

Cultural Competence in Healthcare

Self-Learning Packet 2008

This self-learning packet is approved for 2 contact hours for the following professionals:

1. Registered Nurse
2. Licensed Practical Nurse
3. Respiratory Therapist
4. Radiology (1.5 hours- personal development)
5. Surgical Tech
6. Advanced Clinical Tech
7. Licensed Clinical Social Workers, Licensed Mental Health Therapists, and Licensed Marriage and Family Therapists
8. Certified Nursing Assistants (1.0 in-service hours)



When it matters most.



STUDY OBJECTIVES:

After reading “*Cultural Competence in Healthcare*” the reader will be able to:

1. Clearly define cultural competence;
2. Comprehend and be able to identify six primary reasons for seeking to become a culturally competent caregiver;
3. Define and describe CLAS Standards;
4. Identify existing skills in cultural competence as well as opportunities for development;
5. Understand and know how to properly utilize interpretation services;
6. Have a basic understanding of how cultural differences impact patients’ and families’ view of pain, food & nutrition, death and dying and grief.

INSTRUCTIONS

In order to receive 2.0 contact hours, you must:

- complete the posttest at the end of this packet
- achieve an 84% on the posttest

For Non-ORH employees: Complete the test using the bubble sheet provided. Be sure to complete all the information at the top of the answer sheet. You will be notified if you do not pass, and you will be asked to retake the posttest.

Return to: ORH Education & Development, MP14, 1414 Kuhl Ave, Orlando, FL 32806

For ORH Team Member: Please complete testing via Online Testing Center. Log on to: SWIFT → Departments → E-Learning → Testing Center. Use your ORH Network Login and password. Select “SLP” under type of test; choose correct SLP Title. Payroll authorization is required to download test.

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Let the Journey Begin...

SECTION ONE

Understanding Cultural Competence

WHAT IS CULTURAL COMPETENCE?

And what does it mean to become a culturally competent caregiver in healthcare?

Is it really that important? If so, *why*?

And if it is indeed important, how does one go about becoming culturally competent?

Is learning another language required?

Do I need to know everything about every culture to be an effective employee?

*T*he purpose of “The Journey Toward Cultural Competence” is to discover questions like these and to provide some meaningful information and tools to prepare the caregiver as they make every effort for cultural competence.

Cultural Competence Defined

*T*o begin this important journey, we will first clearly define the destination. How is “culture” defined? And how will the word “competence” be used in the framework of this document? Finally, what is “cultural competence” in healthcare?

The Department of Health and Human Services Office of Minority Health (OMH) offers the following definitions of “culture” and “competence”:

Culture refers to patterns of human behavior that include language, thoughts, communications, actions, customs, beliefs, values and the society of racial, ethnic, religious or social groups.

Competence suggests having the ability to work well as an individual and an organization within the setting of cultural beliefs, behaviors and needs presented by patients and family members within their communities.

In general terms, **cultural competence** in healthcare refers to the ability of a healthcare employee and/or health organization to provide consistent successful care to patients of any race, ethnicity or culture. These broad definitions will serve as the anchors for the rest of this self learning packet. Keeping this in mind let’s now think about the reasons why becoming culturally competent are important to our success as healthcare providers.

Six Reasons to Seek Cultural Competence

1. Changing Demographics Demand It

The population of the United States has changed over the past ten years as the numbers of minority *and people* born in different countries have increased a great deal. In fact, according to 2000 Census data, the number of Americans who speak a language other than English has increased by 48% between 1990 and the year 2000, representing more than 47 million people in the United States.

Here in the State of Florida, 2000 Census data shows that more than one third of the population belongs to different races or ethnic minority groups. In addition, 23% of Florida's population speaks languages other than English in their homes. Looking closer at Central Florida there is a slightly higher percentage of residents (24%) that speak languages other than English in their homes. In addition, 18% (including approximately half of Spanish speakers) spoke English "less than well". The Census also demonstrates that many of those with limited English proficiency (LEP) are elderly with low health literacy or knowledge *even in their native languages*.

The Urban Institute and Kaiser Commission on Medicaid and the Uninsured resulting estimates from more recent Census data indicates a similar trend mid-way through the first ten years of the millennium. Based on this data, we see that by 2005-2006, nearly 40% of Florida's population belonged to racial or ethnic minority groups. As a Nation, more than 1/3 of the population is classified as minority (see Table 1).

Population by Race/Ethnicity		
Florida (2005-2006 data)		
US (2006 data)		
Race/Ethnicity	FL %	US%
White	61%	66%
Black	15%	12%
Hispanic	21%	15%
Other	3%	7%
Total	100%	100%

TABLE 1

The shift toward a more culturally diverse society has a clear impact for all professional caregivers nation-wide seeking to provide quality healthcare that meets the unique needs of the diverse patient populations they serve.

2. Quality Patient Care Requires It

While most healthcare skilled employees would deny any effect of treatment with patients from minority population groups, the reality is that a large body of research over the past ten years shows that racial and ethnic gap *does in fact exist* in how healthcare is made available. One of the most well-known studies was published in 2003 by the Institute of Medicine in a report entitled "*Unequal Treatment: Confronting Racial and Ethnic Disparities in Healthcare*." This important report stated that minority population groups are less likely to receive equal health services in comparison to the Caucasian population- (to include medically necessary procedures) even when other factors such as insurance and ability are equal. *Unequal Treatment* also points out that cultural bias by healthcare practitioners can affect clinical decision-making, leading to healthcare inequality based on race and ethnicity.

Examples of healthcare inequality for various racial and ethnic minorities have been well-documented. To name a few:

- African-Americans may be less likely to be referred for treatment for cardiac symptoms than their Caucasian population even when they express the same symptoms. This can be particularly true for African-American women.
- The asthma mortality rate for Hispanics/Latinos is double the mortality rate for Caucasian Americans.
- Of the 1.25 million Americans living with chronic hepatitis B infection, approximately half are Asian American. In 2002, the hepatitis B-related death rate among Asian Americans was six times higher than the rate among Caucasians.

Researchers have identified factors which may contribute to such health inequality, including (but not limited to) language barriers, lack of cultural abilities among healthcare providers, patient non-compliance, etc. More research is needed to objectively determine why these gaps exist and how we can “level the playing field” for every patient, regardless of race, ethnicity or culture. One thing is clear: healthcare employees at every level must develop skills related to working with patients from different cultures and in the end, change practice patterns (e.g. interpreter services, etc.) to undo unequal healthcare across all ethnic, racial and cultural lines.

3. Legislative and Regulatory Bodies Dictate It

A. Legislative Mandates

The historic Title VI of the Civil Rights Act of 1964 states:

No person in the U.S. shall, on the grounds 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.

