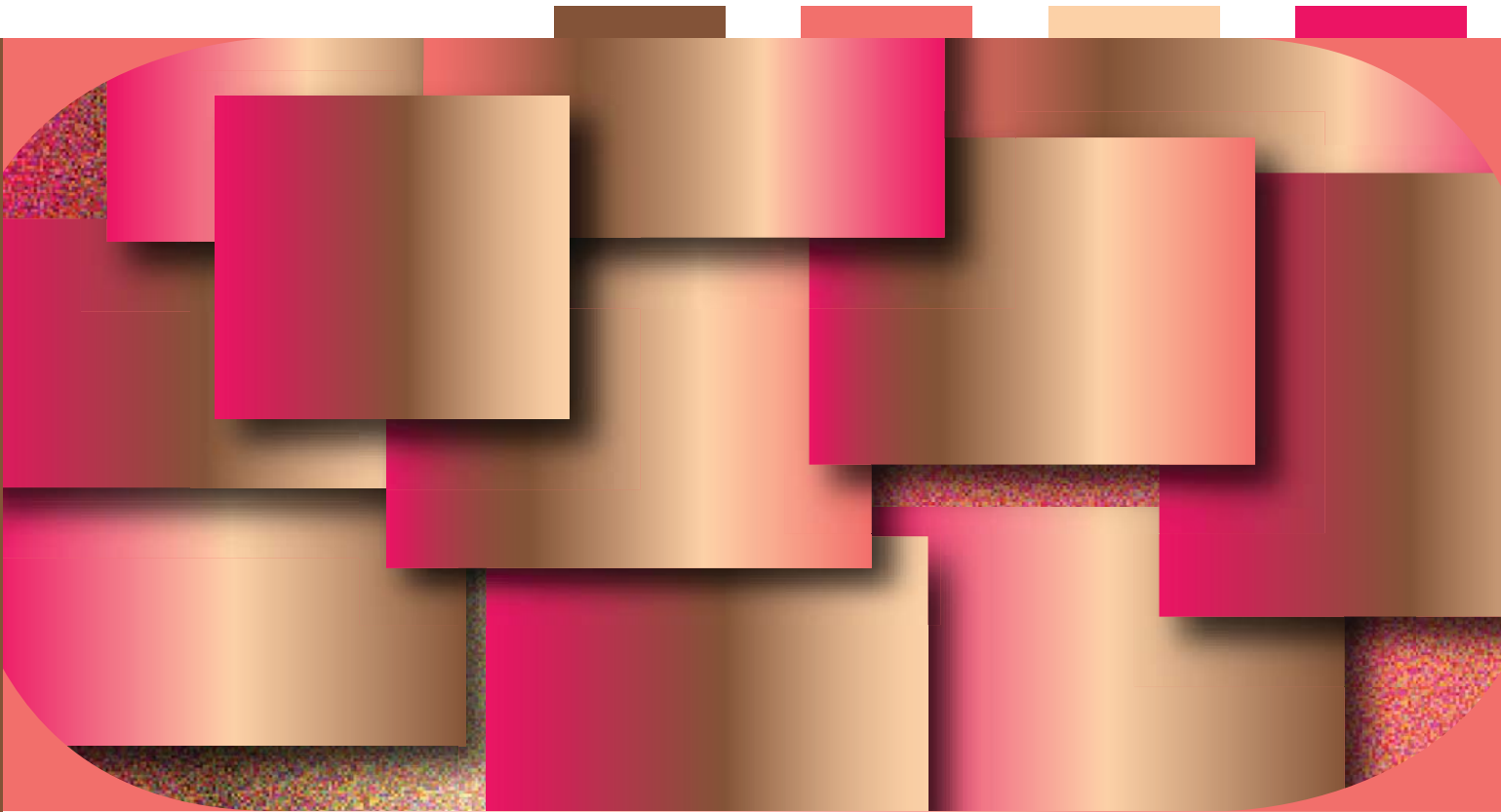THE **COLORADO TRUST**
A GRANTMAKING FOUNDATION

Equality in Health

AN ANNOTATED BIBLIOGRAPHY WITH RESOURCES ON HEALTH DISPARITIES AND CULTURAL AND LINGUISTIC COMPETENCY

The Colorado Trust is a grantmaking foundation dedicated to advancing the health and well-being of the people of Colorado. To learn more about the foundation and its grantmaking initiatives and evaluations, please visit www.coloradotrust.org.

Equality in Health: An annotated bibliography with resources on health disparities and cultural and linguistic competency was prepared for The Colorado Trust by the Association for the Study and Development of Community with Mondi A. Mason serving as the primary author. Other contributors include Yvette Lamb, Kien Lee, DeWitt Webster and Susana Haywood.

The report development was managed by Nancy B. Csuti, DrPH, Director of Evaluation, The Colorado Trust, and edited by Christie McElhinney, Director of Communications, The Colorado Trust.

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To Our Readers:

While Colorado is a relatively healthy state, racial and ethnic minorities experience higher rates of chronic diseases and receive less health care than the rest of the population. According to the Institute of Medicine (IOM, 2002) report, *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care*, "although myriad sources contribute to these disparities, some evidence suggests that a trend in bias, prejudice and stereotyping on the part of health care providers may contribute to differences in care."

Recognizing these disparities, The Colorado Trust funded a seven-year (2005 to 2012), $13.1 million Equality in Health initiative to reduce health disparities in Colorado. As part of the initiative, 26 nonprofit organizations and educational institutions across the state were awarded funding to reduce racial and ethnic health disparities by increasing the cultural competency of individuals and organizations that serve diverse populations. Early on in the initiative, grantees requested resources to help them understand and explore ways to improve cultural competency and address disparities in their communities; this annotated bibliography provides these resources.

While other annotated bibliographies on cultural competency are available, this document fills a unique niche by including web-based links that are often-cited, as well as specific resources and strategies from noted authors in the field that will be useful to organizations in addressing cultural and linguistic competency. Additionally, it includes articles and reports to help people understand health and health care disparities and inequalities that exist in the United States.

This bibliography provides 71 citations for journal articles, books, special reports and web-based resources that describe racial and ethnic health and health care disparities, along with models and concepts of cultural and linguistic competency strategies that have been put forth as a way of addressing these disparities. It also includes a list of frequently utilized assessment tools and performance measures for individuals and organizations, and cultural competency training curricula and educational resources. Direct links are provided to the majority of the resources cited. Each citation includes a brief description of the resource's content. And, at the back of the annotated bibliography, there is an index of materials cited by authors.

Sincerely,

Nancy B. Csuti, DrPH
Director of Evaluation
The Colorado Trust

TABLE OF CONTENTS

1. Introduction

While racial and ethnic disparities in health were originally documented more than a century ago, these disparities have been poorly defined and inadequately researched until recently. Now, a large and growing body of research has documented disparities in the incidence of illness and death, and in the quality of health care among African Americans, Latinos, Native Americans, Asian Americans, Alaskan Natives and Pacific Islanders as compared with the United States population as a whole, after controlling for socioeconomic factors such as income and health insurance. The reasons for these disparities are not well understood; however, the Institute of Medicine report, *Unequal Treatment,* found contributing factors to include discrimination at the personal level, even among well-intentioned health care professionals, combined with the failure of health care organizations and programs to provide culturally and linguistically competent health care to diverse racial, ethnic and cultural populations.[1]

The notion that culture and health are connected has appeared in the literature since the 1940s; however, the concept of addressing cultural and linguistic competency as a strategy to address racial and ethnic disparities in health is relatively new. A number of different terms for this concept have been proposed, such as cultural sensitivity, responsiveness, effectiveness, proficiency and humility. A review of the literature reveals general agreement on use of the term "cultural competence."

