

CULTURAL COMPETENCY AND NURSING: A REVIEW OF CURRENT CONCEPTS, POLICIES, AND PRACTICES

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EXECUTIVE SUMMARY

To help achieve its mission of “improving the health of racial and ethnic minority populations through the development of effective health policies and programs that help to eliminate disparities in health,” the Office of Minority Health (OMH) has contracted with the American Institutes for Research (AIR) to develop and test curriculum modules that effectively equip nurses with cultural and linguistic competencies. These modules will be grounded on the principles outlined in the National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health Care issued in December 2000 and will build on the current work of the Cultural Competency Curriculum Modules (CCCM) for family physicians. Cultural competency training geared toward the nursing profession will greatly affect the quality of healthcare delivery, since nurses spend a great majority of their time on direct patient care. These modules will serve to help nurses develop the skills necessary to facilitate effective patient-nurse interactions and enhance the quality of care for our diverse population.

Purpose and Methods

The environmental scan is part of a larger effort to develop curriculum modules on culturally competent care that nurses can employ to obtain Continuing Education Units. The scan was instituted to determine whether available information on the concepts, policies, and teaching practices for nurses regarding culturally competent health care provided an adequate base for developing the modules and, if so, to summarize and synthesize this information into a usable form. We discuss the three main themes of the CLAS standards as they apply to nursing: culturally competent care, language access services, and organizational supports. Even though we will present them separately, these three themes are ultimately parts of the interrelated and overall construct of cultural competence.

The environmental scan was conducted from October 2003 to March 2004 and gathered information through literature searches; Internet searches from professional organizations, provider groups, Government agencies, and universities; and e-mail contact with nurses in the field. A central goal was to ensure a broad perspective by collecting information from a variety of sources. The primary search methods included using Web-based databases such as PubMed, EBSCO, and CINAHL for literature searches. A complete list of search terms is listed in Appendix B. We also used reference lists from prominent reports, documents, and published articles. At the first meeting of the National Project Advisory Committee (NPAC) in February 2004, members suggested resources and additional search terms regarding nursing and cultural competency. We emphasized information resources that were the most recent and most widely referenced.

Context and Rationale for Cultural Competency in Health Care

This section is divided into three subsections: the first describes the importance of cultural competence for nurses, the second offers an overview of the laws and policies that shape culturally competent practice, and the third section discusses the standards and guidelines of accreditation and professional organizations as well as consumer advocate and interest groups that support culturally competent services.

Racial and ethnic health and healthcare disparities have repeatedly been documented and continue to be a problem. Diverse racial and ethnic groups experience unequal burdens of disease, receive a lower quality of care, and confront linguistic and cultural barriers to accessing health care. Many reasons for these disparities have been cited, and the provision of culturally and linguistically appropriate services is increasingly emphasized as a potential method to eliminate disparities. With 2.7 million nurses, the nursing profession is the largest of all health professions. Nurses spend more time in direct patient care than other health professionals and are employed in a variety of settings across the healthcare system. Nurses have a unique opportunity to influence access to care, quality of care, and patient outcomes, especially for culturally diverse patients who have experienced health or healthcare disparities.

Federal and State laws, Medicaid and Medicare policies, and immigration regulations shape culturally competent practice. The most noted Federal law is Title VI of the Civil Rights Act of 1964, ensuring language access services for people with limited English proficiency. Medicare policies consider bilingual services reimbursable costs as part of overhead. Medicaid requirements vary by State, but many States are requiring culturally and linguistically competent services under Medicaid managed care contracting provisions. In response to nursing shortages, Congress established the H—1A visa with the Immigration Relief Act of 1989. This allows U.S. employers to sponsor petitions for foreign nursing graduates to enter the United States. The Commission on Graduates of Foreign Nursing Schools (CGFNS), established in 1977 by the American Nurses Association (ANA) and the National League for Nursing (NLN), evaluates and tests foreign nursing graduates before they enter the United States to ensure that they are eligible and qualified to meet U.S. licensure requirements (i.e., to pass the National Council Licensure Examination for Registered Nurses [NCLEX—RN]).

Standards and guidelines governing the implementation, instruction, and promotion of cultural competency strengthen organizational and individual commitment to providing high quality care. Standards and guidelines not only provide a foundation and support for organizations already participating in culturally competent practices, but also encourage the adoption of these practices in nonparticipating organizations. We examine standards and guidelines supporting cultural competency for accrediting organizations, the ANA Code of Ethics for Nurses, evidence-based nursing practice, professional nursing organizations, and consumer advocacy groups.