The Civil Rights Act provides the basic expectation of all healthcare providers to offer equal treatment to all patients, regardless of race, color or national origin. Unfortunately, the studies located in the previous section shows the nation’s healthcare organizations are falling short of the goal of equal treatment.

In the year 2000 President Bill Clinton signed into law Executive Order 13166 bringing much greater focus and definition to Title VI (refer to Appendix “A”). This executive order requires:

“Improved access to services for persons with Limited English Proficiency (LEP),” offering “meaningful access to federally conducted and funded programs.”

Later that same year, the Department of Health & Human Services Office of Minority Health (OMH) published 14 standards specific to providing healthcare to a culturally diverse population. These standards, called the National Standards for Culturally and Linguistically Appropriate Services in Healthcare (CLAS) spells out clear expectations about providing culturally and linguistically appropriate health services. CLAS standards were created to eliminate racial and ethnic inequality in healthcare.

The 14 standards are broken down into three categories:

- Culturally Competent Care,
- Language Access Services,
- Organizational Supports for Cultural Competence.

Out of these standards, four are *mandated* for organizations receiving federal funding. These federally required standards all relate to the user-friendliness of language services. Nine of the remaining *guidelines* are recommended for future adoption as mandates by Federal, State and accrediting agencies. The remaining standard is a *recommendation* for adoption by healthcare organizations. Table 2 below lists the four mandated standards which all relate to language access services.

**Summary of Four Federally Mandated National Standards for
Culturally and Linguistically Appropriate Services in Healthcare (CLAS)**

Adapted from Culturally Competent Healthcare Systems: A Systematic Review, Anderson, L. (2003)

Language access services

Standard 4. Healthcare organizations must offer and provide language assistance services, including bilingual staff and interpreter services, at no cost to each patient or consumer with limited English proficiency at all points of contact, in a timely manner during all hours of operation.

Standard 5. Healthcare organizations must provide to patients or consumers in their preferred language both verbal offers and written notices informing them of their right to receive language assistance services.

Standard 6. Healthcare organizations must assure the competence of language assistance provided to limited English proficient patients or consumers by interpreters and bilingual staff members. Family and friends should not be used to provide interpretation services (except on request by the patient or consumer).

Standard 7. Healthcare organizations must make available easily understood patient-related materials and post signage in the languages of the commonly encountered groups or groups represented in the service area.

Table 2

For a complete summary of the 14 CLAS standards, see Appendix “B”.

B. Regulatory Requirements

In addition, accreditation and regulatory agency requirements also highlight the need to effectively address cultural competency. The Joint Commission, the primary regulatory agency for healthcare institutions in the US developed standards for providing culturally competent healthcare. For example, Joint Commission standard R 1.2.100 clarifies the right to and the need for effective communication, stating:

“The (patient, resident, client) has the right to receive information in a manner that he or she understands. The Joint Commission also requires that healthcare organizations facilitate provisions of interpretation and translation services as needed.”

Addressing the culturally diverse needs of our patients is not optional, but it is to some extent mandated by federal law, and it is required by healthcare regulatory and accreditation agencies such as the Joint Commission. Moreover, it is the right thing to do.

4. Risk Management Calls for It

Healthcare workers and organizations must carefully consider the legal implications of providing - or not providing, as the case may be – healthcare that is considerate of the needs of a diverse patient population. Patient care that does not look to the needs of a culturally diverse patient population can create a legal burden for healthcare organizations. Consider, for example, the obvious impact of failing to provide timely and effective interpretation services to a patient whose knowledge of English is limited. What factors are affected when the patient can neither fully understand his or her caregivers nor adequately communicate their symptoms, concerns, medical history and other relevant information? A 2003 report on cultural and linguistic competence in healthcare sites several potential liabilities:

“Lack of awareness about cultural differences and failure to provide appropriate 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, healthcare 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 patient’s failure to follow instructions because they conflict with values and beliefs may raise a presumption of negligence on the part of the provider.” (Good, T, Dunne, C & Bronheim, S. (2006).

While the avoidance of liability is not the primary motivation for providing culturally competent care, it remains a very relevant consideration and its importance cannot be minimized. In a healthcare climate in which resources are limited, avoiding unnecessary legal action is essential.

5. A Competitive Market Requires It

Today's healthcare market is more competitive than ever. In an era of reduced reimbursement, growing demand and shrinking budgets, capturing market share is vital to every healthcare organization's survival. For any business, large or small, not-for-profit or for profit, knowing the customers you serve, identifying their particular needs and preferences and identifying effective tactics for meeting those specific needs is essential for long-term success. If healthcare organizations fail to take the time and initiative necessary to understand and meet the diverse needs of the patient population of the markets they serve, they can be sure a competitor will. From an economic point of view, lost market share equals lost revenue in a very competitive healthcare environment.

A 2007 report by Alliance of Community Health Plans Foundation and the Merck Foundation took an interesting look at the business case for implementing CLAS standards. In their review of 42 case studies of organizations that had established plans tied to at least one CLAS standard, they found 13 organizations achieved increased market share, measurable cost savings and/or greater effectiveness in the delivery of care

While putting into action culturally appropriate services may not always give way to direct and measurable financial benefits, there are certainly opportunities to explore cost savings, throughput and process improvements.

6. Patient Satisfaction Depends on It

The Picker Institute and Harvard University conducted ten years of research to find out what factors influence patient satisfaction. They surveyed 8000 patients and healthcare professionals to learn what mattered most to them in a healthcare setting. Their research identified eight "Dimensions of Care" including: emotional support, physical comfort, respect, coordination and integration of care, information and education, involvement of family and friends and access to care.

Each of these "dimensions" is strongly influenced by cultural beliefs and practices. Consider, for example, the impact of culture on the expression of pain. A Chinese patient may be reluctant about expressing his or her true level pain while a Hispanic patient with the same level of pain may be very vocal and physically demonstrative. Either response could be misinterpreted without a culturally proficient caregiver to listen and respond appropriately to each patient's needs. Listening to, communicating with, and responding to patients in a culturally sensitive manner facilitates mutual understanding and is a key factor for increasing patient satisfaction and ultimately, health outcomes.

SECTION TWO

Becoming Culturally Competent From the Inside Out

Developing Culturally Competent Skills

Developing in the arena of cultural competence – for individual caregivers as well as healthcare organizations - is an ongoing developmental process.

Here are two ways you can develop your skills.

