treat Native American patients either exclusively or in large numbers. Rotations are four weeks long, and nine Native American medical students participated in these activities. Ten dental students at another COE participated in six- to eight-week summer clinical rotations in communities of URMs.

Another method the COEs used to teach about different population groups was through Web-based learning. One COE incorporated computer-aided instruction in all seven of its clinical sciences department curricula. Another COE developed a COE Website that includes curricula regarding Native American health issues.

One COE incorporated cultural and linguistic competence as a required training topic for residents, thus combining instruction on clinical issues and different population groups.

Faculty members at some COEs also received instruction on different population groups. One COE had plans to initiate diversity training for all faculty members. At the time the report was submitted, the COE was planning the program and conducting a preliminary survey to assess the need for such training.

One COE used two different methods to educate the community about Hispanic/Latino health issues. This COE held a bi-National health issues lecture series for faculty, staff, and service providers at a hospital and sponsored a Latino health conference for community health workers.

Clinical practice issues arise when treating different ethnic populations and when practicing cultural and linguistic competence in clinical settings. The eight COEs addressed clinical

practice issues through community immersion, case studies, workshops and trainings, and classroom learning. Four of the COEs were Hispanic/Latino, three were Other, and one was Native Hawaiian. All of the nine catalogued activities were directed at students.

One COE coordinated a lecture, "Cultural Sensitivity in Clinical Interactions" for all third-year students. Another COE emphasized cultural and linguistic competence during interviewing skills in its "Fundamentals of Medicine I and II" courses for first- and second-year students.

A number of COEs used community immersion clinical programs among ethnic populations to train students. Ten students in one COE participated in six- to eight-week summer clinical rotations in areas with a high population of ethnic groups. All students at another COE received clinical exposure to medical training at sites away from the main campus that are heavily populated with Native Hawaiians. One school cited a promising practice that included the development of a simulation program to recreate a clinical setting, monitor actual clinical interactions, and adjust the clinical situation to maximize learning. Interactions can be videotaped, and instructors can provide immediate feedback, allowing for dynamic learning in a "real" environment.

Communication, language, and literacy issues encompass all teaching content related to proper communication with ethnic populations, including such topics as medical language, interpreter issues, health literacy, and clinical communication. The majority of communication and language issues addressed Spanish-speaking populations. No COE offered courses in medical language in any language other than Spanish.

The five COEs that chose to address communication, language, and literacy issues did so using classroom-based measures. Two were African American COEs and the other three were Hispanic/Latino. Many COEs offered medical Spanish courses that ranged from 10 to 16 hours a week. One COE used a combination of teaching methods in its medical Spanish course. Students received didactic instruction in a classroom at the beginning of the semester and then met in small groups for the remainder of the semester. The COE also offered a Spanish-only rotation as an elective. One COE offered a conversational Spanish class for faculty. Other COEs offered courses that instructed students on working effectively with translators.

In one instance cited as a promising practice, a COE videotaped students' interactions with standardized patients who did not speak English. The students were required to perform a focused history, assess the patient's understanding of the disease, explain what procedures they were to conduct, and provide patient education. After the interview, the standardized patients provided feedback on the students' communication skills.

Community, public health issues includes the different issues that affect the larger community in which the COE is a part. Many of the COEs taught this topic to students using clerkship or community immersion programs in community-based clinics. One COE developed a community health internship for its students. Another COE developed a community preceptorship program and recruited community-based health professionals as preceptors. One such promising practice was the rural health clerkship for senior medical students. This clerkship was designed to teach students how to interact successfully with diverse groups of people; students were assigned

readings, held discussions, and planned activities to raise awareness of cultural diversity in the health care system. Students were expected to understand the effects of socioeconomic status, race/ethnicity, cultural values, and community and family support on health status of rural residents and communities. During the clerkship, students resided in rural communities for four weeks to learn in a dynamic, participatory way.

Health and illness related topics relate to physical health and illness, including health disparities and specific diseases that affect certain populations. Four COEs had programs related to health and illness topics. One COE had a lecture series that featured a lecture on minority health disparities. Another COE developed two problem-based learning cases on Native American and Hispanic/Latino health issues. One COE assembled specialists from various departments and created grand rounds presentations, which included a presentation on health disparities.

At another school, as a result of student requests, a symposium was conducted called "Patient Experiences, Diversity, and Disparities: A Cross-Cultural Documentary." This session provided a brief didactic overview of racial and ethnic disparities and cross-cultural care, followed by the viewing of a video vignette and breakout discussions led by volunteer faculty from the COE and affiliated hospitals. The activity was reported as a promising practice.