Three Themes of CLAS and Nursing

Culturally Competent Care

The theme of culturally competent care is addressed by the first three CLAS standards (see Figure 1) and, for the purpose of this report, refers to the culturally competent services delivered by individual nurses to patients and their families. After reviewing the materials we gathered on culturally competent care, we saw the following themes emerge: caring and the nurse-patient relationship, skill-centered and fact-centered approaches to acquiring cultural competence, transcultural nursing, bias and racism, the acquisition of cultural competence as a developmental process, understanding alternative sources of care, and communication with patient cultural assessment tools. Each theme is briefly discussed below.

Nursing theorists and researchers have defined caring as a fundamental value for nursing care (Dingman et al., 1999). However, the concept of caring remains elusive in the field of nursing as there is no consensus regarding the definition of caring (Paley, 2001). This theme encompasses cultural expectations of care, the nurse-client therapeutic relationship, and patient-centered care. Different cultures have different expectations of care (Leininger, 1988). Provision of culturally and linguistically appropriate services by nurses seeks to meet the different cultural expectations of care. As part of culturally competent services, nurses may have to alter their focus of caring from the individual to the person as a member of a family (Covington, 2001).

Methods to teach nurses about cultural competence attempt to balance a skill-centered and fact-centered approach (Burchum, 2002; Campinha-Bacote, 1999; Engebretson and Littleton, 2001; Giger and Davidhizar, 2003; Purnell, 2002; Warren, 1999). Providing information about specific cultures may be a starting point for discovering an individual patient's cultural beliefs and behaviors (Galanti, 2003). However, published literature with descriptions of specific cultural groups presents a caveat regarding making stereotypes or assumptions about an individual's cultural practices. Culturally competent care should not reinforce stereotypes, but respect individual variations within cultures.

Transcultural nursing can be defined as “a formal area of study and practice focused on comparative culture care (caring) values, beliefs, and practices of diverse and similar cultures in order to provide culturally congruent nursing care that contributes to the health and well-being of individuals, family groups, community groups, and institutions” (Leininger, 1994a, p. 23). The field of transcultural nursing uses Leininger’s Theory of Culture Care Diversity and Universality (see Appendix F) with the ethn nursing research method (Leininger, 1996; Leininger, 1997; Leininger, 1988) to study more than 100 different Western and non-Western cultures (Leininger Information Pack, 2002).

Although bias, ethnocentrism, and racism prevent cultural competence, nursing literature is just beginning to address these issues (Harris and Cummings, 1996; Puzan, 2003), and few cultural competency training programs or courses address these issues directly (Eliason, 1999; Vaughan, 1997).

Attributes of cultural competency can be best described as a process or journey, not an outcome (Burchum, 2002; Campinha-Bacote, 1997; Campinha-Bacote and Campinha-Bacote, 1999). Becoming culturally competent is a process that requires major changes in the attitudes, beliefs, behaviors, and communication style that each person has developed throughout his or her lifetime. As a result, it cannot be accomplished in a single training session (Salimbene, 1999). The process requires healthcare providers to see themselves as *becoming* culturally competent rather than *being* culturally competent (Campinha-Bacote, 1999).

During a health history, the nurse should ask about health beliefs and practices, including the use of herbs or medicines. While routinely asking about the use of complementary and alternative medicine (CAM) is important, determining the compatibility of CAM with biomedical treatments is also critical (Halcon et al., 2003).

Several tools have been developed to aid with communication during the interaction between the patient and the healthcare provider (Andrews and Boyle, 2003; Davidhizar and Giger, 2001; Leininger, 1991; Pacquiao, In press; Purnell, 2002; Spector, 2003). Cultural assessment tools have been developed specifically for nurses to use with every patient, not just those who are from a different cultural group.

Language Access Services

Providing language access services in healthcare settings to people with limited English proficiency (LEP) is the second theme of the CLAS standards. Standards 4 through 7 (see Figure 1) represent the set of CLAS standards that are guidelines for providing appropriate language access services for LEP patients so that they can have equal access to healthcare services. Using information from the sources we reviewed on language access services, we discuss these four prominent themes, examined briefly below: language access strategies, cost of language services, working with interpreters, and patient education and patient-related materials.