A. Take an Honest Self Inventory

One of the most important first steps in the journey toward cultural competence is taking an honest “self inventory” of one’s own beliefs about culture. Developing an accurate **self awareness** about our assumptions, attitudes and potential biases as well as self-assessing our skills, strengths and opportunities in the area of cultural competence will provide a strong foundation upon which to build.

Self awareness is simply defined as *having or showing awareness, perception, or knowledge about one's own personality or individuality*. It can also be defined as *having a true picture of who you are as a person and understand the impact you have upon those around you*. One of the greatest challenges of cultural competence is recognizing that some part of our personality and/or methods of healthcare practice will be positively received by patients from one culture but may have the absolute opposite effect on those from another. This isn’t a personal thing. It is not right or wrong. It is just a fact. Developing an accurate “cultural self awareness” and recognizing the need to adapt our style of relations based on the cultural preference and beliefs of patients is a trait of culturally competent care-giving.

Self assessment of cultural competencies is an important exercise for determining existing skills as well as identifying areas needing further development. How aware are you of your own skills and knowledge related to working with patients from various cultures? While many assessments tools exist, two examples are listed below for your benefit:

Georgetown University’s National Center for Cultural Competence developed *The Cultural Competence Health Practitioner Assessment* to assess the healthcare practitioner’s level of cultural knowledge in six areas, including, 1) Values and Belief Systems; 2) Cultural Aspects of Epidemiology; 3) Clinical Decision-Making; 4) Life Cycle Events; 5) Cross-Cultural Communication and 6) Empowerment/Health Management. It is a strengths-based, non-judgmental model, designed to foster individual growth and enhance the caregiver’s ability to deliver culturally and linguistically competent services. To assess your level of cultural knowledge, go to: <http://www11.georgetown.edu/research/gucchd/nccc/features/CCHPA.html>

The Provider’s Guide to Quality and Culture also offers an online self assessment of cultural competence through a series of 23 questions. It can be found at: <http://erc.msh.org/mainpage.cfm?file=1.0.htm&module=provider&language=English>

In short, to prepare for the journey toward becoming a highly competent healthcare provider, take the time to identify and reflect on your own assumptions about yourself and others. Ask yourself, “How do my attitudes, assumptions and actions impact patients, families and team members from backgrounds that differ from my own?” Then assess your existing skill set and identify potential barriers to your success as a culturally competent caregiver. “Self inventory” exercises like the ones referenced above are useful tools that can assist you in mapping out your own road toward cultural competence.

B. Take Initiative to Participate in Ongoing Educational Opportunities

The Nation’s demographic “personality” has shifted substantially over the past twenty years spawning what some refer to as the cultural competence movement. As a result of this surge of interest, a host of educational resources and opportunities – many at no cost - are now available. Drawing on these resources and taking some very practical steps will help to strengthen and develop cultural competence skills (see Appendix “C” for suggested educational opportunities).

Achieving growth in the area of cultural competence takes initiative, hard work and commitment to learning about those who are different from oneself on an ongoing basis. The fact that you are reading *The Journey to Culturally Competent Care* indicates you have a built-in motivation to deepen your understanding and to develop growth in this important arena.

The next section offers some very practical tips for delivering culturally competent care.

SECTION THREE

Tips and Tools for Effective Cross-Cultural Communication

Tools of the Trade

In order to provide patient care in a culturally competent manner, effective communication must take place. The two primary means of communication are verbal (speech) and non-verbal (body language) – both of which are equally important for clinicians to note.

A. Verbal Communication

Patients and their families often become anxious when working with people in medical roles. This anxiety is more complex when there is also a language barrier. This barrier may be addressed through the use of medical interpreters, bilingual clinicians and other language assistance tools available today.

BEST PRACTICES

When using an interpreter the clinician should:

- Brief the interpreter before meeting with the patient/family.
 - Explain the purpose of the meeting, the interpreter’s role, and the physical set-up of the room.
 - Warn the interpreter ahead of time if he/she will be discussing end-of-life issues and/or using the word “dying”.
 - Emphasize that his/her statements should not be changed and that if a statement cannot be translated directly, the interpreter should alert him/her to rephrase.
- Together with the interpreter, plan to be at eye level with the patient and directly face the patient while speaking.
 - Avoid the tendency for the patient and provider to give the appearance of speaking to the interpreter, rather than to each other.
 - When at the bedside, you and the interpreter should be on the same side of the bed next to each other to prevent unnecessary turning of the patient’s head from side to side.
- Keep sentences and questions concise.
- Avoid saying to the interpreter, *Ask him...* or *Tell her....* Speak directly to the patient using the first person: “I am here today to talk to you about...”
- Do not tell the interpreter, “Do not translate this...” Professional interpreters are required to interpret all information that is provided as outlined in their code of ethics.
- Resist the tendency to raise your voice when trying to communicate with someone who speaks a different language.
- Pause at the end of each statement to allow the interpreter time to interpret.

- Pay attention to non-verbal clues that indicate the patient/family is confused or that your comments were misinterpreted (i.e., puzzled look, raised brow). Stop and clarify that the interpreter and patient/family have understood the information.
- Following the interview give the interpreter an opportunity to ask you questions or make comments about the encounter.

When using bilingual staff to interpret for a patient, the clinician should:

- Ensure the same principles used by professional interpreters are followed by bilingual clinicians (who have equal proficiency in both English and the foreign language being interpreted).
- Contact your Language Services department for a list of qualified internal interpreters or ask your manager for qualified interpreters within your department.

B. Non-Verbal Communication

Body language and non-verbal behavior are important details to note. They can make an important difference in those situations where you have no language or cultural background in common with your patient. A large percentage of the relationship between patient and clinician is the result of non-verbal language. It is therefore important to be aware of non verbal cues, which may be misunderstood.

BEST PRACTICES

EYE CONTACT

While some Latin American cultures consider eye contact to be disrespectful or inappropriate, Latin American populations from different countries eye contact will be appreciated. European Americans typically encourage members to look people in the eye when speaking to them; other American populations may consider this disrespectful or impolite (e.g. some Asian and Native American groups). Some Muslim groups may consider eye contact inappropriate between men and women. What would be the best response? Observe and listen to the patient when they are speaking to get clues regarding appropriate eye contact.

LACK OF EYE CONTACT

While listening without eye contact means respect and concentration to a number of Asian patients; listening without eye contact is disrespectful for the western cultures. The clinician should ask the patient for more detail about a patient's concerns if they observe a lack of eye contact.

NODDING

When Limited English Proficient (LEP) patients repeatedly nod with a subtle nervousness it sometimes means they are listening intently but don't understand. Ask more questions and encourage demonstration to determine if they understood.

SMILE

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 or not appreciated.