Teaching Delivery/Methods

This matrix catalogs the delivery and methods the COEs used when teaching cultural and linguistic competence.

Classroom directed learning catalogs such learning that has been incorporated into the curriculum either as a required course, elective, or unit in an established course. It was the most frequently used method for teaching cultural and linguistic competence. Of the 14 COEs that used classroom directed learning as a teaching method for students, four were Other, four were Hispanic/Latino, four were American Indian, two were African American, and one was Native Hawaiian.

Six of the COEs produced their own curriculum, all for students. One COE developed and implemented five modules: minority health core competency, culture and development, culture of the patient-culture of the physician, medicine minorities and cultures in literature and medicine, and history of African Americans in medicine. One COE developed a course called "Culturally Competent Care" and is pending approval by the school of medicine's curriculum committee. Another COE also developing a questionnaire to be completed by pharmacy faculty and current students to assess the presence of designated core concepts in the curriculum. The faculty members are identifying the core concepts.

The faculty members of another COE are guiding the development of a multicultural curriculum. The objectives of this curriculum include:

- Having students recognize their own attitudes, beliefs, and values and the impact of these beliefs on clinical practice

- Increasing understanding of similarities in attitudes, behaviors, and values across groups

- Communicating effectively

- Increasing knowledge of variation

For this course, the students are required to complete 50 hours of cultural and linguistic competence training during their preclinical years.

Other COEs developed curricula specific to particular ethnic groups. One COE developed and implemented a course that provides an introduction on research methodology and research topics while incorporating Native Hawaiian health issues. Another COE used funds to maintain the course, "Native American Health Care Issues" as a requirement for students. This course addresses Indian cultural issues, tribal governance, art in Native American culture, and presentations by various guest lecturers who are familiar with Indian health.

Some COEs made cultural and linguistic competence part of the required curriculum. One incorporated cultural and linguistic competence as required resident training topics. Another school required three sessions (10 hours) of a new series called "Culture Matters" for its entire first-year class. One COE reported a promising practice that described the ongoing attempt to develop a cultural and linguistic competency curriculum for the entire medical school.

Other COEs incorporated cultural and linguistic competence discussions into the standard curriculum. One COE discussed issues of culture and ethnicity in lectures on such topics as cultural and linguistic competency and health, cancer, theories of health promotion, obesity, physical activities, access to health care, and health disparities. The first-year students at another COE took a course titled, "Introduction to the Patient Care Model" that focused on cultural and linguistic competency issues.

Other COEs offered communication and language issues in a classroom-based atmosphere. Many COEs offered medical Spanish courses for medical students. One COE offered a Spanish medical terminology course that was 16 hours a week of didactic teaching.

Community immersion activities allow students to experience clinical practice in a community setting. Fourteen of the COEs had students work with different population groups in community-immersion activities. Six of the COEs were Hispanic/Latino, five were Other, and there was one each of Native Hawaiian, African American, and American Indian. Nearly all of the 15 of the community immersion activities were directed at students, except one program for residents, which was conducted by a Hispanic/Latino COE.

Some community immersion activities were directed primarily at specific ethnic groups. Native American students at one COE took clinical rotations at sites that treated exclusively or large numbers of Native American patients. These rotations were four weeks long, and nine Native American medical students participated in these activities. Another COE had its medical students conduct rotations in *colonias* clinics. *Colonias* are unincorporated settlements along the U.S.—Mexico border that often lack basic water and sewer systems, paved roads, and safe and sanitary

housing. Another COE offered home care electives in the community in which 90% of the homes were occupied by African Americans. One COE offered Spanish-only rotations as an elective for some of their medical students. All medical students at another COE receive clinical exposure at community sites with large populations of Native Hawaiians.

In other community immersion activities students worked at community-based sites with a variety of ethnic groups. One COE had 25 of its URM students complete a summer practical immersion experience (PIE) of 3 to 12 weeks at clinical sites in predominantly URM, rural, or underserved areas. One school incorporated the students' experiences in the community-based clinic into its cultural and linguistic competence teaching curriculum.

A promising practice in this area is a four-week immersion program designed to encourage students to consider practicing in Native Hawaiian communities and increase cultural and linguistic competency. The Native Hawaiian health care elective includes traditional healers as teachers and mentors and has several purposes, including having students:

- Gain an appreciation for the unique cultural and societal aspects of Native Hawaiian health

- Learn about the importance of traditional healing for Native Hawaiian patients

- Understand how to interact with traditional healers (by working with traditional healers)

- Improve their cultural and linguistic competence by being immersed them in the medical-cultural-social milieu of a Native Hawaiian community

Precepting/clerkships include activities that place students in clerkships with preceptors. This was the third-most used teaching method. All of the preceptored experiences and clerkships are for students. The majority of these programs are set in community-based settings with large ethnic populations. Of the 13 COEs that had clerkships, seven were Other, four were Hispanic/Latino, and two were Native American.