In the fields of public health and health care, cultural and linguistic competency refers to a prevailing systemic culture, including behaviors, attitudes and policies, that respects and takes into account each person's cultural background, cultural beliefs and values, and incorporates these elements of identity into the way health care and services are delivered to that person. Often seen as an endpoint, cultural and linguistic competency are best viewed instead as an ongoing process with multiple points of intervention.[2-5]

Historically, cultural and linguistic competency interventions have focused on changing attitudes and knowledge, especially those of health care professionals. In general, components of these interventions are limited to understanding a client's "superficial" characteristics (e.g., language, music, clothing) rather than the deep structural forces (e.g., cultural values; social, historical, environmental and psychological forces) that may influence health status. Much of the current thinking, however, encourages a focus not only on individuals, but also on indicators at the organizational, community and systemic levels needed to enhance communication and effective interaction between health care providers and consumers. With systemic change in mind, health care and social service institutions also need to take into consideration how the historic and contemporary social and economic inequalities of our society affect health status and contribute to health disparities. In fact, some argue that, to truly affect health and health care disparities, interventions should focus on institutionalized racism rather than just cultural and linguistic competency.

The field of cultural and linguistic competency is young, but growing. This annotated bibliography provides a resource for people interested in developing an understanding of health disparities, as well as cultural and linguistic competency. Herein are easily accessible and commonly cited articles and reports that highlight recommendations, benchmarks, best practices, assessment tools and training resources for Colorado organizations working toward social change, with the ultimate goal of eliminating racial and ethnic disparities in health.

2. Defining Health Disparities

Health disparities, or health inequalities as they are sometimes called, refer to differences in quality of health and health care across racial and ethnic groups. Recent research findings have shown health inequities in African Americans, Native Americans, Asian Americans, Alaskan Natives, Pacific Islanders and Latinos when compared to whites. Though there is a debate about the exact causes of these disparities, existing research suggests that the causes include factors such as socioeconomic conditions, quality of care, access to health care, linguistic barriers and cultural influences. More recently, health disparities have been attributed to structural or institutional factors and the broader context of institutional racism and other inequities in our society.

Given these findings, multiple programmatic and policy strategies and research agendas have been recommended to reduce or eliminate health disparities. The importance of systematically identifying and monitoring disparities by enhancing the quality, reliability and completeness of an organization's data collection and evaluation infrastructure are critical first steps. Though more work needs to be done to determine their effectiveness in eliminating health disparities, developing cultural and linguistic competency policies and practices in health services are highly recommended.

3. Methodology

This annotated bibliography was created through a targeted review of the published literature on cultural and linguistic competency and health disparities in the fields of health care, medical education, nursing and public health. With the exception of several seminal articles on health disparities and cultural and linguistic competency, the literature review was limited to the last 10 years. The academic literature was located via the bibliographic search engine PUBMED. Additionally, books, reports and web-based resources from government agencies and foundations were identified through contact with experts in the field and review of secondary referenced materials included in all documents. The inclusion criteria for the materials were: 1) the resource was cited in multiple resources, 2) the resource was written by noted authors or organizations in the field of health disparities and cultural and linguistic competency and 3) the models and material contained within each resource could be immediately accessible and useful to organizations working on these issues.

4. How to Use This Resource

This annotated bibliography is meant to be used as a resource guide for organizations addressing cultural and linguistic competency and health disparities. Most of the resources listed are available from the Internet or a local college library or through interlibrary loan. Where applicable, web addresses have been included to facilitate obtaining the publication.

While the resources selected for inclusion in this bibliography were reviewed by staff of the Association for the Study and Development of Community, checking the date of publication on any material is always wise as new concepts, methods and strategies to address health disparities are constantly being developed.

The bibliography is organized into two groups of resources:
- Health disparities (Section 5)
- Cultural and linguistic competency (Section 6).

Within each of these categories, citations are listed under sections that describe the emphasis of the material. The health disparities category has two sections: 1) understanding disparities and inequality and 2) strategies to reduce disparities.

The cultural and linguistic competency category has five sections: 1) assessment tools and performance measurement, 2) health and health care, 3) language access and interpreter issues, 4) mental health and 5) training and education.

Throughout the bibliography, the reader will note a ☼ symbol. This symbol designates seminal literature in the area of cultural and linguistic competency and frequently-cited articles with ideas or perspective supported by many other authors.

5. Health Disparities

5.1 Understanding Disparities and Inequality

Research and critical thinking on the nature and impact of health disparities among African Americans, Native Americans, Asian Americans, Alaskan Natives, Pacific Islanders and Latinos have focused on defining what constitutes "health disparity" and how this concept can be measured. Articles in this section provide a foundation for exploring the history of thinking on this issue. Researchers point to racism, social and economic conditions and structural issues (e.g., access to health services, payment systems, quality of care) as possible determinants of disparity and address possible strategies to alleviate adverse impacts.

Carter-Pokras O, Baquet C. What is a "health disparity"? *Public Health Reports* [serial online]. 2002;117:426-434. Available at: http://www.publichealthreports.org. Accessed May 18, 2007.

This article explores the definitions of the terms "health disparity" versus "inequality" and "inequity." While "disparity" and "inequality" share similar definitions (e.g., "difference in age, rank, condition or excellence" or "condition of being unequal"), "inequity" corresponds to "an instance of unjustness or unfairness." The authors, however, explain how "disparities" are being looked at in terms of unjustness and unfairness. They discuss several determinants, classified as avoidable or unavoidable, for measuring disparities. These determinants include conditions such as education, culture, income, social status and working conditions, among others. Finally, the authors explore the policy implications of the many definitions of "disparity."

Colorado Department of Public Health and Environment. *Racial and ethnic health disparities in Colorado.* Denver, CO: Office of Health Disparities; 2005. Available at: http://www.colorado.gov/cs/Satellite/CDPHE-Main/CBON/1251643639332. Accessed January 4, 2006.

This annual surveillance report illustrates the differences in health among groups and attempts to explore why these differences exist by examining socioeconomic, psychological and cultural factors that influence health. The report also outlines the social and economic costs of these disparities and urges a prevention-focused health agenda as well as multi-level approaches (i.e., individual, institutional, community, policy) to reduce disparities.

☼ Jones CP. Levels of racism: a theoretic framework and a gardener's tale. *American Journal of Public Health* [serial online]. 2000;90:1212-1215. Available at: http://ajph.aphapublications.org/doi/abs/10.2105/AJPH.90.8.1212. Accessed May 18, 2007.

This distinguished author outlines her theoretical framework for understanding racism on three levels: 1) institutionalized racism: differential access to goods, services and societal opportunities according to race; 2) personally mediated racism: prejudice, discrimination and differential assumptions about and actions toward others according to race and 3) internalized racism: the acceptance by members of a stigmatized race of negative message about their own abilities and intrinsic worth. She then uses an allegory, "The Gardener's Tale," to illustrate the relationships between the three levels of racism. This article has been used to stimulate dialogues about race and health inequities.

Kaiser Family Foundation. *Key facts: race, ethnicity and medical care.* Menlo Park, California: The Henry J. Kaiser Family Foundation; 2007. Available at: http://www.kff.org/minorityhealth/upload/6069-02.pdf. Accessed May 18, 2007.

This quick reference serves to highlight data, research and select literature on health, health insurance coverage and health care access and quality among racial and ethnic groups in the United States. The guide attempts to understand the causes of health disparities and the actions being taken to mitigate them. The presented data demonstrates whether health disparities are decreasing, increasing or continuing in certain minority communities. Specific health topics such as heart disease, cancer, asthma and HIV/AIDS relating to these communities are covered.

☼ Smedley BD, Stith AY, Nelson AR, eds. *Unequal Treatment: Confronting Racial and Ethnic Disparities in Healthcare.* Committee on Understanding and Eliminating Racial and Ethnic Disparities in Health Care. Institute of Medicine. Washington, DC: National Academy Press; 2003. Available at: http://www.nap.edu/books/030908265X/html/. Accessed May 18, 2007.

This report, written at the request of Congress, 1) assesses the extent of racial and ethnic differences in health care not attributable to known factors such as access to care, 2) evaluates potential sources of racial and ethnic disparities in health care (at the individual, institutional and systemic levels) and 3) provides recommendations regarding the elimination of health care disparities. The committee

reviewed over 100 studies published in peer-reviewed journals between 1993 and 2003 and searched for differences in health care services by patient socioeconomic status and geographic region. They found that health disparities exist in the context of broader historic and contemporary social and economic inequalities. Health systems and health providers may contribute to health disparities. The authors concluded that more research is needed to understand the prevalence and influence these factors have on patient compliance and clinical outcomes.