TOUCH

While physical touch is an important form of non-verbal communication, the etiquette of touch is highly variable across and within cultures. For instance warm and polite physical touch is considered a sign of empathy by most international patients. However, some Muslim and Orthodox Jews consider male/female physical contact out of place no matter how well intended.

PACE OF CONVERSATION

Some cultures are comfortable with long periods of silence, while others are fast paced and consider it appropriate to speak before the other person is finished talking.

PHYSICAL DISTANCE

In general, individuals from some cultures (i.e., Northern European) prefer to be about an arm's length away from another person, while those from some other cultures prefer closeness (i.e., some Hispanic cultures) or greater distance (i.e., some Asian cultures).

EMOTIONAL EXPRESSIVENESS

Some cultures value expressionless appearance (i.e., British); while others encourage open expressions of feelings, such as sorrow, pain, or joy. Elders from some backgrounds may laugh or smile to mask other emotions (i.e., Japanese, Thai, and Chinese).

BODY MOVEMENTS

Body motion can be easily misinterpreted based on what is considered culturally appropriate. Individuals from some cultures may consider some types of finger pointing or other typical American hand gestures or body postures disrespectful or obscene (i.e., Filipino, Chinese, Thai, Iranian), while others may consider forceful hand shaking as a sign of aggression (i.e., some American Indian) or a sign of good will (i.e., European).

C. Technology Based Communication

Because there are times when interpreters are not available, technology can allow use of an off-site interpreter who interprets and relays through headphones to both the physician and the patient. Video and telecommunication may become prominent in the future as an alternative to on-site interpreters. Last, telephonic interpreting can provide an immediate 24/7 solution offering access to over one hundred languages at a reasonable cost.

BEST PRACTICES

- Contact your IT department to find out the type of phone lines within your facility (i.e., analog or digital). This will determine what type of telephonic devices may be compatible to the existing phone system.
- Select several technology-based language assistance tools in order to provide your staff a choice of services.

D. Other Communication Facts and Tips

BEST PRACTICES

- Even when the patient and the healthcare provider speak the same language, if their cultural background is different, their response to the clinical experience may be considerably different.
- The cost of translation services is not the responsibility of the patient. The US Department of Health and Human Services, in its March 2001 *National Standards for Culturally and Linguistically Appropriate Services in Health Care: Final Report*,⁷ established 14 national standards, several of which concern services for individuals with limited English proficiency. Standard 4 states that "health care organizations must offer and provide language assistance services, including bilingual staff and interpreter services, at no cost to each patient/consumer with limited English proficiency at all points of contact, in a timely manner during all hours of operation."
- All communication is cultural – it draws on ways we have learned to speak *and* give non-verbal messages.
- Culture influences what we see, how we perceive, and how we express ourselves.
- Learn from cultural generalization but do not use them to stereotype.
- Do not assume all English speaking clients have the same belief system concerning healthcare.
- Do not assume there is only one “right” way to communicate (i.e., yours). Remember, different does not equal wrong. It is simply different.

SECTION FOUR

Cultural Sensitivity and Awareness Facts

History and Tips for Effective Cross-Cultural Communication

A. The Pain Experience

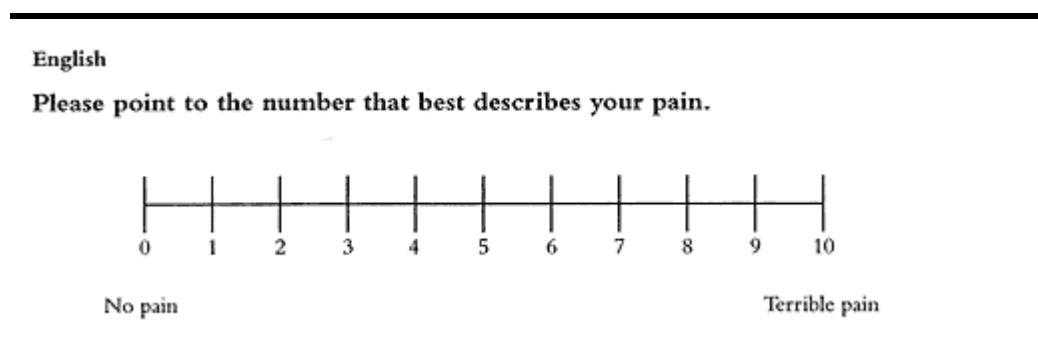
Culture has a huge influence on patients' illness behaviors, healthcare practices, help-seeking activities, and interest to medical care interventions. In this section we will highlight five areas commonly impacted by culture.

Social, cultural and psychological factors will determine whether private pain is spoken or not, how it will be expressed, the social setting where it will occur, and the response of others to the person's pain experience.

Admitting different cultural beliefs may help us know what to expect from each culturally distinct group and the best ways to approach and target services. For example, culturally, we expect Hispanics to dramatize pain and suffering, Asians to repress it, Jews to report it, and the White Anglo-Saxon Protestant population to rely on technology to address it. One group will express pain, expecting the family to take care of them without outside help. Another will keep the pain a secret even from the family and refuse to be cared for by medical practitioners. Still another will report the pain and seek outside help rather than impose on any member of their family.

Both patients and healthcare professionals bring their own cultural attitudes to the communication and interpretation of the patient's pain experience. Thus, in this interaction, it is the healthcare professional's responsibility to know how to interpret the expression of pain based on an educated understanding of culture.

In Table 2: below you will see two examples of pain assessment scales. These scales should be translated in several languages to cover the patient populations your facility serves.



Wong-Baker FACES Pain Rating Scale



B. Family Dynamics

Family dynamics differ from one culture to the next. In a number of cultures, the male head of household makes the decisions for the family. He may also expect to be present for the medical examinations of family members. Often, he will be the one to answer your questions. In these families, if the male is not present during a family member's assessment, decisions about medical procedures may be delayed. Therefore, you will want to include him during the plan of care. You will also need to create an opportunity to talk with the patient alone, so that you can learn more about his/her personal concerns and beliefs.

In other cultures, it may be an older female in a large extended family that plays an important role in presenting information to the rest of the family. Also, some cultures may have large numbers of visitors during a patient's hospitalization while others may include only immediate family. Thus, clinicians must take great care in asking the patient *from the beginning* about who will be making the healthcare decisions and or who will be communicating the same to other family members. Once decisions are made by the patient, a designated member of the family or by the family of the patient as a unit; patient care should reflect patient satisfaction. As a result, communication with the family will be more likely to be stress free and cordial.

C. Food and Nutrition

A person's culture or religion may affect the types of food that are unacceptable or preferred during illness. In some cultures, the temperature of the food is important. Hot foods are regarded as helpful for some conditions and cold foods helpful for others.