Many of the preceptors are recruited from community clinics. One COE created a community health internship program in which students are supervised by preceptors as they carry out health projects in community based organizations. Another COE developed a program, the American Indian Clerkship Pathway, which created clerkship options in three tribal communities.

Some COEs are making community-based clerkships readily available for their URM students. One COE provides all of its American Indian medical students with the opportunity to receive clinical preceptorships at a facility that serves an American Indian population. Another COE is proposing that all of its URM students receive preceptored experiences in community health. One COE reported a promising practice family medicine clerkship that uses problem-based learning to demonstrate and illustrate cases in a culturally relevant manner paying attention to the psychosocial and cultural factors in health and illness that is reflective of the local community. Additional activities in the clerkship include an introduction to the history of the neighborhood,

discussion of immigration to the community, and a bus tour of various parts of the neighborhood. Visits were also conducted to local complementary health care sources.

Some centers are developing their clerkship programs by concentrating on hiring faculty. One COE hired a clinical preceptor director who has developed two clinical sites in the community.

Seminars and lectures related to cultural and linguistic competence were used in five different activities among the COEs and the target audience varied. Three of the COEs were Other, one was Hispanic/Latino and one was African American. Due to the short time length of seminars and lectures, COEs may have considered this an effective way to reach out to non-students. Most of the seminars or lectures featured guest lecturers. One COE had a seminar series with one lecture on minority health disparities. Another COE sponsored or coordinated five nationally recognized speakers on Hispanic/Latino and Native American health issues. All faculty at another COE attended a two-day seminar on cultural and linguistic competence. One COE sponsored a professional lecture series for all residents, faculty, providers, and staff on bi-National health. Another COE reported a promising practice that included lectures by health professionals on such topics as traditional Indian medicine, paleopathology, urban/reservation Indian health care, and social problems.

Workshops and training on cultural and linguistic competence differ from seminars and lectures in that they place a greater emphasis on the delivery and acquisition of a specific set of skills or knowledge, generally for a clear purpose. They differ from classroom-based learning methods in that they are typically individual events that have not been incorporated into the curriculum.

Some COEs had workshops directed at students. One COE created a diversity training session for first-, second-, and third-year students. Another COE held a cultural and linguistic competence workshop as a required part of intern, resident, and faculty orientation sessions. Another COE created a workshop session called "Appropriate Use of a Medical Interpreter" for students in clinical rotations.

Faculty also attended workshops and trainings. One COE held cultural and linguistic competence workshops for preceptors. The workshops were called "Cultural and linguistic competence 101: Becoming an Effective Preceptor and Pharmacist." One COE director participated in a workshop on cultural and linguistic competence at Georgetown University. Another COE is planning to initiate diversity training for all faculty. The first step toward implementation was to evaluate the current status and survey faculty members to assess whether a need for training exists.

A promising practice in this area is a series of Native Hawaiian conferences done in collaboration with community organizations focusing on Native Hawaiian health issues and faculty development. The target audience is both clinical and academic faculty. In these conferences, the purpose is to teach and train faculty in cultural and linguistic competency as well as general faculty development topics.

Topics that have been addressed include:

- Overview of Native Hawaiian health with an emphasis on disparate rates of cardiovascular disease, cancer, diabetes, and obesity

- Conflict resolution training including an introduction to Hooponopono, the traditional Native Hawaiian practice of conflict resolution

- The "Dos" and "Don'ts" of conducting research in Native Hawaiian communities

- Writing scientific papers

- The long-term effects on nuclear testing on the culture and health of Pacific islanders

- Leadership skills training including the special role of being a leader in the Native Hawaiian community

- Genetic and related research in indigenous communities

- The lost generations, which includes a discussion of the psychosocial, behavioral, economic, generational, and cultural effects of generations lost to adoption (when adopted outside of the birth culture), drugs and alcohol, prison, domestic and sexual abuse, and other forms of exploitation

- The effect of emerging infectious diseases on Pacific Islander populations

- Cultural and linguistic competency in faculty and in curriculum development

- Geriatrics and the medical, psychosocial, and economic challenges on Native Hawaiian elderly

- The role of la`au lapa`au (herbal medicine) in Native Hawaiian health and healing

Case studies involve actual studies of patients' cases and simulated patient interactions. The COEs that used case studies to teach cultural and linguistic competence created culturally relevant case simulations. One COE developed 14 problem-based learning cases, two of which addressed Hispanic/Latino and Native American health issues. All freshman and sophomore students at another COE interviewed Native American simulated patients. At another COE, all first years spent 15 minutes in case simulation with culturally relevant simulation patients with a feedback period. A promising practice in this area is a standardized patient (SP) program in which Native Americans were trained as SPs not only to simulate a disease or disease process, but also to exhibit a number of behaviors and effects that were cultural in nature and not necessarily related to the disease.