Williams DR, Ruckner T. Understanding and addressing racial disparities in health care. *Health Care Financing Review* [serial online]. 2000;21(4):75-90. Available at: http://www.cms.hhs.gov/HealthCareFinancingReview/Downloads/00summerpg75.pdf. Accessed May 18, 2007.

This article examines historical instances of racism and discrimination that led to policy creation or changes in the United States. The authors argue that the policies implemented to end discrimination have failed to eliminate problems, including personal discrimination, which occurs most commonly as unconscious or unintentional behavior and contributes to health disparities; however, other barriers in health care also should be addressed. The article highlights the importance of educating medical students and offers other ideas and solutions to improve policy.

Williams DR, Neighbors HW, Jackson JS. Racial/ethnic discrimination and health: findings from community studies. *American Journal of Public Health* [serial online]. 2003;93(2):200-209. Available at: http://www.ajph.org/cgi/reprint/93/2/200?ck=nck. Accessed May 18, 2007.

This article is a review of population-based studies of the association between health and racial and ethnic discrimination. The authors reviewed a total of 53 studies, completed between 1998 and 2003, in the areas of mental health, physical health and health behaviors. Results indicated that perceived discrimination might be a race-related stressor that negatively affects health; however, the evidence was insufficient to explain how exposure to discrimination can increase the risk of disease. Racial bias also may be a determinant that affects health, but has not been studied as a contributor to health disparities. The report notes the lack of an optimal consensus measure to capture exposure to discrimination. Nevertheless, findings consistently suggested an association between perceived discrimination and poorer health, especially among socially disadvantaged groups.

5.2 Strategies to Reduce Health Disparities

Various strategies are being employed to reduce health disparities. Models and interventions include: 1) large-scale federally-funded interventions designed to reduce the impact of health disparities on chronic diseases, 2) strategies to improve access to services and 3) community-based and community-driven disparity initiatives. Articles in this section explore the evidence surrounding the efficacy of these types of models. Emphasis is also placed on the importance of tracking and monitoring changes in health status resulting from these interventions.

Cooper LA, Hill MN, Powe NR. Designing and evaluating interventions to eliminate racial and ethnic disparities in health care. *Journal of General Internal Medicine* [serial online]. June 2002;17(6):477-486. Available at: http://www.pubmedcentral.nih.gov/articlerender.fcgi?artid=1495065. Accessed May 19,2007.

This article presents a modified version of the Institute of Medicine's model of access to health services to eliminate health care disparities. This new model incorporates the features of other access models and highlights barriers and mediating factors important to include in interventions (e.g., community partnerships, multifaceted and intense approaches, culturally and linguistically appropriate methods). The authors also recommend that interventions to eliminate health disparities be considered within the broader context of improving quality of care.

The Centers for Disease Control and Prevention. REACH 2010 page. Available at: http://www.cdc.gov/reach/about.htm. Accessed May 18, 2007.

Racial and Ethnic Approaches to Community Health (REACH) is a federal initiative intended to eliminate racial and ethnic disparities in health by the year 2010 in the following six priority areas: infant mortality, breast and cervical cancer, cardiovascular diseases, diabetes, HIV/AIDS and child and adult immunizations. REACH supports community coalitions in designing, implementing and evaluating community-driven strategies to eliminate health disparities in communities, health care settings, schools and work sites around the United States. To date, REACH communities have shown an increase in mammography, Pap test, cholesterol and HgA1c screenings.

National Committee on Vital and Health Statistics (NCVHS). *Eliminating health disparities: strengthening data on race, ethnicity and primary language in the United States.* Washington, DC: NCVHS; 2005. Available at: http://www.ncvhs.hhs.gov/051107rpt.pdf. Accessed May 18, 2007.

This report is a summary of the NCVHS findings and recommended strategies for the U.S. Department of Health and Human Services and its partners to address the collection of data on race, ethnicity and primary language. Two key recommendations are presented: 1) enhance the quality, reliability and completeness of data collection and data integration and 2) increase and strengthen the capacity of health statistics infrastructure to analyze, report and disseminate data on the various ethnic, racial and linguistic subpopulations in the U.S. and its territories.

Physicians for Human Rights. *The right to equal treatment: an action plan to end racial and ethnic disparities in clinical diagnosis and treatment in the United States.* Boston, MA: Physicians for Human Rights; 2003. Available at: http://physiciansforhumanrights.org/library/documents/reports/report-rightequaltreat-2003.PDF. Accessed May 19, 2007.

After examining the evidence on racial and ethnic disparities in medical care, Physicians for Human Rights invokes a civil and human rights perspective and emphasizes the role the federal government needs to play in systematically identifying and monitoring disparities in the quality of health services in the United States. This report extends the conclusions of the Institute of Medicine's *Unequal*

Treatment and gives 24 detailed policy recommendations and 11 research recommendations for a sustained advocacy campaign to reduce and eliminate racial and ethnic disparities in health care.

Siegel B, Berliner H, Adams A, Wasongarz D. *Addressing health disparities in community settings: an analysis for best practices in community-based approaches to ending disparities in health care*. Princeton, NJ: Robert Wood Johnson Foundation; 2003. Available at: http://www.rwjf.org/files/research/UrgentMatters-disparitiesfin.pdf. Accessed May 18, 2007

This report describes and analyzes the following best practices that have emerged through community-based disparity initiatives: 1) mobilizing and managing a continuum of resources and services for clients, 2) one-on-one outreach that facilitates health education and navigation of the health system and 3) embracing multiple strategies for cultural competency. The authors point out that good evaluation is lacking; that community models are developed in response to local idiosyncrasies and that small community-based disparity initiatives are unlikely to have a large impact on the health of minority populations or solve greater issues of poverty, racism and lack of health insurance for millions of Americans.

U.S. Department of Health and Human Services. *Healthy People 2010*. Washington, DC: Office of Disease Prevention and Health Promotion; 2000. Available at: http://www.healthypeople.gov/Document/pdf/uih/2010uih.pdf. December 17, 2005.

This document sets forth health objectives for the nation to achieve by 2010, with two overarching goals: 1) increase quality and years of healthy life and 2) eliminate health disparities. Many different people, states, communities, professional organizations and others use this report as a guide in developing programs to improve health.

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6. Cultural and Linguistic Competency

6.1 Assessment Tools and Performance Measurement

Research suggests a probable link between health and health care disparities and the need for improved cultural and linguistic competency in the provision of health care. Because of these findings, instruments for assessing cultural and linguistic competency at the individual and organizational levels have proliferated over recent years. This compilation of assessment tools and performance measures highlights site-specific and population-specific tools including step-by-step guides and participatory and multiple-method approaches for assessing individuals and organizations.

☼ Andrulis D, Delbanco R, Avakian L, Shaw-Taylor Y. Conducting a cultural competency self-assessment. 2000. Available at: http://www.consumerstar.org/pubs/Culturalcompselfassess.pdf. Accessed December 19, 2005.

This cultural competency assessment tool is one of the most cited instruments in the cultural competency literature. The packet of information walks the assessor through the assessment steps, provides sample questions for one-on-one interviews, includes a questionnaire that relates to three levels of cultural competency (i.e., individual, organizational and community) and provides recommendations for how to use assessment results.

American Hospital Association. *Strategies for leadership: does your hospital reflect the community it serves? A diversity and cultural proficiency tool for leaders.* Washington: DC: American Hospital Association; 2004. Available at: http://www.consumerstar.org/pubs/AHAassessment.pdf. Accessed December 20, 2005.

This short assessment was developed as a starting point in evaluating the diversity and cultural proficiency of health care organizations and identifying what activities and practices are in place or need to be implemented. The tool assesses at the levels of community, patient care, workforce development and organizational leadership. The document contains suggestions for using the tool to raise awareness in the organization and case studies of successful diversity and cultural proficiency programs from hospitals around the country.

Blank RM, Dabady M, Citro CF. *Measuring Racial Discrimination: Panel on Methods for Assessing Discrimination.* Washington, DC: National Academies Press; 2004. Available at: http://www.nap.edu/books/0309091268/html/. Accessed January 4, 2006.

This book discusses the findings of an expert panel convened to consider how best to measure discrimination. The book defines racial discrimination; assesses current methodologies for measuring discrimination (e.g., controlled laboratory experiments and field experiments, analysis of observational data and natural experiments, measures of reported perceptions and experiences of discrimination from surveys and administrative records) and identifies and makes recommendations for new, low-cost approaches (e.g., longitudinal interdisciplinary methods, augmenting current data collection).