Observers of the Hindu religion do not eat beef because cows are considered sacred. Many are also vegetarians. Additionally, it is very important not to give food to a Hindu patient with the left hand, since this hand is considered unclean.

Some persons of the Jewish faith eat only kosher foods, which require special preparation, avoid mixing certain foods together, and ban eating of specific foods such as pork. Therefore, if a healthcare provider discovers that a Jewish patient was given pork chops in error, the entire meal must be removed. Just taking away the pork chops from the plate and replacing it with beef would be unbearable to this patient.

In all cases, healthcare providers must ask patients if they have any special dietary needs and communicate these needs to the Food and Nutrition/Dietary Department of the institution. Patients will then be served meals that are in accordance to their prescribed dietary order and appropriate to their culture and religion.

Please take special thought when you give discharge dietary information to foreign patients. They will follow instructions literally and may not consider exchanging foods or portions if not advised verbally and or in writing.

D. Death and Dying

The patient's spiritual and or religious beliefs can affect how he/she approaches death and the grieving process. For many cultures, there are specific rituals or practices that are important with death or dying patient.

While many religions exist, the following table offers examples of two examples of religions' views on death and dying.

BUDDHISM	CATHOLICISM
<p>Belief about death Death of the physical body is certain, but only a part of an ongoing process of re-incarnation until one receives enlightenment. After death it is believed that the dead person goes through a transformation in which they discover death, and prepare for their rebirth.</p> <p>Funeral practices In early times and commonly today, Buddhists cremate the bodies of their dead. The first seven days after death are the most important leading to the final funeral prayer.</p> <p>Mourning rituals Prayers are said weekly, during a 49-day funeral period. It is during this period that the prayers of the mourners are believed to help the deceased during the post-death transformation and awaken their spirit to the true nature of death.</p>	<p>Belief about death Catholics see death as a passage from this life to the new, everlasting life promised by Christ. The soul of the deceased goes on to the afterlife, which includes Purgatory as well as Heaven and Hell. According to Catholic belief, the bodies of the dead will be resurrected at the end of time. Last rites are provided to individuals during their perceived last hours in an effort to absolve the person of their sins and give them peace prior to their death.</p> <p>Funeral practices The Catholic funeral service is called the Mass of the Resurrection. During it, Jesus Christ's life is remembered and related to that of the deceased. Eulogies are not allowed during the funeral mass, but may be delivered at a wake or other non-religious ceremony. There is also a final graveside farewell, and additional traditions depending on the region. The Church encourages Catholics to be buried in Catholic cemeteries. In 1963, the Vatican lifted the ban on cremation for Catholics. However, the remains must be interred, not scattered or kept at home.</p> <p>Mourning rituals The community and the church support mourners through the funeral mass and through non-religious services such as wakes.</p>

Source: <http://www.Beliefnet.com>

E. Culture and Response to Grief and Mourning

Death, grief, and mourning are normal life events. All cultures have developed ways to cope with death. Interfering with these practices may interfere with the necessary grieving processes.

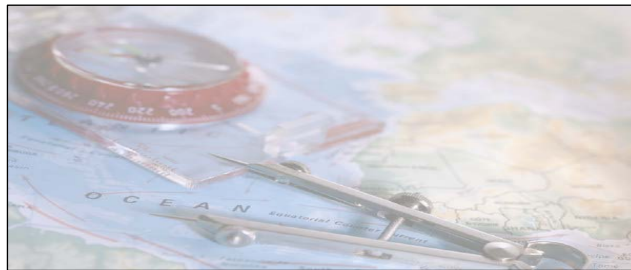
Helping families cope with the death of a loved one includes showing respect for the family's cultural heritage and encourages them to decide how to honor the death. Important questions to keep in mind with families who are dealing with the loss of a loved one include:

- What are the cultural rituals for coping with dying, the deceased person's body, the final arrangements for the body, and honoring the death?
- What are the family's beliefs about what happens after death?
- What are the family beliefs on normal expression of grief and the acceptance of the loss?
- What does the family consider to be the roles of each family member in handling the death?
- Are certain types of death less acceptable (for example, suicide), or are certain types of death especially hard to handle for that culture (for example, the death of a child)?

Understanding different cultures' responses to death and dying can help clinicians provide sensitive, culturally appropriate support to grieving families.

IN SUMMARY

Our hope is that this document has stimulated your thinking and provided you with some meaningful resources to draw upon towards becoming a culturally competent caregiver. It is a lifelong endeavor that requires a personal commitment to do what it takes to provide quality healthcare to all. Enjoy the journey!



CONGRATULATIONS! You have completed The Journey toward Cultural Competence self learning packet.

FINAL INSTRUCTIONS

In order to receive 1.0 contact hours, you must:

- Complete the post test at the end of this packet.
- Achieve an 84% on the post test.

In order to receive 1.0 contact hours, you must:

- complete the posttest at the end of this packet
- achieve an 84% on the posttest

For Non-ORH employees: Complete the test using the bubble sheet provided. Be sure to complete all the information at the top of the answer sheet. You will be notified if you do not pass, and you will be asked to retake the posttest.

Return to: ORH Education & Development, MP14, 1414 Kuhl Ave,
Orlando, FL 32806

For ORH Team Member: Please complete testing via Online Testing Center. Log on to: SWIFT → Departments → E-Learning → Testing Center. Use your ORH Network Login and password. Select “SLP” under type of test; choose correct SLP Title. Payroll authorization is required to download test.

Post Test

Select the *best* answer in the following questions

1. Which of the following statement correctly defines cultural competence?
 - a. Ability of the healthcare employee to know different cultural generalizations.
 - b. Provide consistent effective care to patients of any race, ethnicity or culture.
 - c. Ability to apply personal cultural beliefs to all populations.
 - d. Provide the same patient care you would provide your own mother.

2. You are to explain how cultural diversity effects patient care. Which of the following statements is correct?
 - a. Human beings all have the same basic needs when they are ill.
 - b. Culture can change the individual patient's plan of care.
 - c. Regardless of their culture, patients will adhere to their treatment regimens as long as they understand what is being taught.
 - d. Two patients who speak the same foreign language can be treated alike because of their common culture.

3. Which of the following statements regarding being culturally competent is true?
 - a. As long as you are a medically skilled healthcare provider, you will be culturally competent.
 - b. Only healthcare providers who are members of minority groups can truly be culturally sensitive and are on the way to becoming culturally competent.
 - c. Healthcare providers who are committed seek out cultural education and provide quality services for all patients have most likely started the process for becoming culturally competent.
 - d. Only practicing healthcare providers who complete an accredited college course in world cultures is culturally competent.