Non-Teaching Delivery/Methods

This matrix is meant to catalog other non-teaching delivery mechanisms and methods that the COEs use to increase their cultural and linguistic competence capacity.

Research pertaining to people of color. This category is meant to determine the COEs' activities involving academic or community-based research pertaining to people of color. The research activities could generally be divided into two categories. The first is both underrepresented minority and non-URM students and faculty conducting research on URM communities. The second is URM student and faculty-conducted research.

Student research was widely done across the COEs, and 16 COEs were involved in such research. Seven of the COEs were Other, five were Hispanic/Latino, three were American Indian, and one was African American. It appears that the COEs' goal in student research is supporting students' educational and research capacity. One COE developed a tracking system to monitor the participation of URM students in research activities. In one COE, 47 of the 71 research projects for faculty and staff were relevant to URM health issues in New Mexico. Some COEs created research programs for URM students. For example, students from one COE participated in summer research projects for nine weeks that focused on Native American health issues. Another COE established what it called a Cultural Diversity Summer Research Experience, in which students participated in didactic seminars, received one-on-one mentoring from faculty preceptors, and completed presentations on various topics. Other schools established fellowships for students. One COE is examining the possibility of having all 24 medical students complete a senior thesis as a requirement to graduation, and the research must be related to health care for the underserved.

Faculty research was also widely conducted. Faculty researched URM health-related issues in ten of the COEs. One COE hired a research associate to coordinate research activities and support faculty research projects. It also established a faculty advisory committee to identify research mentors and support academic and research mentoring of individual faculty scholars.

Some COEs made their URM research activities COE-wide. One COE established a Center on Diversity and Disparity in Health. Another COE maintains a registry of minority health projects, funding support, research training and services, and developed a Center for Health Equity Research and Promotion. It also hosted a conference, "Current Opportunities and Trends in Health Research for a Diverse America."

A COE cited a promising practice that is designed to improve cultural and linguistic competency by exposing students to Native Hawaiian health issues and traditional practices by teaching them about how to work with the Native Hawaiian community especially with regard to conducting research, which is an area of much controversy in indigenous cultures. The Native Hawaiian Community Medicine Research Program is an elective within community medicine. It is designed to:

- Give students formal research training in the basics of research methodology, design, and implementation

- Expose students to traditional Native Hawaiian health care practices

- Expose students to Native Hawaiian researchers, topics, and issues involving conducting research in Native Hawaiian communities

- Have students conduct research projects in an area dealing with Native Hawaiian health

This program uses Native Hawaiian faculty, a diverse student group (of Native Hawaiian and non-Native Hawaiian students), and Native Hawaiian community elders and experts. By teaching students about Native Hawaiian health issues, traditional healing, and the importance of respecting and working within a community, the elective is designed to produce students that are more culturally competent.

Recruiting included students, residents, fellows, and faculty. The assessment team recorded recruiting activities for URM individuals. A diverse student body and faculty is one indicator of developing organizational cultural and linguistic competence.

COEs recruited URM students to their respective schools by using a variety of methods. Fourteen COEs recruited students; eight were Other, five were Hispanic/Latino, and one was American Indian. Some methods included sponsoring summer camps, institutes, and academies, making health career presentations at schools, and offering test preparation classes. Other COEs worked directly with high schools, community colleges, and undergraduate institutions to identify URM pre-medical students and invite them to participate in research or academic programs. One COE created a two-pronged plan that distinguished between targeting URM students for 1) application and enrollment (acute plan) and 2) placement in the competitive student applicant pool (long-range plan).

Faculty recruitment activities were not as detailed as student recruitment. The reports did not provide the actual activities that each school conducted, but rather just stated that the COEs recruited faculty. One COE established a faculty steering committee to develop recommendations to improve the recruitment and retention of both URM faculty and students and to link with community effort to promote the goals. Two COEs offered fellowships to junior URM faculty. Thirteen COEs were involved in faculty recruitment.

Two COEs recruited fellows to their programs by creating fellowships. One maintained a Hispanic/Latino COE health services fellowship in general pediatrics. Another COE established one Latino research fellowship and two faculty research positions at 25% each at the UCSF-Fresno Latino Center.