Doorenbos AZ, Meyers Shim S, Benkert R, Borse NN. Psychometric evaluation of the cultural competence assessment instrument among healthcare providers. *Nursing Research* [serial online]. 2005;54(5):324-331. Available at: http://www.nursing-research-editor.com/authors/OMR/6/OMRManuscript.pdf. Accessed May 18, 2007.

This article briefly reviews the Cultural Competence Assessment instrument (CCA) and the extent to which this instrument appropriately measures the cultural competency of health care providers. Using hospice providers and health care providers in non-hospice settings, the authors tested the reliability of the CCA (i.e., whether or not the CCA consistently measured the cultural competency of the providers). Their findings confirmed the potential of the CCA as an instrument for measuring

provider cultural competence and its usefulness to future research studies and intervention approaches.

Goode TD. *Promoting cultural and linguistic competency: self-assessment checklist for personnel providing primary health care services*. Maryland: Georgetown University Center for Child and Human Development. 2004. Available at: http://www11.georgetown.edu/research/gucchd/nccc/documents/Checklist%20PHC.pdf. January 10, 2006.

This brief cultural competency self-assessment tool is frequently cited in the assessment literature. Multiple variations of the tool are available for different settings (i.e., primary care service setting, early childhood setting, service setting for families with special health needs). Each variation asks the same questions, but uses terms appropriate to the setting. The assessment asks respondents to evaluate the physical environment in which they work, the materials and resources with which they work, their communication style and their values and attitudes.

Kairys JA, Orzano J, Gregory P, Stroebel C, DiCicco-Bloom B, Roemheld-Hamm B, Kobylarz FA, Scott JG, Coppola L, Crabtree BF. Assessing diversity and quality in primary care through the multi-method assessment process (MAP). *Quality Management in Health Care*. Summer 2002;10(4):1-14.

In this article, the authors argue that the multi-method assessment process (MAP), a comprehensive quality improvement assessment technique, can provide a systematic way to understand disparities in relation to diversity, cultural competence and quality improvement in clinical practice. MAP data are derived primarily from direct observation, interviews, document review, family medical histories and surveys. The authors encourage data collection in the following domains: 1) values/attitudes; 2) cultural sensitivity; 3) communication; 4) policies and procedures; 5) training and staff development; 6) facility characteristics; 7) intervention and treatment model features; 8) family and community participation and 9) monitoring, evaluation and research. Limitations of MAP include: 1) intensity of data collection and 2) difficult of analysis.

The Lewin Group, Inc. *Indicators of cultural competence in health care delivery organizations: an organizational cultural competence assessment profile*. Washington, D.C.: Health Resources and Services Administration, U.S. Department of Health and Human Services; 2002. Available at: http://www.hrsa.gov/culturalcompetence/indicators/. Accessed December 29, 2005.

The assessment profile described in this article is an analytic and organizing framework that can be used as a tool for examining, demonstrating and documenting cultural competence in organizations involved in direct health care delivery, especially those that are community-oriented. The framework is based on a synthesis of 120 published and unpublished literature sources given in the document cited immediately below (*Health Resources and Services Administration study on measuring cultural competency in health care delivery settings*). The profile has three focus areas: 1) domains of cultural competence; 2) focus areas within domains and 3) structure, process and outcome indicators related to focus areas. Domains include: organizational values, governance, planning, monitoring and evaluation, communication, staff development, organizational infrastructure and services/interventions.

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The Lewin Group, Inc. *Health Resources and Services Administration study on measuring cultural competency in health care delivery settings.* Washington, DC: Health Resources and Services Administration, U.S. Department of Health and Human Services; 2001. Available at: http://www.hrsa.gov/culturalcompetence/measures/. Accessed December 29, 2005.

This comprehensive review of the cultural competency literature is an outgrowth of a Health Resources and Services Administration project to contribute to an understanding of how cultural competency can be measured and advance the capacity of organizations to carry out such measurement. The literature review provides the basis for the project's objectives: 1) to develop a conceptual framework for measuring cultural competence in health care settings, 2) to identify specific indicators and measures for assessing cultural competence in health care and 3) to assess the feasibility and practical application of these measures.

☼ 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; 1995. Available at: http://www.rtc.pdx.edu/PDF/pbCultCompSelfAssessQuest.pdf. Accessed May 20, 2007.

This frequently cited organizational cultural competence self-assessment tool includes direct service provider and administrative staff assessments and a step-by-step manual for administering the questionnaire.

National Center for Cultural Competence. *A guide for using the cultural and linguistic competence policy assessment instrument.* Washington, DC: Georgetown University; 2006. Available at: http://www.clcpa.info/documents/CLCPA_guide.pdf Accessed May 18, 2007.

This guide provides a systematic process to plan for and assess organizational cultural and linguistic competency, specifically, attitudes and practices of personnel and program structures and policies. The guide helps organizations to engage in a strengths-based approach to assessment and disseminate results in a non-judgmental way.

National Technical Assistance Center for State Mental Health Planning (NTAC). *Cultural competency: Measurement as a strategy for moving knowledge into practice in state mental health systems.* Alexandria, VA: NTAC; 2004. Available at: http://www.nasmhpd.org/general_files/publications/cult%20comp.pdf. Accessed May 18, 2007.

This report advocates that cultural competence must be integrated into and permeate the entire mental health system. It outlines the rationale for cultural competence, approaches to implementation, measurement of cultural competency as a strategy and steps that can be taken to move research into practice.

Research & Training Center for Children's Mental Health. *Organizational cultural competence: A review of assessment protocols.* Tampa, FL: University of South Florida; 2006. Available at: http://rtckids.fmhi.usf.edu/rtcpubs/CulturalCompetence/protocol/CultCompProtocol.pdf Accessed May 21, 2007.

This monograph presents the findings from a review of cultural competence assessment tools designed for use at the organizational level. The findings contribute to the goal of developing cultural competence in systems of care wherein participating organizations must support the delivery of culturally competent services and develop collaborative relationships with diverse communities. A conceptual model for organizational cultural competence was informed by and guided this review, illustrating the relationships between the community's populations, organizational structures and processes, direct service structures and processes, and the overall community context.

Siegel C, Davis-Chamber E, Haugland G, Bank R, Aponte C, McCombs H. Performance measures of cultural competency in mental health organizations. *Administration and Policy in Mental Health*, November 2000;28(2):91-106.

This article describes a multi-level framework for assessing the cultural competency of mental health systems. A steering committee reviewed more than 20 reports and papers on cultural competency developed by state/federal agencies and multicultural focus groups. Based upon the review, the steering committee synthesized the data into six domains: 1) needs assessment, 2) information exchange, 3) services, 4) human resources, 5) policies and procedures, and 6) outcomes. These domains help assess cultural competency within three different organizational structures: administrative, provider network and individual caregiver. Within each domain, there are factors, indicators and measures that can be applied to assess cultural competency. The steering committee identified a total of 117 cultural competency indicators and 173 cultural competency measures.

Siegel C, Haugland G, Davis-Chambers E. *Cultural competency methodological and data strategies to assess the quality of services in mental health systems of care: A project to select and benchmark performance measures of cultural competency.* New York: Nathan Kline Institute for Psychiatric Research; 2002. Available at: http://csipmh.rfmh.org/other_cc.pdf. Accessed May 18, 2007.

This report includes recommendations and benchmark performance measures for mental health systems to increase their responsiveness to the needs of multicultural populations. A conceptual framework identifies five domains in which the performance measures can be applied to achieve good outcomes: 1) needs assessment, 2) information exchange, 3) services, 4) human resources and 5) policies and plans. The framework also highlights three organizational levels that need to be involved in the delivery of culturally competent services: 1) administrative, 2) service delivery and 3) individual.

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Siegel C, Haugland G, Davis-Chambers E. Performance measures and their benchmarks for assessing organizational cultural competency in behavioral health care service delivery. *Administration and Policy in Mental Health.* 2003;31(2):141-170.