The main resources to ensure language access include oral communication (e.g., professional interpreters, family or friends, the AT&T language line) and multicultural aids (e.g., signs, appointments, phrase sheets for staff and patients, foreign language patient education materials and videos) (Duffy and Alexander, 1999; Gravely, 2001; Rivero-Kempf, 1999).

A recent report from the Office of Management and Budget estimates that language access services would add an extra 0.5 percent to the cost of an average healthcare visit (Office of Management and Budget, 2002).

Although interpretation ensures adequate communication with LEP patients, the process of an interpretation session may create problems for all parties involved. Understanding the potential barriers and difficulties, nurses may take steps to ensure smoother and more effective communication.

Nurses are required to provide information to all patients, but providing information to LEP and lower literacy patients is especially important as those patients are more vulnerable to miscommunication (Dreger and Tremback, 2002).

Organizational Supports

The third theme of the CLAS standards, addressed in standards 8 through 14, is organizational support for cultural and linguistic competence (see Figure 1). From our review of the literature, the following five themes emerged for this section: commitment at every level of the organization, recruiting and retaining diverse nursing students and staff, integrating foreign nurse graduates, training and professional development programs, and techniques for organizational assessment. Each theme is discussed briefly below.

Implementing culturally and linguistically appropriate services requires commitment at every level of the organization (Bess et al., 2003; Frederick and Frederick, 1995). Organizational commitment to the goal of cultural competency leads to a similar commitment and goal in individual employees (Anderson et al., 2003).

To achieve a diverse nursing workforce, nursing schools and training programs need to recruit culturally diverse students. Various methods to recruit minority nurses to specific nursing fields have been described in the published literature (Bennett et al., 2003; Boutain and Olivares, 1999; Rew, 1996). Not only do workplace organizations need to be culturally competent, but also institutions of higher learning need to adopt culturally competent practices, especially regarding the retention and education of a diverse student body. Programs may assign mentors to culturally diverse students (Bennett et al., 2003; Boutain and Olivares, 1999; Rew, 1996), offer scholarships for diverse students (Bennett et al., 2003), or alter class schedules for working students (Bennett et al., 2003; Boutain and Olivares, 1999).

Given the nursing shortage, foreign nurse graduates (FNGs) are increasingly employed in healthcare settings. Recruitment and retention programs for FNGs differ across organizations. Once FNGs are hired by an organization, their acclimation as employees regards not only working with patients, but interacting with coworkers and supervisors as well (Pizer et al., 1994). Given the different demographics of the FNG population, the processes used to acculturate and assimilate FNGs may be different from those used to train and retain domestically educated nurses. Assimilation to the U.S. “nursing culture” is a concern for international nurses.

Organizations are not only responsible for ensuring a culturally competent work environment for a diverse nursing staff; all nurses within the organization should have training and support to implement the CLAS standards. Examples include using cultural brokers, new employee orientation, or continuing education trainings.

At the organizational level, the ability to measure cultural competency is still in the development stages. Given the qualitative nature of cultural competency and interactions between providers and patients, quantitative measures at the organizational level may come from a variety of sources.

Curriculums and Training

For this section, we conducted a content analysis of several curriculums used in nursing schools across the United States to determine whether they covered common core concepts and competencies, used common teaching techniques, and conducted evaluations of their curriculums. Of the courses reviewed, we identified the following common core concepts: examining one’s own cultural beliefs, exploring the influence of culture on health and health behaviors, providing information for specific cultural groups, using a theoretical approach, and integrating concepts into university curriculums. The majority of courses used a combination of lecture and discussion. Several programs used case studies, audiovisual materials such as films and videos, and Internet resources. Methods used depended on the availability and cost of materials, participant’s comfort level, and community resources. Although the ideal situation would include evaluation of all programs presented, this situation is not always possible. A few programs from

both universities and healthcare organizations reported evaluation results. These evaluation show that students and professional nurses are open to receiving information about culture and that cultural competency trainings may increase cultural knowledge and self-efficacy.

Conclusion

The information available provides a sufficient basis to begin defining modules for cultural competency for nurses. However, recommendations from the NPAC and consensus building members, insight from the three expert concept papers commissioned for this project, and the results of the initial focus groups with practicing nurses will be essential information for designing the curricular modules. Despite the need for further research, this environmental scan shows that much information and many resources are available that address all three themes of the CLAS standards.