One COE recruited Hispanic/Latino residents by meeting with resident directors to assist in recruiting and developing brochures.

Development activities were designed to increase the capacity of URM students, residents, faculty, and others. By helping the development of URM individuals, the COEs also may be advancing their diversity.

Student development activities centered primarily on academic assistance, including tutorial programs, mentoring, and supplemental instruction. One COE developed a program for URM

students, the HCOE Scholars Program, that provides advisors and tutorials. Ten COEs conducted student development activities.

Faculty development activity was conducted in 15 COEs. Most COE URM faculty participate in development programs that advance professional skills in teaching and research. These programs vary in length from a six workshop session (84 hours) to two years. All six URM faculty members at one COE are currently enrolled in the General Clinical Research Center Scholars Training Program, a 10-module intensive training for junior faculty in research, statistics, writing, public presentation, and pedagogical skills. The COE provides additional professional development workshops. One COE granted five faculty development awards. Another COE conducted Blackboard training sessions and paired new African American faculty with tenured faculty for mentorship as part of its faculty development program. Hispanic/Latino junior faculty at another COE completed the school's National Center of Leadership in Academic Medicine, a program developed by the COE and institutionalized in the school of medicine.

One promising practice involving community immersion described a four-day conference at an isolated island for faculty and medical students. Access was restricted and participants had to bring in their own food and water, take a boat, swim to shore (since there were no piers or docks), and camp. Family members were allowed to participate. All activities were related to Hawaiian values, such as sharing work (including loading and unloading gear, cooking, and cleaning).

Other cultural activities included learning chants to request permission to enter and leave, hiking to historical and archaeological sites, time for meditation and group sharing, one on one interactions, and work projects to restore damaged parts of the island. More traditional activities also were offered, including lectures and demonstrations by a variety of traditional and complementary and alternative medicine healers and group discussions and lectures on the meaning of cultural and linguistic competency and how to increase the cultural and linguistic competency of practices.

Resource building for minority health issues. All of the catalogued activities were for the benefit of the entire COE with the exception of one activity that was directed toward the community. Many COEs added to their library's collection of materials related to minority health. Two COEs obtained additional user licenses for OVID online articles that facilitated the access to articles related to minority health.

Other COEs developed their own resource centers on minority health. One COE developed a minority health information resources center that included print, video and audio media, computer based resources, and access to National health information and databases. Faculty, staff, and students use the center. Another COE developed a new Web page that integrates three collections of diverse holdings, including one on complementary and indigenous medicine, one on diversity, and COE additions. Similarly, one COE cited Website development as a promising practice and offered cross-cultural cases and cultural and linguistic competency resources for faculty and students on its site.

Some COEs compiled existing literature on minority health. One COE completed a literature review of resources for Indian health and cultural and linguistic competency in 2002. The

resource list is used to develop competency concepts and curriculum topics. Another COE is establishing a clearing house that will include a database of Native Hawaiian health issues.

One COE's activities were intended to affect the community when it developed a partnership with an alcohol research center to disseminate information on alcohol-related research outcomes to health care practitioners.

Other. Three COEs established other student-directed programs that could not be coded into the existing categories of the Non-Teaching Methods/Delivery matrix. One COE reached out to its URM students to increase their participation in the masters of science program in community health. Another COE that is not located on the mainland facilitated a student exchange program with other medical schools in the mainland United States. Another COE created a community ambassador program, in which students received training in how to disseminate information successfully to the community surrounding the COE, which is predominantly Hispanic/Latino and/or rural.

One COE cited the development of partnerships as a promising practice. The COE reported that its university hospital received funding from New Jersey to develop a medical interpreter curriculum that could serve as a best practice model in health care institutions throughout the state. The Cross-Cultural Medical Interpreter Curriculum Pilot Program represented a first step by the state, in collaboration with a university hospital, toward ensuring that every New Jersey resident receives high quality health care by making trained medical interpreters available to limited English proficient patients. As a result, the state published a detailed curriculum for the training of medical interpreters. The university hospital now funds the Center for Multicultural Health care Communications, a direct result of its Cross-Cultural Medical Interpreter Curriculum Pilot Program.

Evaluation

This matrix is intended to catalog the evaluation activities the COEs are currently doing for their curriculum, students' clinical experience, impact evaluations, and other evaluations. The evaluations were further categorized into formative, summative, and immediate evaluations. Formative evaluation is designed to strengthen or improve programs by examining their delivery, implementation, and the assessment of the organizational context, personnel, procedures, and inputs. Summative evaluations, however, examine the effects or outcomes of programs. That is, they summarize it by describing what happens subsequent to delivery, assessing whether it is responsible for the outcome, determining the overall effect of the causal factor beyond only the immediate target outcomes, and estimating the relative costs associated with the object (Trochim, 2000). Finally, immediate evaluations measure the mastery of knowledge and skills at or near the end of specific activities.