This article outlines the second phase of a two-phase effort to identify performance measures to assess organizational progress toward cultural competency. The following benchmarks emerged as indicators of a commitment to cultural competence at the administrative, service and individual levels, respectively: 1) an organizational cultural competency plan, an advisory committee, a person responsible for cultural competency, budget line items and a governing board; 2) telephone instruction available in languages other than English, language assistance available at first contact as well as other points of contact, bilingual staff, educational and other materials in non-English languages and information on rights and grievances in non-English languages and 3) knowledge of target populations and the cultural needs of patients, linguistic capacity, cultural competency training and education, equitable recruitment and hiring practices, and consumer education about outcomes.

6.2 Health and Health Care

Recommendations, benchmarks and best practices for cultural competence abound. This section is a compilation of resources that highlight approaches to cultural competency in health and health care. Most resources discuss the importance of focusing on the following areas: 1) values and attitudes; 2) staff recruitment and retention; 3) staff education and development; 4) communication; 5) planning, monitoring and evaluation; 6) organizational infrastructure; 7) services and intervention; and 8) linguistic capacity. A common limitation of the current literature is an overall lack of assessment in these areas to connect interventions to a reduction in racial and ethnic disparities in health and health care. As organizations move forward with their own initiatives to address cultural and linguistic competency, measuring the effectiveness of programs and policies should be an area of focus.

☼ Anderson LM, Scrimshaw SC, Fullilove MT, Fielding JE, Normand J. Culturally competent health care systems: A systematic review. *American Journal of Preventive Medicine* [serial online]. 2003;24(3S):68-79. Available at: http://minority-health.pitt.edu/archive/00000409/01/Culturally_Competent_Healthcare_Systems.pdf. Accessed May 18, 2007.

In this article, the authors review five interventions to improve cultural competency in health care systems: 1) recruitment of a culturally diverse workforce, 2) availability of interpreters or bilingual staff who speak the clients' languages, 3) cultural competency training for healthcare providers, 4) development of appropriate education materials and 5) providing a culturally specific health care setting (i.e., clinicians of the same culture group as clients). Due to a limited number of studies that measured outcomes of interest, the authors were unable to determine the effect of each of these interventions in three key outcome areas: client satisfaction, racial and ethnic differentials in health care utilization, and treatment and improvements in health status. The authors argue that future studies must assess patient outcomes, not only changes in provider knowledge and attitudes. They make recommendations for research questions related to cultural competence and outcomes.

Beach MC, Gary TL, Price EG, Robinson K, Gozu A, Palacio A, Smarth C, Jenckes M, Feuerstein C, Bass EB, Powe NR, Cooper LA. Improving health care quality for racial/ethnic minorities: A systematic review of the best evidence regarding provider and organization interventions. *BMC Public Health* [serial online]. 2006;6:104. Available at: http://www.pubmedcentral.nih.gov/picrender.fcgi?artid=1525173&blobtype=pdf. Accessed May 18, 2007.

This article synthesizes the findings from studies of interventions targeted at health care providers to improve health care quality or reduce disparities for racial or ethnic minorities. Despite the paucity of evidence-based studies, several promising strategies may improve health care quality for racial and ethnic minorities. These strategies include provider reminder systems for standard services, offering preventive services directly to patients, use of simultaneous interpretation and use of structured questionnaires. Combining multiple strategies may be even more beneficial.

☼ Betancourt JR, Green AR, Carrillo JE. *Cultural competence in health care: Emerging frameworks and practical approaches*. New York: The Commonwealth Fund; 2002. Available at: http://www.cmwf.org/usr_doc/betancourt_culturalcompetence_576.pdf. Accessed May 18, 2007.

To help address the questions of how to make health care systems more culturally competent and what future physicians should be taught about cultural competence, this field report explores the many definitions of cultural competence. The report also aims to identify the benefits of and barriers to achieving a culturally competent care system. The authors studied four models (one in academia, one in government, one a managed care system and the fourth a community health model) and make recommendations about what factors need to be in place to achieve organizational, systemic and clinical cultural competence.

☼ Betancourt JR, Green AR, Carrillo JE, Ananeh-Firempong O. Defining cultural competence: A practical framework for addressing racial/ethnic disparities in health and health care. *Public Health Reports* [serial online]. 2003;188:293-302. Available at: http://www.publichealthreports.org/userfiles/118_4/118293.pdf. Accessed May 18, 2007.

For this article, the leaders in cultural competency framework development surveyed the medical and public health literature for answers to two questions: 1) What are the major components of cultural competency? and 2) How do we incorporate culturally competent interventions into the delivery of health care? The authors identified three major levels of health care at which sociocultural barriers contribute to disparities in health and health care: organizational (leadership and workforce), structural (processes of care) and clinical (provider-patient encounters). The authors' recommendations include: hiring more people of color in health professions, developing interpreter services and culturally and linguistically appropriate health education materials and providing education on cross-cultural issues to health care providers.

☼ Brach C, Fraser I. Can cultural competency reduce racial and ethnic disparities? A review and conceptual model. *Medical Care Research and Review.* 2000;57(S1):181-217.

In this seminal article, a comprehensive literature review found that cultural competence has not been linked to patient outcomes and tends to focus only on the individual (patient or provider), rather than the system in which the individual participates. The literature is weak on identifying sources of disparities, and almost no literature focuses on techniques to reduce disparities. Drawing upon the literature, the authors provide a conceptual model and evidence of ways in which the cultural competency techniques most often cited in the literature (e.g., interpreter services, recruitment and retention, training, coordinating with traditional healers, hiring community health workers, culturally competent health promotion, including family members in the care model, immersion into another culture, administrative and organizational accommodation of cultural differences) theoretically could affect the processes (and therefore outcomes) of care for racial and ethnic minorities.

☼ Campinha-Bacote J. The process of cultural competence in the delivery of healthcare services: A model of care. *Journal of Transcultural Nursing.* 2002;13(3):181-184.

This seminal article outlines the author's cultural competency model that views cultural competence as an ongoing process for the health care provider, consisting of cultural awareness, cultural knowledge, cultural skill, cultural encounters and cultural desire. The author stresses that there is more variation within ethnic groups than across ethnic groups, that cultural competence is essential and that there is a direct relationship between the level of competence and the ability to provide effective culturally responsive services.

The Commonwealth Fund. *The role and relationship of cultural competence and patient-centeredness in health care quality.* Beach MC, Saha S, Cooper LA, eds. New York: The Commonwealth Fund; 2006. Available at: http://www.commonwealthfund.org/usr_doc/Beach_rolerelationshipcultcomppatient-cent_960.pdf?section=4039. Accessed May 18, 2007.

This report explores the historical evolution of patient-centered care. Early models focused on provider-patient interactions, whereas current models focus on how patients are treated by the health care system as a whole. The authors advocate that combining patient-centered approaches with the principles of cultural competence may be a promising approach for improving the quality of health care.

The Commonwealth Fund. *Improving quality and achieving equity: The role of cultural competence in reducing racial and ethnic disparities in health care.* Betancourt JR, ed. New York: The Commonwealth Fund; 2006. Available at: http://www.commonwealthfund.org/usr_doc/Betancourt_improvingqualityachievingequity_961.pdf?section=4039. Accessed May 18, 2007.

This report reviews the principles of quality of care and the evidence for the existence and root causes of racial and ethnic health disparities. It provides a framework and recommendations to link

the quality-of-care and cultural competence movements and outlines hypothetical and proven strategies for delivering high quality, culturally competent care.

Geiger HJ. Racial stereotyping and medicine: The need for cultural competence. *Canadian Medical Association Journal* [serial online]. 2001;164(12):1699-1700. Available at: http://www.cmaj.ca/cgi/reprint/164/12/1699. Accessed May 22, 2007.

This commentary by a noted health disparities researcher proposes that lack of cultural competence may be the most remediable cause of health disparities if honestly recognized and addressed in health care systems. The current movement toward acknowledgement of the need for cultural competency training among health care professionals and international consideration of institutional racism as a factor in creating disparities are described as encouraging signs of progress. The author advocates for more evaluation with an emphasis on health outcomes.

Goode TD, Dunne MC, Bronheim SM. *The evidence base for cultural and linguistic competency in health care.* New York: The Commonwealth Fund; 2006. Available at: http://www.commonwealthfund.org/usr_doc/Goode_evidencebasecultlinguisticcomp_962.pdf?section=4039. Accessed May 21, 2007.