SECTION I. INTRODUCTION

In 1999, the U.S. Department of Health and Human Services' (HHS') Office of Minority Health (OMH) first proposed national standards for culturally and linguistically appropriate services (CLAS) as a means to correct inequities that exist in the provision of health care (*Federal Register* 64(240), 70042–70044). The standards were developed on the basis of an analytical review of key laws, regulations, contracts, and standards used by Federal and State agencies and other national organizations, with input from a national advisory committee of policymakers, healthcare providers, and researchers. Open public hearings also were held to obtain input from communities throughout the Nation. The standards represent the first national standards for cultural competence in health care. The 14 standards apply to all recipients of Federal funds. They follow three general themes: culturally competent care (standards 1–3), language access services (standards 4–7), and organizational supports (standards 8–14) (see Figure 1). The final CLAS standards were issued in the *Federal Register* on December 22, 2000 (*Federal Register* 65(247), 80865–80879), and the final report, *National Standards for Culturally and Linguistically Appropriate Services in Health Care*, was published in March 2001.

The CLAS standards recognize that culture and language are central to the delivery of health services. It is essential for healthcare providers to be sensitive to cultural and linguistic factors while serving people from all backgrounds. One prerequisite for implementing culturally competent health care is teaching healthcare providers how to practice it. Because the efforts to teach cultural competency have been largely isolated across the country, OMH recently contracted with the American Institutes for Research (AIR) to carry out the first national effort to design and assess Cultural Competence Curriculum Modules (CCCM) for family physicians. Work on the CCCM project highlighted the need for a similar curriculum designed specifically for nurses. As CCCM for family physicians become available to the general public, OMH has continued its dedication to educating healthcare professionals by working with AIR to design and assess Culturally Competent Nursing Modules (CCNM) that effectively equip nurses with cultural and linguistic competencies. Cultural competency training geared toward the nursing profession will greatly impact the quality of healthcare delivery, because nurses spend a majority of their time on direct patient care. These modules will serve to help nurses develop the skills necessary to facilitate effective patient-nurse interactions and enhance the quality of care for our diverse population.

This report was undertaken as part of the larger effort to develop curriculum modules on culturally competent care that nurses can employ to obtain Continuing Education Units. An environmental scan was instituted first to determine whether available information on the concepts, policies, and teaching practices for nurses regarding culturally competent health care provided an adequate base for developing the modules and, if so, to summarize and synthesize this information into a usable form.

Figure 1. National Standards for Culturally and Linguistically Appropriate Services
The CLAS standards, proposed by the OMH, will serve as the framework for Culturally Competent Nursing Modules.

Source: *Federal Register* 65(247), 80865–80879 (2000).

Culturally Competent Care
<ol style="list-style-type: none"> 1. Health care organizations should ensure that patients/consumers receive from all staff members effective, understandable, and respectful care that is provided in a manner compatible with their cultural health beliefs and practices and preferred language. 2. Health care organizations should implement strategies to recruit, retain, and promote at all levels of the organization a diverse staff and leadership that are representative of the demographic characteristics of the service area. 3. Health care organizations should ensure that staff at all levels and across all disciplines receive ongoing education and training in CLAS delivery.
Language Access Services
<ol style="list-style-type: none"> 4. Health care organizations must offer and provide language assistance services, including bilingual staff and interpreter services, at no cost to each patient/consumer with LEP at all points of contact and in a timely manner during all hours of operation. 5. Health care organizations must provide to patients/consumers in their preferred language both verbal offers and written notices informing them of their right to receive language assistance services. 6. Health care organizations must ensure the competence of language assistance provided to limited English proficient patients/consumers by interpreters and bilingual staff. Family and friends should not be used to provide interpretation services (except on request by the patient/consumer). 7. Health care organizations must make available easily understood patient-related materials and post signage in the languages of the commonly encountered groups and/or groups represented in the service area.
Organizational Supports
<ol style="list-style-type: none"> 8. Health care organizations should develop, implement, and promote a written strategic plan that outlines clear goals, policies, operational plans, and management accountability/oversight mechanisms to provide CLAS. 9. Health care organizations should conduct initial and ongoing organizational self-assessments of CLAS-related activities and are encouraged to integrate cultural and linguistic competence-related measures into their internal audits, performance improvement programs, patient satisfaction assessments, and outcomes-based evaluations. 10. Health care organizations should ensure that data on the individual patient's/consumer's race, ethnicity, and spoken and written language are collected in health records, integrated into the organization's management information systems, and periodically updated. 11. Health care organizations should maintain a current demographic, cultural, and epidemiological profile of the community as well as a needs assessment to accurately plan for and implement services that respond to the cultural and linguistic characteristics of the service area. 12. Health care organizations should develop participatory, collaborative partnerships with communities and utilize a variety of formal and informal mechanisms to facilitate community and patient/consumer involvement in designing and implementing CLAS-related activities. 13. Health care organizations should ensure that conflict and grievance resolution processes are culturally and linguistically sensitive and capable of identifying, preventing, and resolving cross-cultural conflicts or complaints by patients/consumers. 14. Health care organizations are encouraged to make available regularly 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.