The *curriculum* category catalogued the curriculum evaluation activities of the COEs. Only a few COEs conducted any kind of curriculum evaluation. Two COEs conducted formative evaluations to assist in developing cultural and linguistic competence curriculum. One COE had faculty and students complete a questionnaire to assess the presence of cultural and linguistic competence concepts in existing curriculum. Another COE is attempting to establish a procedure

by which every course is evaluated on its ability to address issues relating to minorities and women, including cultural and linguistic competence. Currently, cultural and linguistic competency working groups are in place to ensure that the cultural and linguistic competence objectives are met.

Another COE conducted an immediate assessment of the effect of the program by having students evaluate a medical Spanish class after completing the course.

The *clinical evaluation* category catalogued the clinical evaluation of the students. One COE developed and implemented a standardized patient case to assess students' level of cultural and linguistic competence. Another COE completed a formative and summative evaluation of each student's clinical ability.

One COE's promising practice evaluation activity involves the evaluation of resident cultural and linguistic competency using standardized patients. Standardized patients were trained and subsequently treated in resident clinics. Although the residents agreed via informed consent forms to be visited by a standardized patient, they did not know when the patient would visit. The activity was evaluated by comparing the results of the standardized patient's ratings across each resident group (first and third years) and the results for those residents tested as both first and third years will be compared to determine if their ratings improved after a cultural and linguistic competency workshop, computer module, and seminar.

Other evaluation. COEs performed evaluations for other programs. One COE designed a survey to determine faculty perceptions of the need for diversity training, the issues that such a program would address, the preferred method of delivery, and the potential participation of faculty. Another COE had faculty development program participants complete pre- and post-training questionnaires. This evaluation was both formative and immediate impact.

The *impact evaluation* category tracks the long-term effect of the programs. Different from summative evaluations, impact evaluations are broader and measure the overall effect, intended or otherwise, of the program as a whole (Trochim, 2000). Only one COE conducted a tracking survey for its Hispanic/Latino COE scholars who have completed their training and are now in academic positions.

Conclusion

The assessment results and the promising practices reveal that the COEs have been engaging in a broad array of activities consistent with their legislative mandate and as providers of cultural and linguistic competency training. As may be expected, the topic taught with the most frequency among the 29 COEs was "Different Population Groups." This topic includes the general health-related and cultural beliefs of an ethnic group, as well as instruction on diversity and multiculturalism. In addition, the teaching method the COEs employed most was "Classroom-Directed Learning," which includes activities that have been incorporated into the curriculum

either as a required course, elective, or unit in an established course. And finally, the non-teaching method most frequently used was "Research Pertaining to People of Color."

Although the assessment results and promising practices reveal that cultural and linguistic competence has yet to be fully incorporated in the educational process, focus group participants had wanted to see COEs progress to this level. As participants remarked, however, resources are often sparse for cultural and linguistic competency initiatives. Focus group participants also expressed a desire for the dissemination of the efforts of the various COEs. The inclusion of this COE Assessment and Promising Practices Report within the cultural and linguistic competency curriculum guide would be part of achieving that goal and a way to overcome the competitiveness that hinders the sharing of information between COEs.

The promising practice highlights the degree to which COEs have been able to develop their curricula. The vast majority of reported practices reveal the variety of approaches COEs have employed in teaching cultural and linguistic competency. Community based research and practice, immersion activities, raising awareness of disparities, and other such practices represent promising models, which, if properly adopted, can greatly enhance a school's curriculum.

ASSESSMENT RESULTS: CONTENT BY AUDIENCE

	Different Population Groups	Clinical Practice Issues	Communication, language and health literacy issues	Community, Public Health Issues	Health and illness-related topics	Other	Ethnopharmacology	Substance Abuse Related Topics	Complementary, Alternative, Integrative Medicine	TOTAL
Students	Activities: 32 COEs: 18	Activities: 9 COEs: 8	Activities: 8 COEs: 5	Activities: 6 COEs: 5	Activities: 4 COEs: 4	Activities: 1 COEs: 1	Activities: 1 COEs: 1	Activities: 1 COEs: 1	Activities: 1 COEs: 1	Activities: 63 COEs: 21
Residents	Activities: 1 COEs: 1	Activities:1 COEs: 1								Activities: 2 COEs: 1
Fellows										
Faculty	Activities: 3 COEs: 3		Activities: 1 COEs: 1			Activities: 2 COEs: 2				Activities: 6 COEs: 5
Staff										
Managers										
Deans/Leaders										
COE-wide										
Community-wide	Activities: 2 COEs: 2									Activities: 2 COEs: 1
TOTAL	Activities: 38 COEs: 20	Activities: 10 COEs: 9	Activities: 9 COEs: 5	Activities: 6 COEs: 5	Activities: 4 COEs: 4	Activities: 3 COEs: 3	Activities: 1 COEs: 1	Activities: 1 COEs: 1	Activities: 1 COEs: 1	Activities: 73 COEs: 21