4. The demographic changes in the US have changed. Which of the following answer correctly reflect the change?
 - a. The diversity of the population will not change.
 - b. The racial and ethnic groups will become more similar.
 - c. The population classification of Caucasian (white) population will increase.
 - d. The classification of minority racial or ethnic population will increase.

5. How does the demographic and population change impact our delivery of patient care?
 - a. Language barriers and/or inadequate health literacy may be a barrier to patient education.
 - b. There is no difference in how healthcare is provided for minority groups.
 - c. There is no shift culturally diverse society.
 - d. Providing written education in the patient's language is adequate education.

6. What are the findings of recent research published by the Institute of Medicine report in regards to medical treatment of minority population groups?
 - a. Medically necessary procedures are distributed equally
 - b. They are to receive equal health services
 - c. Clinical decisions are made consistently based on race and ethnicity.
 - d. Medically necessary procedures are less likely to be distributed equally.

7. By CLAS standards, when working with a patient that does not speak English, the hospital is required to:
 - a. Give the patient basic English lessons so that she can communicate and understand her treatment options.
 - b. Provide language assistance at no cost
 - c. Find the patient's family so that they can translate and interpret for her.
 - d. Provide language assistance and bill her insurance company.

8. Patient and family members will be billed for language services when the family cannot provide interpretation themselves.
 - a. True
 - b. False

9. If harm comes to the patient because the healthcare provider did not take their cultural and/or language barrier into consideration, the healthcare institution may be held liable.
 - a. True
 - b. False

10. Family members or friends should not be used for interpretation services.
 - a. True
 - b. False

11. What are two ways to develop your personal cultural competency skills?
 - a. Assess your culture on your floor and your community.
 - b. Research and complete a self inventory and attend continuing education on culture.
 - c. Promote an inventory of patient and visitor cultures.
 - d. Educate your patient and staff on culture.

12. You do not have a qualified interpreter available to interpret for the physician. What would be a **best** solution for your problem?
 - a. Call a family member to interpret for you.
 - b. Call a staff member with two years training with the same language.
 - c. Utilize a telephonic interpreter service within your facility.
 - d. Call a friend of the patient to interpret for you.

13. How does culture change what is communicated?
 - a. Non-verbal and spoken words are influenced by culture.
 - b. Stereotyping is useful when trying to learn what is said.
 - c. Cost of interpretation is the responsibility of the patient.
 - d. Assume there is one way to speak within each culture.

14. You have a visitor who does not speak English and you are having difficulty communicating with him. Which of the following suggestions would help you communicate effectively?
- Use gestures since each one has the same meaning universally.
 - Communication will not be a problem as long as he understands that you are providing the best quality care.
 - Follow the hospital's policy regarding obtaining an interpreter as soon as possible.
 - Ask a family member to interpret for you.
15. Which of the following examples demonstrate the correct use of an interpreter?
- When you do not want a patient to hear something instruct the interpreter to not translate it.
 - Raise your voice so that the patient can hear everything you say.
 - To avoid confusion when speaking to the interpreter begin every sentence with "tell him/her."
 - When you are done with the conversation give the interpreter time to ask questions or give comments.
16. Which of the following is a correct statement involving non – verbal communication?
- Physical touch is essential with patient care and is acceptable for all patients.
 - Lack of eye contact is considered a sign of disrespect and should be avoided at all times.
 - Patients with limited English proficiency will nod when they understand.
 - Body movement could be easily misunderstood.
17. Which of the following scenarios BEST demonstrates the non – English speaking patient understood the medication instructions?
- She nods her head up and down after each instruction is discussed.
 - She gives the "Okay" sign with his fingers after hearing the instructions.
 - She speaks via a family member and asks questions.
 - She speaks via a qualified interpreter, and rephrases the instruction.
18. Different cultures have varying ideas about family involvement in patient care therefore you should:
- Consult the head of the family regarding who should be included in decision-making.
 - Research the patient's culture so that appropriate care decisions may be made.
 - Consult the hospital's policy and procedures regarding patient/family involvement in care.
 - Ask the patient to whom information should be given, and who to consult for decision-making.

19. When caring for a patient fresh from surgery how would you meet their cultural and physical needs? Which of the following is the BEST answer?
- Pain only exists if the patient verbalizes it does.
 - An individual's culture influences behavior and help seeking activities.
 - Everyone within a specific culture demonstrate pain the same.
 - Stereotyping culture will help you assess your patient's pain.
20. Your patient was given bacon and scrambled eggs for breakfast. He informs you that his religion does not permit him to eat pork. You would:
- Call the Dietary/Nutrition Department for a new plate of eggs.
 - Remove the bacon from his plate.
 - Replace the bacon with beef side dish.
 - Instruct him to eat only the eggs and leave the bacon on the tray.
21. A patient died and the family has not arrived yet, how would you consider their cultural and religious beliefs?
- Speak to the family members and share with them your beliefs on death.
 - Openly discuss your experience with a loss of a loved one.
 - Arrange for a team member with similar ethnic background to consol the family.
 - Ask the family questions to discover what the wishes and expectations of the family are when dealing with death.
22. Healthcare providers must provide timely language services during all hours of operation.
- Standard 4
 - Standard 5
 - Standard 6
 - Standard 7
23. Healthcare organizations must informing the patient and family members of their right to receive language assistance services in their verbal and written language.
- Standard 4
 - Standard 5
 - Standard 6
 - Standard 7
24. Healthcare organizations must assure the competence of language assistance provided to limited English proficient patients or consumers by interpreters and bilingual staff members. Family and friends should not be used to provide interpretation services (except on request by the patient or consumer).
- Standard 4
 - Standard 5
 - Standard 6
 - Standard 7

25. Healthcare organizations must make available easily understood patient-related materials and post signage in the languages of the commonly encountered groups or groups represented in the service area.
- a. Standard 4
 - b. Standard 5
 - c. Standard 6
 - d. Standard 7

APPENDICES

Appendix A: Executive Order 13166

Press Release of Executive Order 13166

(Source: <http://www.usdoj.gov/crt/cor/Pubs/eolep.htm>)

THE WHITE HOUSE

Office of the Press Secretary
(Aboard Air Force One)

For Immediate Release

August 11, 2000

EXECUTIVE ORDER

13166

IMPROVING ACCESS TO SERVICES FOR PERSONS WITH LIMITED ENGLISH PROFICIENCY

By the authority vested in me as President by the Constitution and the laws of the United States of America, and to improve access to federally conducted and federally assisted programs and activities for persons who, as a result of national origin, are limited in their English proficiency (LEP), it is hereby ordered as follows:

Section 1. Goals.