This report reviews the published scientific literature for evidence of the impact of cultural and linguistic competency on health outcomes, as well as the cost-benefit ratio of such competency for the health care system. The majority of literature focuses on the concept of cultural competency, without considering health outcomes and cost-benefit issues. The authors identify gaps in the literature and make recommendations for future research.

Kim-Godwin YS, Clarke PN, Barton L. A model for the delivery of culturally competent community care. *Journal of Advanced Nursing.* 2001;35(6):918-925.

This article describes a process for developing and testing a culturally competent community care model for community health nurses working with diverse populations. Dimensions of the model include: caring, cultural sensitivity, cultural knowledge and cultural skills. The model emphasizes the relationship between cultural competence and health outcomes.

☼ Leininger M. Towards conceptualization of transcultural health care systems: Concepts and a model (classic article from 1976). *Journal of Transcultural Nursing.* 1993;4(2):32-40.

This seminal article, in what would become known as the field of "cultural competency," was originally published in 1976. Drawing from both anthropological and nursing perspectives, the author identified major trends, challenges and concepts related to trans-cultural health care, an evolving body of knowledge and practices regarding health and illness care patterns from a comparative perspective. The author's conceptual model defines four distinct levels of analysis: 1) social structure (political, economic, religious, technological, educational); 2) cultural values, beliefs and the meaning of health and care and how it is expressed; 3) health care systems (traditional and

modern) and their features (holistic versus compartmentalized) and 4) roles, functions and activities of health providers and client outcomes.

Johnson RL, Saha S, Arbelaez JJ, Beach MC, Cooper LA. Racial and ethnic differences in patient perceptions of bias and cultural competence in health care. *Journal of General Internal Medicine* [serial online]. 2004;19:101-110. Available at: http://www.pubmedcentral.nih.gov/picrender.fcgi?artid=1492144&blobtype=pdf. Accessed May 18, 2007.

This articles reports on the findings of the 2001 Commonwealth Fund Health Care Quality Telephone Survey to assess racial and ethnic differences in patients' perceptions of primary care providers. The findings showed that African Americans, Hispanics and Asians were more likely than Whites to perceive that 1) they would have received better medical care if they belonged to a different racial or ethnic group and 2) medical staff treated them unfairly or with disrespect based on race, ethnicity or how well they spoke English.

Napoles-Springer AM, Santoyo J, Houston K, Perez-Stable EJ, Stewart AL. Patients' perceptions of cultural factors affecting the quality of their medical encounters. *Health Expectations* [serial online]. 2005;8:4-17. Available at: http://repositories.cdlib.org/cgi/viewcontent.cgi?article=2408&context=postprints. Accessed May 18, 2007.

Recognizing that most cultural competency research is conducted from the perspective of the provider, these authors set out to understand the perspectives of patients in three ethnic groups. Nineteen focus groups were conducted with a sampled group of diverse participants recruited from a wide variety of settings in the San Francisco area. Specific recommendations for ways in which providers could enhance the quality of medical encounters included: being sensitive to patient privacy, using a humanistic approach and treating patients as equals.

Resnicow K, Baranowski T, Ahluwalia JS, Braithwaite RL. Cultural sensitivity in public health: Defined and demystified. *Ethnicity and Disease*. Winter 1999;9:10-21.

In this article, health communication researchers described a framework for developing culturally sensitive public health programs. Within this framework, cultural sensitivity has two dimensions: 1) surface structure, which refers to matching intervention materials and messages both to the target group's observable, "superficial" characteristics (e.g., language, music, food, clothing) and to appropriate avenues for message or program delivery (e.g., churches, schools) and 2) deep structure, which refers to understanding the core cultural values; explanatory models; and social, historical, environmental and psychological forces that influence the health behavior of the target population. Focus groups and pre-testing can help practitioners address both surface and deep structures during interventions. This article also describes some of the model's limitations, such as conflict between public health goals and cultural values, and the limited research about the efficacy of cultural competency interventions.

Shen Z. Cultural competence models in nursing: A selected annotated bibliography. *Journal of Transcultural Nursing.* 2004;15(4):317-322.

This annotated bibliography was compiled to reflect the current status of research on cultural competence in nursing. The focus is on book literature, supplemented by journal articles, that emphasizes the construction, development or conceptualization of cultural competence models and cultural competency assessment models and guides.

Watson SD. *Equity measures and systems reform as tools for reducing racial and ethnic disparities in health care.* New York: The Commonwealth Fund; 2005. Available at: http://www.commonwealthfund.org/usr_doc/776_Watson_equitymeasuressystems_reform.pdf?section=4039. Accessed May 21, 2007.

This report advocates for reform in the Medicare and Medicaid systems. It provides a template for new administrative policies that mandate quality assessment and performance improvement initiatives to reduce racial and ethnic disparities in health care, and recommends policy and accreditation mandates and financial incentives to encourage health care systems to adopt performance measures that track data by race and ethnicity.

6.3 Language Access and Interpreter Issues

Though linguistic competency is not the only facet of cultural competency, discussions of cultural competency tend to focus on language access issues, or linguistic competency, primarily because 1) communication and culture are integrally linked and 2) language is the only facet of cultural competency based in law. The U.S. Department of Health and Human Services has long considered providing language assistance a key component of Title VI of the Civil Rights Act of 1964, specifically, the clause that prohibits discrimination based on national origin. Frequently, health and social service agencies have provided suboptimal language assistance for their clients with limited English proficiency (LEP). Research has demonstrated that reliance on ad hoc interpreters, family, friends or the provider's own poor language skills can result in negative outcomes for the client-provider relationship and undermines confidentiality, client satisfaction with services, access to mental health services, the ability to adhere to recommended treatment regimens and participation in preventive services. This section of resources includes the federal mandate for language access as required by the Civil Rights Act. Also included are resources that provide strategies for reducing language barriers and for ensuring culturally and linguistically appropriate services in health care settings.

Change PH, Fortier JP. Language barriers to health care: An overview. *Journal of Health Care for the Poor and Underserved.* 1998;9:S5-S25.

This article provides a context for the discussion of language access in health care by reviewing federal and state laws and related initiatives, and discussing the case history of language access in Seattle, Washington. Additionally, it describes different models for providing language services (e.g.,

interpreter banks, translator pools, cultural advocates). Finally, it discusses delivery, financing and regulation of language services in managed care environments.

Ferguson WJ, Candib LM. Culture, language and the doctor-patient relationship. *Family Medicine* [serial online]. 2002;34(5):353-361. Available at: http://www.stfm.org/fmhub/fm2002/may02/mcappc.pdf. Accessed May 18, 2007.

This article reviews the literature on the doctor-patient relationship and communication to determine how differences between providers and patients in race, ethnicity and language influence the quality of their relationship. Twenty-one articles were found and divided into: 1) outcome studies with limited English-speaking versus English-speaking patients; 2) studies of strategies that improve outcomes with patients who speak limited English; 3) studies of physician bias, rapport-building and patient preference, with race and ethnicity as variables and 4) studies on relationship-building with race and ethnicity as variables. The review provides evidence that race, ethnicity and language all influence the quality of doctor-patient relationships. African American and Hispanic patients, especially those with limited English, are less likely to engender empathetic responses from doctors, establish rapport with doctors or receive sufficient information and encouragement to participate in medical decisionmaking. Minority patients are more likely to choose providers of the same race, ethnicity or language and also more likely to be satisfied, connected and involved in decisionmaking with such providers.

Office for Civil Rights. *Title VI of the Civil Rights Act of 1964; Policy guidance on the prohibition against national origin discrimination as it affects persons with LEP.* Federal Register: U.S. Department of Health and Human Services. 2000;65(169). Available at: http://www.hhs.gov/ocr/lep/guide.html. Accessed May 18, 2007.

This policy guidance clarifies the responsibilities of health and social service providers that receive financial assistance from the U.S. Department of Health and Human Services (DHHS) and provides guidance for fulfilling those responsibilities under Title VI of the Civil Rights Act of 1964. The policy guidance reiterates DHHS' longstanding position that, to avoid discrimination against LEP persons on grounds of national origin, health and social service providers must take adequate steps to ensure that such persons receive, free of charge, the oral and written language assistance necessary to afford them meaningful access to services. The policy guidance specifically states that use of family members and friends as interpreters is not considered an adequate means of guaranteeing such access.