ASSESSMENT RESULTS: CONTENT BY COE TYPE

COE Type	Different Population Groups	Clinical Practice Issues	Communication, language and health literacy issues	Community, Public Health Issues	Health and illness-related topics	Other	Ethnopharmacology	Substance Abuse Related Topics	Complimentary, Alternative, Integrative Medicine	TOTAL
African American	Activities: 2 COEs: 2		Activities: 2 COEs: 2				Activities: 1 COEs: 1	Activities: 1 COEs: 1		Activities: 6 COEs: 2
American Indian	Activities: 9 COEs: 4									Activities: 9 COEs: 4
Hispanic	Activities: 15 COEs:7	Activities: 6 COEs: 5	Activities: 7 COEs: 4	Activities: 3 COEs: 2	Activities: 1 COEs: 1	Activities: 1 COEs: 1			Activities: 1 COEs: 1	Activities: COEs: 8
Native Hawaiian	Activities: 1 COEs:1	Activities: 1 COEs: 1								Activities: 2 COEs: 1
Other	Activities: 11 COEs: 6	Activities: 3 COEs: 3		Activities: 3 COEs: 3	Activities: 3 COEs: 3	Activities: 2 COEs: 2				Activities: 22 COEs: 8
TOTAL	Activities: 38 COEs: 20	Activities: 10 COEs: 9	Activities: 9 COEs: 5	Activities: 6 COEs: 5	Activities: 4 COEs: 4	Activities: 3 COEs: 3	Activities: 1 COEs: 1	Activities: 1 COEs: 1	Activities: 1 COEs: 1	Activities: 73 COEs: 21

ASSESSMENT RESULTS: TEACHING DELIVERY/METHODS BY AUDIENCE

Audience	Classroom-directed learning	Community Immersion	Precepting/ Clerkships	Seminars/ Lectures	Workshops/ Trainings	Case Studies	Journal Club	Web directed learning	Grand Rounds	Experiential Small Groups	Other	TOTAL
Students	Activities: 22 COEs: 14	Activities: 15 COEs: 14	Activities: 13 COEs: 13	Activities: 5 COEs: 5	Activities: 3 COEs: 3	Activities: 5 COEs: 5	Activities: 3 COEs: 3	Activities: 1 COEs: 1	Activities: 2 COEs: 2	Activities: 2 COEs: 2	Activities: 1 COEs: 1	Activities: 72 COEs: 25
Residents	Activities: 2 COEs: 2	Activities: 1 COEs: 1		Activities: 1 COEs: 1	Activities: 1 COEs: 1							Activities: 5 COEs: 4
Fellows	Activities: 1 COEs: 1											Activities: 1 COEs: 1
Faculty	Activities: 1 COEs: 1			Activities: 2 COEs: 2	Activities: 4 COEs: 3							Activities: 7 COEs: 5
Staff				Activities: 1 COEs: 1								Activities: 1 COEs: 1
Managers												
Deans/ Leaders												
COE-wide								Activities: 2 COEs: 2				Activities: 2 COEs: 2
Community-wide				Activities: 2 COEs: 1								Activities: 2 COEs: 1
TOTAL	Activities: 26 COEs: 17	Activities: 16 COEs: 14	Activities: 13 COEs: 13	Activities: 11 COEs: 7	Activities: 8 COEs: 6	Activities: 5 COEs: 5	Activities: 3 COEs: 3	Activities: 3 COEs: 3	Activities: 2 COEs: 2	Activities: 2 COEs: 2	Activities: 1 COEs: 1	Activities: 90 COEs: 25