The Federal Government provides and funds an array of services that can be made accessible to otherwise eligible persons who are not proficient in the English language. The Federal Government is committed to improving the accessibility of these services to eligible LEP persons, a goal that reinforces its equally important commitment to promoting programs and activities designed to help individuals learn English. To this end, each Federal agency shall examine the services it provides and develop and implement a system by which LEP persons can meaningfully access those services consistent with, and without unduly burdening, the fundamental mission of the agency. Each Federal agency shall also work to ensure that recipients of Federal financial assistance (recipients) provide meaningful access to their LEP applicants and beneficiaries. To assist the agencies with this endeavor, the Department of Justice has today issued a general guidance document (LEP Guidance), which sets forth the compliance standards that recipients must follow to ensure that the programs and activities they normally provide in English are accessible to LEP persons and thus do not discriminate on the basis of national origin in violation of title VI of the Civil Rights Act of 1964, as amended, and its implementing regulations. As described in the LEP Guidance, recipients must take reasonable steps to ensure meaningful access to their programs and activities by LEP persons.

Sec. 2. Federally Conducted Programs and Activities.

Each Federal agency shall prepare a plan to improve access to its federally conducted programs and activities by eligible LEP persons. Each plan shall be consistent with the standards set forth in the LEP

Guidance, and shall include the steps the agency will take to ensure that eligible LEP persons can meaningfully access the agency's programs and activities. Agencies shall develop and begin to implement these plans within 120 days of the date of this order, and shall send copies of their plans to the Department of Justice, which shall serve as the central repository of the agencies' plans.

Sec. 3. Federally Assisted Programs and Activities.

Each agency providing Federal financial assistance shall draft title VI guidance specifically tailored to its recipients that is consistent with the LEP Guidance issued by the Department of Justice. This agency-specific guidance shall detail how the general standards established in the LEP Guidance will be applied to the agency's recipients. The agency-specific guidance shall take into account the types of services provided by the recipients, the individuals served by the recipients, and other factors set out in the LEP Guidance. Agencies that already have developed title VI guidance that the Department of Justice determines is consistent with the LEP Guidance shall examine their existing guidance, as well as their programs and activities, to determine if additional guidance is necessary to comply with this order. The Department of Justice shall consult with the agencies in creating their guidance and, within 120 days of the date of this order, each agency shall submit its specific guidance to the Department of Justice for review and approval. Following approval by the Department of Justice, each agency shall publish its guidance document in the Federal Register for public comment.

Sec. 4. Consultations.

In carrying out this order, agencies shall ensure that stakeholders, such as LEP persons and their representative organizations, recipients, and other appropriate individuals or entities, have an adequate opportunity to provide input. Agencies will evaluate the particular needs of the LEP persons they and their recipients serve and the burdens of compliance on the agency and its recipients. This input from stakeholders will assist the agencies in developing an approach to ensuring meaningful access by LEP persons that is practical and effective, fiscally responsible, responsive to the particular circumstances of each agency, and can be readily implemented.

Sec. 5. Judicial Review.

This order is intended only to improve the internal management of the executive branch and does not create any right or benefit, substantive or procedural, enforceable at law or equity by a party against the United States, its agencies, its officers or employees, or any person.

WILLIAM J. CLINTON

THE WHITE HOUSE,
August 11, 2000.

#

Appendix B: CLAS Standards Summary, by Category

Summary of National Standards for Culturally and Linguistically Appropriate Services in Healthcare (CLAS)

(Adapted from Culturally Competent Healthcare Systems: A Systematic Review, Anderson, L., (2003).

Culturally Competent Care

Standard 1. Healthcare organizations should ensure that patients or consumers receive from all staff members effective, understandable, and respectful care that is provided in a manner compatible with their cultural health beliefs and practices and preferred language.

Standard 2. Healthcare organizations should implement strategies to recruit, retain, and promote at all levels of the organization a diverse staff and leadership that are representative of the demographic characteristics of the service area.

Standard 3. Healthcare organizations should ensure that staff members at all levels and across all disciplines receive ongoing education and training in culturally and linguistically appropriate service delivery.

Language access services

Standard 4. Healthcare organizations must offer and provide language assistance services, including bilingual staff and interpreter services, at no cost to each patient or consumer with limited English proficiency at all points of contact, in a timely manner during all hours of operation.

Standard 5. Healthcare organizations must provide to patients or consumers in their preferred language both verbal offers and written notices informing them of their right to receive language assistance services.

Standard 6. Healthcare organizations must assure the competence of language assistance provided to limited English proficient patients or consumers by interpreters and bilingual staff members. Family and friends should not be used to provide interpretation services (except on request by the patient or consumer).

Standard 7. Healthcare organizations must make available easily understood patient-related materials and post signage in the languages of the commonly encountered groups or groups represented in the service area.

Organizational supports for cultural competence

Standard 8. Healthcare organizations should develop, implement, and promote a written strategic plan that outlines clear goals, policies, operational plans, and management accountability or oversight mechanisms to provide culturally and linguistically appropriate services.

Standard 9. Healthcare organizations should conduct initial and ongoing organizational self-assessments of CLAS-related activities and are encouraged to integrate cultural and linguistic competence-related measures into their internal audits, performance improvement programs, patient satisfaction assessments, and outcomes-based evaluations.

Standard 10. Healthcare organizations should ensure that data on the individual patient's or consumer's race, ethnicity, and spoken and written language are collected in health records, integrated into the organization's management information systems, and periodically updated.

Standard 11. Healthcare organizations should maintain a current demographic, cultural, and epidemiologic profile of the community as well as a needs assessment to accurately plan for and implement services that respond to the cultural and linguistic characteristics of the service area.

Standard 12. Healthcare organizations should develop participatory, collaborative partnerships with communities and use a variety of formal and informal mechanisms to facilitate community and patient or consumer involvement in designing and implementing CLAS-related activities.

Standard 13. Healthcare organizations should ensure that conflict and grievance resolution processes are culturally and linguistically sensitive and capable of identifying, preventing, and resolving cross-cultural conflicts or complaints by patients or consumers.

Standard 14. Healthcare organizations are encouraged to regularly make available to the public information about their progress and successful innovations in implementing the CLAS standards and to provide public notice in their communities about the availability of this information.