Definition of Cultural Competence

Derived from the field of medical anthropology, the concept of cultural competence has been employed in many fields of healthcare delivery. The first published mention of the term “cultural competence” was by Cross, Bazron, Dennis, and Isaacs in 1989 (Burchum, 2002). For the purposes of this project, we adopt the definition used in the National Standards for Culturally and Linguistically Appropriate Services in Health Care (*Federal Register* 65(247), 80865–80879) issued in December 2000 by the OMH:

Cultural and linguistic competence is a set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among professionals that enables effective work in cross-cultural situations. “Culture” refers to integrated patterns of human behavior that include the language, thoughts, communications, actions, customs, beliefs, values, and institutions of racial, ethnic, religious,

or social groups. “Competence” implies having the capacity to function effectively as an individual and an organization within the context of the cultural beliefs, behaviors, and needs presented by consumers and their communities (Based on Cross et al., 1989).

In this definition of cultural competence, social groups encompass not only race, ethnicity, and religion, but also gender, sexual orientation, age, disability, and socioeconomic status. Linguistic minorities include not only people with limited English proficiency (LEP), but also people with low literacy skills and the deaf and hearing impaired.

Figure 2. Social Groups Recognized in the Definition of Cultural Competence

The definition of cultural competence encompasses a variety of social groups.

Social Groups

- Race
- Ethnicity
- Religion
- Gender
- Sexual Orientation
- Age
- Disability
- Socioeconomic Status

Linguistic Minorities

- Limited English proficiency
- People with low literacy skills
- Deaf and hearing impaired

Purpose of the Environmental Scan

This report summarizes and synthesizes existing information gathered during an environmental scan on the concepts, policies, and teaching practices for nurses regarding culturally competent health care. It provides background information on culturally and linguistically appropriate services both to the CCNM National Project Advisory Committee (NPAC), a group of experts who will guide the development of the CCNM, and to the AIR staff who will develop the modules.

The 14 CLAS standards (see Figure 1) form the starting point for this initiative. Directed primarily at healthcare organizations, they represent a comprehensive set of recommendations for implementing culturally and linguistically appropriate services at all levels of the organizations. This includes individual providers, who are encouraged to use the standards to make their practices more culturally and linguistically accessible (*Federal Register* 65(247), 80865–80879). Because the nursing profession is the subject of this project, we use the CLAS standards as the framework, but examine them as they apply specifically to the education of nurses. We discuss the three main themes of the CLAS standards as follows.

Themes of CLAS Standards as Applied to Nursing

1. **Culturally Competent Care** refers mainly to the nurse-client relationship and the delivery of culturally competent care to patients and their families by individual nurses.
2. **Language Access Services** focus on the nurse’s role in ensuring appropriate language access services to every patient.
3. **Organizational Supports** focus on the nurse’s functioning as part of a healthcare team within an organization.

Even though we will present them separately, these three themes are interdependent. Authentic culturally competent care requires language access services for LEP patients and support by the organization at large. Similarly, effective language access services will be delivered in a culturally appropriate manner. Organizational supports ensure that nurses provide consistent culturally and linguistically appropriate services on an ongoing basis. The three themes are ultimately parts of the interrelated and overall construct of cultural competence.