ASSESSMENT RESULTS: TEACHING DELIVERY/METHODS BY COE TYPE

COE Type	Classroom-directed learning	Community Immersion	Precepting/Clerkships	Seminars/Lectures	Workshops/Trainings	Case Studies	Journal Club	Web directed learning	Grand Rounds	Experiential Small Groups	Other	TOTAL
African American	Activities: 3 COEs: 2	Activities: 1 COEs: 1		Activities: 1 COEs: 1	Activities: 1 COEs: 1		Activities: 1 COEs: 1	Activities: 1 COEs: 1				Activities: 8 COEs: 2
American Indian	Activities: 4 COEs: 3	Activities: 1 COEs: 1	Activities: 2 COEs: 2			Activities: 1 COEs: 1		Activities: 1 COEs: 1			Activities: 1 COEs: 1	Activities: 10 COEs: 4
Hispanic	Activities: 12 COEs: 6	Activities: 8 COEs: 6	Activities: 4 COEs: 4	Activities: 7 COEs: 3	Activities: 4 COEs: 2	Activities: 2 COEs: 2			Activities: 1 COEs: 1	Activities: 1 COEs: 1		Activities: 39 COEs: 8
Native Hawaiian	Activities: 1 COEs: 1	Activities: 1 COEs: 1										Activities: 2 COEs: 1
Other	Activities: 6 COEs: 5	Activities: 5 COEs: 5	Activities: 7 COEs: 7	Activities: 3 COEs: 3	Activities: 3 COEs: 3	Activities: 2 COEs: 2	Activities: 2 COEs: 2	Activities: 1 COEs: 1	Activities: 1 COEs: 1	Activities: 1 COEs: 1		Activities: 31 COEs: 10
TOTAL	Activities: 26 COEs: 17	Activities: 16 COEs: 14	Activities: 13 COEs: 13	Activities: 11 COEs: 7	Activities: 8 COEs: 6	Activities: 5 COEs: 5	Activities: 3 COEs: 3	Activities: 3 COEs: 3	Activities: 2 COEs: 2	Activities: 2 COEs: 2	Activities: 1 COEs: 1	Activities: 90 COEs: 25

ASSESSMENT RESULTS: NON-TEACHING DELIVERY/METHODS BY AUDIENCE

Audience	Research pertaining to People of Color	Recruiting	Develop-ment	Resource Building for Minority Health Issues	Curriculum Develop-ment	Mentoring	Other	Fellowships	Hiring Practice Protocols	TOTAL
Students	16	14	9		3	4	3	1		21
Residents		1								1
Fellows		2				1				3
Faculty	10	13	15						1	23
Staff										
Managers										
Deans/ Leaders										
COE-wide	2			14	3					17
Community-wide				1						1
TOTAL	19	21	18	15	6	5	3	1	1	25

The numbers in the cells represent the total number of COEs that participate in an activity.

ASSESSMENT RESULTS: NON-TEACHING DELIVERY/METHODS BY COE TYPE

COE Type	Research pertaining to People of Color	Recruiting	Development	Resource Building for Minority Health Issues	Curriculum Development	Mentoring	Other	Fellowships	Hiring Practice Protocols	TOTAL
African American	2	2		1	2					2
American Indian	3	4	2	1	1					4
Hispanic	6	7	6	5		2	2	1	1	7
Native Hawaiian			1	1	1					1
Other	9	7	9	6	3	3	1			11
TOTAL	20	20	18	14	7	5	3	1	1	25

The numbers in the cells represent the total number of COEs that participate in an activity.

ASSESSMENT RESULTS: EVALUATION BY AUDIENCE

Audience	Curriculum	Clinical Performance Evaluation	Other	Impact Evaluations	TOTAL
Students	3 (Formative: 2, Immediate: 1)	2 (Formative, Form/Summ)			5 (Formative: 3, Immediate: 1, Form/Summ: 1)
Residents					
Fellows					
Faculty			2 (Formative, Formative/immed)	1	3 (Formative: 1, Formative/Immed: 1)
Staff					
Managers					
Deans/Leaders					
COE-wide					
Community-wide					

F: Formative
I: Immediate
S: Summative

The numbers in the cells represent the total number of COEs that participate in an activity.

ASSESSMENT RESULTS: EVALUATION BY COE TYPE

COE Type	Curriculum	Clinical Performance Evaluation	Other	Impact Evaluations	TOTAL
African American					
American Indian	1 (Formative)				1 (Formative)
Hispanic	2 (Formative, Immediate)	1 (Form/Summ)	2 (Formative, Formative/Immed.)	1	6 (Formative: 2, Immediate: 1, Formative/ Immed: 1)
Native Hawaiian					
Other		1 (Formative)			1 (Formative)
TOTAL	3 (Formative: 2, Immediate: 1)	2 (Formative: 1 Form/Summ: 1)	2 (Formative, Formative/Immed.)	1	

F: Formative
I: Immediate
S: Summative

The numbers in the cells represent the total number of COEs that participate in an activity.