☼ Office of Minority Health. *National standards for culturally and linguistically appropriate services (CLAS) in healthcare: Final report.* Washington, DC: U.S. Department of Health and Human Services; 2001. Available at: http://www.hablamosjuntos.org/pdf_files/National_Standards_finalreport_Mar2001.pdf. Accessed May 18, 2007.

With input from a national advisory committee of policymakers, health care providers and researchers, these 14 standards were developed based on an analytical review of key laws, regulations, contracts and standards currently in use by federal and state agencies and other national organizations. The standards were created to ensure that all people entering the health care system receive equitable and effective treatment in a culturally and linguistically appropriate manner.

☼ Perkins J, Simon H, Cheng F, Olson K, Vera Y. *Ensuring linguistic access in health care settings: An overview of current legal rights and responsibilities.* Los Angeles, CA: National Health Law Program for the Henry J. Kaiser Family Foundation; 2003. Available at: http://www.kff.org/uninsured/loader.cfm?url=/commonspot/security/getfile.cfm&PageID=22093. Accessed May 18, 2007.

This manual provides an overview of the status of linguistically appropriate access to health care and the array of national and state legal requirements, as well as accreditation agencies, affecting the delivery of linguistically appropriate services to non-English speaking patients. Recommendations include: educating health administrators and providers about the laws related to linguistic access, strengthening monitoring and enforcement of the laws, collecting data on the health status and health care utilization of patients with limited English proficiency and hiring bilingual staff and interpreters.

Riddick S. Improving access for limited English-speaking consumers: A review of strategies in health care settings. *Journal of Health Care for the Poor and Underserved.* 1998;9:S40-S61.

Written by one of the leaders in the language access movement, this paper describes different strategies developed to provide health care services to patients with limited English skills. Some of these strategies include: hiring bilingual/bicultural providers, creating an outreach position for the minority population, using bilingual employees as interpreters, hiring or contracting professional interpreters, using bilingual volunteers, etc. The paper also discusses new approaches being used in medical interpreting, such as remote-simultaneous interpretation, remote-consecutive interpretation, video conferencing and software programs. The author explains how various health care settings are applying these strategies in their daily functions.

☼ Woloshin S, Bickell NA, Schwartz LM, Gany F, Welch G. Language barriers in medicine in the United States. *Journal of the American Medical Association.* 1995;273(9):724-728.

This article reviews the status of interpreter services in the U.S. health care system and the legislative responses to meet the needs of patients with limited English proficiency. Providers frequently rely on three suboptimal mechanisms for interpretation: 1) their own language skills, 2) the patient's

family or friends or 3) ad hoc interpreters (e.g., other patients in waiting room). These mechanisms can compromise information transfer, undermine patient confidentiality and informed consent, disrupt the provider from the clinical evaluation and increase frustration for both providers and patients. Federal policies (i.e., the Civil Rights Act) have been created to ensure equal access; however, these policies are vague and unfunded and rely on ad hoc enforcement. Recommendations for improving interpretation in health care include: development of clear standards for medical interpreter training and certification; training appropriate ad hoc interpreters (i.e., bilingual staff); contracting with telephonic interpretation services and having multilingual literature, videos and signage available. Additionally, the authors encourage increasing the recruitment of multilingual persons to the health care work force and teaching English to patients with limited English proficiency.

Woloshin S, Schwartz LM, Katz SJ, Welch HG. Is language a barrier to the use of preventive services? *Journal of General Internal Medicine.* 1997;12:472-477. Available at: http://www.pubmedcentral.nih.gov/picrender.fcgi?artid=1497155&blobtype=pdf. Accessed August 14, 2007.

This article describes a study that found that women in Ontario, Canada who spoke a language other than English at home were less likely to receive preventive services (i.e., breast examinations, mammograms and Pap tests). Even with the presence of universal and comprehensive insurance in the Canadian health care system, and controlling for variables known to be related to the utilization of preventive services (e.g., education, income, family size, number of doctor visits, ethnic self-identification and immigration status), language was significantly related to fewer breast exams, Pap tests and mammograms.

6.4 Mental Health

The mental health field has taken the lead in making valuable contributions to the cultural and linguistic competency literature on the development of standards for culturally competent practices. The most frequently cited work is a two-volume monograph by Cross, et al. that outlines a philosophical framework for developing and implementing a mental health service delivery system that provides culturally competent care. The resources below highlight the current literature on evaluation needs in the area of mental health and step-by-step guides to the provision of care.

Bhui K, Warfa N, Edonya P, McKenzie K, Bhugra D. Cultural competence in mental health care: a review of model evaluations. *BMC Health Services Research* [serial online]. 2007;7(15):1-10. Available at: http://www.biomedcentral.com/content/pdf/1472-6963-7-15.pdf. Accessed May 18, 2007.

This article is a systematic review of evaluated models of culturally competent practice and service delivery in mental health. Very few studies were found to include an evaluation component and none included evaluation of client satisfaction. The authors recommend that future studies evaluate the effectiveness of cultural competency training and culturally competent service delivery.

The Colorado Trust. *Keys to cultural competency: a literature review for evaluators of recent immigrant and refugee service programs in Colorado.* Denver, CO: The Colorado Trust; 2002. Available at: http://www.coloradotrust.org/repository/publications/pdfs/KeystoCulturalCompetency04.pdf. Accessed May 20, 2007.

This report provides an overview of immigrant and refugee groups from Bosnia-Herzegovina, Central America, Kurdistan, Laos, Mexico, Somalia, Sudan, the former Soviet Union and Vietnam. For each group, the report briefly describes the following: history, entry status, social networks, intergenerational and gender conflict, social identification, at-risk youth, education, employment and stress experiences (e.g., war trauma). The report also discusses challenges for evaluators and provides recommendations for how best to work with immigrant and refugee populations when conducting evaluations.

Hogg Foundation for Mental Health. *Cultural competency: a practical guide for mental health service providers.* Saldaña D, ed. Texas: Hogg Foundation for Mental Health; 2001. Available at: http://www.hogg.utexas.edu/PDF/Saldana.pdf. Accessed May 18, 2007.

This guide offers a wide variety of concrete strategies to improve the cultural competency of mental health service provision. Examples of strategies include: building rapport, conducting culturally sensitive assessments, evaluating culturally-related syndromes, addressing interpreter challenges and ensuring confidentiality.

Working Group on Cultural Competence in Managed Mental Health Care. *Cultural competence standards in managed mental health care for four underserved/underrepresented racial/ethnic groups.* Rockville, MD: Center for Mental Health Services of the Substance Abuse and Mental Health Services Administration, Department of Health and Human Services; 1998. Available at: http://www.wiche.edu/MentalHealth/Cultural_Comp/ccstoc.htm. Accessed December 27, 2005.

This document was developed as a result of the separate and joint work of four national panels to develop cultural competency standards in mental health services for four racial or ethnic groups (i.e., African Americans, Latinos, Native Americans, and Alaskan Natives and Asian and Pacific Islander Americans). Each panel reviewed the literature on mental health research and services pertaining to their particular racial or ethnic group and developed a set of 16 guiding principles for providing mental health care to that population. The panels also developed standards for eight aspects of health care systems and nine aspects of clinical care. Standards developed for providers included: 1) knowledge and understanding of patient populations' backgrounds, clinical issues for different ethnic groups and sub-groups, how to provide appropriate treatment, and agency and provider roles and 2) the knowledge and skills to communicate effectively across cultures, provide quality assessments, formulate and implement quality care and treatment plans, provide quality treatment and demonstrate respectful attitudes.

☼ Cross TL, Bazron BJ, Dennis KW, Isaacs MR. *Towards a culturally competent system of care: a monograph on effective services for minority children who are severely emotionally disturbed.* Washington, DC: National Institute of Mental Health, Child and Adolescent Service System Program Technical Assistance Center, Georgetown University Child Development Center; 1989. Available at: http://www.eric.ed.gov/ERICDocs/data/ericdocs2sql/content_storage_01/0000019b/80/22/d8/37.pdf. Accessed August 14, 2007.