Appendix C: Suggested Educational Opportunities

SUGGESTED EDUCATIONAL OPPORTUNITIES	
Activity	Resources
Read up on the subject.	You will find a list of recommended books and other documents are listed in Appendix "D".
Attend Conferences, Seminars and Meetings	One of the best known national conferences is the <i>National Conference on Quality Health Care for Culturally Diverse Populations</i> , held by Diversity Rx. If financial resources are not available to attend a conference seminar or meeting dedicated to this issue, look for sessions on related topics at other conferences you may be attending.
Go Surfing (i.e., search the internet)	Take full advantage of free Federal resources and information and resources made available by major health foundation websites A list of excellent websites is listed in Appendix "D".
Contact Your Professional Association or Organization	Find out what resources, research and information they offer in this important arena. The American Healthcare Association, American Nurses Association, American Medical Association and others offer cultural competency resources.
Establish or Join a Cultural Competence Committee at your organization.	Be an agent of change in your organization. Learning is often best accomplished by "doing." If you are not in a leadership role, ask your supervisor, manager or administrator to include you in any established initiatives or, if none exist, share your interest and volunteer to be a part of establishing one.
Contact Local Foreign Embassy Offices	Representatives from local foreign embassies can be an excellent source of potential speakers for your organization.
Network	Learn from the experience of other healthcare colleagues and organizations with experience in cultural competence. Seek out those organizations that serve racially and ethnically diverse communities and ask if you can schedule a visit to their facility to learn more. Most will be eager to share what they have learned.
Broaden Your Circle of Friends	Choose to spend time with others whose backgrounds differ from your own. Make it your goal to develop a relationship with at least one person from another racial, ethnic and/or cultural background this year. As simple as this may sound, getting to know someone personally can make a profound impact on your understanding of and appreciation for other cultures. Somehow, personal experience seems to be the best teacher. Malcolm Gladwell, author of the bestselling book <i>Blink: The Power of Thinking Without Thinking</i> , says, "We learn by example and by direct experience because there are real limits to the adequacy of verbal instruction." Take advantage of "ready-made" opportunities to learn through people.

Appendix D: Resources

REPORTS, WEBSITES & BOOKS

REPORTS

Hospitals, Language and Culture: A Snapshot of the Nation

The Joint Commission, April 2007.

http://www.jointcommission.org/NR/rdonlyres/E64E5E89-5734-4D1D-BB4D-C4ACD4BF8BD3/0/hlc_paper.pdf

Unequal Treatment: Confronting Racial and Ethnic Disparities in Healthcare.

Institute of Medicine, National Academies Press, 2003.

<http://www.nap.edu/openbook.php?isbn=030908265X>

Crossing the Quality Chasm: A New Health System for the 21st Century

Institute of Medicine, National Academies Press, 2001.

http://www.nap.edu/openbook.php?record_id=10027

Improving Quality and Achieving Equity: The Role of Cultural Competence in Reducing Racial and Ethnic Disparities in Health Care

Joseph R. Betancourt, Massachusetts General Hospital, 2006.

www.commonwealthfund.org/usr_doc/Betancourt_improvingqualityachievingequity_961.pdf?section=4039

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

Department of Health and Human Services: Health Resources and Services Administration, 2004

<http://www.hrsa.gov/culturalcompetence/curriculumguide/chapter1.htm>

Culturally Competent Healthcare Systems: A Systematic Review

Laurie M. Anderson, PhD, et al, American Journal of Preventative Medicine, 2003

<http://www.thecommunityguide.org/social/soc-AJPM-evrev-healthcare-systems.pdf>

Making the Business Case for Culturally and Linguistically Appropriate Services in Health Care: Case Studies from the Field

Alliance of Community Health Plans Foundation, 2007

http://www.achp.org/page.asp?page_id=1059

Cultural Competence in Health Care: Emerging Frameworks and Practical Approaches

Joseph R. Betancourt, Massachusetts General Hospital–Harvard Medical School

Alexander R. Green and J. Emilio Carrillo

New York-Presbyterian Hospital–Weill Medical College of Cornell University, October 2002

http://www.commonwealthfund.org/usr_doc/betancourt_culturalcompetence_576.pdf?section=4039

WEBSITES

Office of Minority Health

www.omhrc.gov/

Office of Minority Health & Health Disparities

www.cdc.gov/omhd/

Office of Minority Health & Health Disparities – Racial & Ethnic Populations Information

www.cdc.gov/omhd/Populations/populations.htm

Office of Minority Health Final Report on CLAS Standards

<http://www.omhrc.gov/assets/pdf/checked/finalreport.pdf>

Health Resources and Services Administration

www.hrsa.gov

Department of Health & Human Services

www.hhs.gov

Institute of Medicine

www.iom.edu

Centers for Disease Control & Prevention (CDC)

www.cdc.gov

National Center For Cultural Competence, Georgetown University

<http://gucdc.georgetown.edu/nccc/>

Diversity Rx

www.diversityrx.org

The Providers Guide to Quality Care

<http://erc.msh.org/mainpage.cfm?file=1.0.htm&module=provider&language=English>

The Institute for Healthcare Improvement

www.IHI.org

Kaiser Family Foundation Minority Health

www.kff.org

The Henry J. Kaiser Family Foundation's State Health Facts website:

www.statehealthfacts.org

The Commonwealth Fund

www.commonwealthfund.org

Robert Wood Johnson Foundation

www.rwjf.org

A Family Physician's Practical Guide to Culturally Competent Care

<https://cccm.thinkculturalhealth.org>

Beliefnet.com – Site with information about various religious beliefs

www.beliefnet.com

Cultural beliefs and medical issues

www.ethnomed.org

Translated health information

www.healthinfotranslations.com

Medical and Healthcare Books and Dictionaries

intransbooks.com/index.shtml

24 Hour Health Information

www.MEDLINEplus.gov

Información de Salud las 24 Horas (Spanish)

www.MEDLINEplus.gov/esp

Consumer Health Information Resources in Many Languages

<http://nnlm.gov/oureach/consumer/multi.html#A13>

www.HealthInfoTranslations.com

www.culturemed.sunyit.edu/culture/sites/index.html

www.nlm.gov/outreach/consumer/multi.html

<http://www.health.utah.gov/cmh/multilinguallibrary/otherlibraries.htm>

New York Online Access to Health (Spanish)

www.noah-health.org

Patient Information Resources in Asian Languages

<http://spiral.tufts.edu/index.html>

Patient Information Resources: Creole

www.library.med.utah.edu/24languages/hcreole.html

18 Multi-language Pain Assessment Scales

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

BOOKS

Cultural Competence in Health Care: A Practical Guide

Authors: Anne Rundle, Maria Carvalho, Mary Robinson

Publisher: Josey-Bass

Multicultural Manners: New Rules of Etiquette for a Changing Society

Author: Norine Dresser

Publisher: John Wiley & Sons, Inc.

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