This frequently cited two-volume monograph outlines a philosophical framework for developing and implementing a service delivery system that provides culturally competent care. The authors outline the cultural competency continuum; identify principles; and offer practical ideas for improving service delivery at policy, administrative and clinical levels to children of color who are severely emotionally disturbed.

Viccora E. *Creating culturally competent mental health systems for Latinos: perspectives from an expert panel.* National Technical Assistance Center for Mental Health Training; 2001. Available at: http://www.consumerstar.org/pubs/creatingCCLatino.pdf. Accessed December 20, 2005.

This report is one in a series created to provide basic information and guidelines to mental health agencies regarding the needs of racial and ethnic minorities. The report describes the mental health needs of Latinos, their relevant cultural characteristics and traditions, their perceptions of mental illness and their preferences for services and supports. The report also describes successful mental health agencies that have tailored their services to meet the needs of Latino consumers.

6.5 Training and Education

Ongoing training and education of health care professionals is a key recommendation for cultural and linguistic competency. A health care professional's ability to appropriately assess and communicate with a client is critical to the quality of care and to successful treatment outcomes. As recognition of the importance of cultural and linguistic competency grows, there will be continued emphasis on education and training curricula for students, as well as continuing education opportunities for people already working in health care settings. The resources below provide tools, strategies, curricula and further links to education and training resources for organizations and medical schools addressing the training needs of current and future health care professionals.

Association of American Medical Colleges. *Cultural competence education for medical students.* Washington, DC: Association of American Medical Colleges; 2005. Available at: http://www.aamc.org/meded/tacct/culturalcomped.pdf. Accessed December 17, 2005.

This assessment tool was developed to help medical schools integrate cultural competency training into their curricula. Schools can self-administer the tool to identify the major domains of cultural competence and to monitor the educational experience of students.

Beach MC, Price EG, Gary TL, Robinson KA, Gozu A, Palacio A, Smarth C, Jenckes MW, Feuerstein C, Bass EB, Powe NR, Cooper LA. Cultural competence: a systemic review of health care provider educational interventions. *Medical Care.* April 2005;43(4):356-373.

This article is a systematic review of the literature for strategies most effective in improving the quality of care for racial and ethnic minorities. Prior to being chosen for review, articles were examined against criteria developed by the authors. Only 34 articles written between 1980 and June 2003 were eligible for review; these studies measured one or more of the following: provider knowledge, provider attitudes, provider skills, patient outcomes, outcomes associated with specific features of cultural competence training and the cost of cultural competence training. The results illustrated that cultural competence training had a beneficial effect on provider knowledge, attitude, skills and behaviors, and patient satisfaction. Which training strategy affected which types of outcomes, however, was difficult to determine, due to the variety of curriculum content and methods.

The California Endowment. *A manager's guide to cultural competence education for health care professionals.* Gilbert JM, ed. Woodland Hills, CA: California Endowment; 2003. Available at: http://www.calendow.org/reference/publications/pdf/cultural/TCE0217-2003_A_Managers_Gui.pdf. Accessed May 18, 2007.

This guide was designed to help managers and administrators of health care organizations select a cultural competence trainer that best fits the needs of their practicing health care professionals. It complements and should be used with the *Principles and recommended standards for the cultural competence of health care professionals* (also listed in this annotated bibliography, immediately below).

The California Endowment. *Principles and recommended standards for the cultural competence education of health care professionals.* Gilbert JM, ed. Woodland Hills, CA: California Endowment; 2003. Available at: http://www.calendow.org/reference/publications/pdf/cultural/TCE0215-2003_Principles_and.pdf. Accessed December 29, 2005.

Developed by an expert panel with national input, this guide is one in a series of documents that provide guidance and resources to organizations about becoming more culturally competent. This document provides recommendations for cultural competency training content standards, methods for training and how to implement and evaluate programs.

The California Endowment. *Resources in cultural competence education for health care professionals.* Gilbert JM, ed. Woodland Hills, CA: California Endowment; 2003. Available at: http://www.calendow.org/reference/publications/pdf/cultural/TCE0218-2003_Resources_in_C.pdf. Accessed May 21, 2007.

This resource bibliography includes a vast array of data, tools, articles, curricula and other resources relevant to cultural competence education for health care professionals. It was compiled as part of a research and environmental scan for a project funded by The California Endowment. The bibliography also includes a listing of various guides to providing culturally competent care and a

listing of organizational, personal and patient assessments that can be used for evaluating the level of cultural competence in service delivery and of individual care providers.

Loudon RF, Anderson PM, Gill PS, Greenfield SM. Educating medical students for work in culturally diverse societies. *Journal of the American Medical Association*. 1999;282:875-880.

This article reviews the literature on cultural diversity education programs for medical students. After a systematic search, articles about 17 programs (1967 to 1997) were chosen for review. Almost all of the programs were for medical students in their first or second year of training. The impetus for each program was related to perceptions of discrimination. Methods used to teach cultural diversity included: patient simulations, discussion of video vignettes, panels of community members presenting resources, development of language skills, visiting Mexico, role plays and clerkships. Most courses addressed attitudes and health beliefs, alternative healing systems and complementary medicine, demographics and language barriers. A majority of programs were optional and were evaluated via a student satisfaction questionnaire.

National Alliance for Hispanic Health. *A primer for cultural proficiency towards quality health services for Hispanics*. Washington, DC: Estella Press; 2001. Available at: http://www.hispanichealth.org/pdf/primer.pdf. Accessed May 18, 2007.

This short primer and its accompanying workbook were created as an outgrowth of Proyecto Informar, a 15-year initiative to improve communication between health care providers and their patients. The premise of the information is that cultural proficiency is critical to quality care. Quality health services for Hispanics rely not only on learning a specific set of skills, but also on developing proficiency in the art of listening to and communicating with patients and families from a holistic perspective. The primer discusses Hispanic culture and history, language issues, the cultural competency continuum and how providers can ensure that they and the systems within which they work do not inhibit access to care.

Office of Minority Health. *Teaching cultural competency in health care: a review of current concepts, policies and practices*. Washington, DC: U.S. Department of Health and Human Services; 2002. Available at: http://www.omhrc.gov/assets/pdf/checked/em01garcia1.pdf. Accessed May 18, 2007.

This report, a follow-up to the Office of Minority Health's "National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health Care," presents the findings of an "environmental scan" to inform the development of cultural competence curriculum modules for family physicians. Policy and research issues highlight the importance of culturally competent health care and training methods. The report discusses training practices and concepts of cultural competence as they relate to the three major themes of the CLAS standards. Lastly, it reviews sample curricula and analyzes their content, teaching techniques and assessment strategies.

Shaya FT, Gbarayor CM. The case for cultural competence in health professions education. *American Journal of Pharmaceutical Education* [serial online]. 2006;70(6):1-6. Available at: http://www.pubmedcentral.nih.gov/picrender.fcgi?artid=1803701&blobtype=pdf. Accessed May 18, 2007.

This article advocates that schools of the health professions (e.g., medical schools, schools of pharmacy) should develop and implement or expand existing curricula to present the evidence of health disparities among racial and ethnic minorities and the importance of culturally competent care, as well as to provide more exposure to and communication with culturally-diverse populations.

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* [serial online]. 1998;9(20):117-125. Available at: http://healthresearch.berkeley.edu/disparities/docs/CulturalHumility.pdf. Accessed May 21, 2007.

This article proposes a distinction between cultural humility and cultural competence. Cultural humility incorporates a life-long commitment to self-evaluation and critique to counter the power imbalances inherent in the provider-patient dynamic. The culturally humble provider focuses on developing a mutually beneficial and non-paternalistic partnership with communities through advocacy and by practicing patient-focused care.

Thom DH, Tirado MD, Woon TL, McBride MR. Development and evaluation of a cultural competency training curriculum. *BMC Medical Education* [serial online]. 2006;6:38. Available at: http://www.biomedcentral.com/1472-6920/6/38. Accessed: May 21, 2007.

This report evaluates a cross-cultural curriculum created for residents and practicing physicians based on a model of culturally competent physician behaviors. The report also investigates the training plus feedback compared to feedback alone with respect to changes in patient-reported physician behaviors, patient satisfaction, patient trust in his or her physician and disease-specific patient health outcomes. The authors conclude that no statistically significant data related to the effect of the training was found, and therefore the report indicates that the value of cultural competency training remains to be established.

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7. References

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