Methods

The environmental scan consisted of gathering information from October 2003 to March 2004 through literature searches, Internet searches, and e-mail contact with nurses in the field. Our main objective during the gathering phase was to ensure a broad perspective on the subject by collecting information from a variety of sources. The sources focused on materials related to teaching cultural competence to nurses, including the content of specific cultural competency curriculums, conceptual frameworks for cultural competence, policy and accreditation standards, and other information pertaining to the main CLAS themes. The scan covered the following five categories.

Sources of Information

1. **Published Literature**—Peer-reviewed journal articles, editorials and opinion pieces in peer-reviewed journals, books and reports on cultural and linguistic competence, theories, frameworks, practices, surveys, or other research
2. **Nursing Schools**—Information on courses and curriculums in cultural competence, program information, and syllabuses
3. **Federal, State, and Local Agencies**—Policy and legal information, certification standards, and contracting requirements
4. **Public and Private Health Organizations**—Internal institutional guidelines, policies, training materials, accreditation standards, and reports
5. **Consumer and Advocacy Groups**—Information from organizations and associations that advocate for healthcare quality, including associations for patients, nurses, students, racially and ethnically diverse groups, and other advocate or consumer groups

The primary search methods included using Web-based databases such as PubMed, EBSCO, and CINAHL for literature searches. Key words included: “Cultural competence,” “cultural diversity,” “cultural sensitivity,” “nursing models,” “recruitment,” “retention,” “nursing education,” “nursing shortage,” “continuing education,” and “nursing organizations.” A complete list of search terms is listed in Appendix B. We performed Internet searches using the Google search engine for terms related to “cultural competence curriculums,” “cultural diversity,” and “nursing organizations.” We also used reference lists from prominent reports, documents, and published articles. At the first meeting of the NPAC in February 2004, its members suggested resources and additional search terms regarding nursing and cultural competency. We emphasized information resources that were the most recent and most widely referenced.

Another major source of information for curriculums was an e-mail survey of participants at the Transcultural Nursing Conference in September 2003. Approximately 23 participants provided descriptions of how their university or organization incorporates cultural competency and provided syllabuses when available.

Organization of This Report

This report is divided into five main sections: Introduction, Context and Rationale for Cultural Competency in Health Care, Three Themes of the CLAS Standards and Nursing, Curriculums and Training, and Conclusion.

Following the Executive Summary and Introduction, the Context and Rationale section is divided into three subsections: the first describes the importance of cultural competence for nurses, the second offers an overview of the laws and policies that shape culturally competent practice, and the third section discusses the standards and guidelines of accreditation and professional organizations as well as consumer advocate and interest groups that support culturally competent services.

The next section describes the three themes of the CLAS standards as they apply to nurses. As previously identified, the themes of the CLAS standards are culturally competent care, language access services, and organizational supports. For culturally competent care, we saw the following seven themes emerge: caring and the nurse-patient relationship, skill-centered and fact-centered approaches to acquiring cultural competence, transcultural nursing, bias and racism, the acquisition of cultural competence as a developmental process, understanding alternative sources of care, and communication with patient cultural assessment tools. For language access services, we discuss these four prominent themes: language access strategies, cost of language services, working with interpreters, and patient education and patient-related materials. For organizational supports, the following five themes emerged: commitment at every level of the organization, recruiting and retaining diverse nursing students and staff, integrating foreign nurse graduates, training and professional development programs, and techniques for organizational assessment.

The next section, Curriculums and Training, focuses on curriculums and training in nursing schools and healthcare organizations. For this section, we conducted a content analysis of several curriculums used in nursing schools across the United States to determine whether they cover common core concepts and competencies, use common teaching techniques, and conduct evaluations of the curriculums. Before discussing findings from the content analysis, we present issues surrounding cultural competence in the literature from nursing school curriculums and from trainings in healthcare organizations.

The final section concludes our review by summarizing the main findings relevant to this project.

SECTION II. CONTEXT AND RATIONALE FOR CULTURAL COMPETENCY IN HEALTH CARE

Learning the practice of culturally competent care is important for many reasons. In this section, we illustrate the critical need for cultural competence from the perspective of health-related research and the laws and policies that govern the delivery of healthcare services to an increasingly diverse population in the United States. This section is divided into three subsections: the first describes the importance of cultural competence for nurses, the second offers an overview of the laws and policies that address culturally competent practice, and the third section discusses the standards and guidelines of accreditation and professional organizations as well as consumer advocate and interest groups that support culturally competent services.

The Importance of Culturally Competent Nurses

In this section we relate the need for culturally competent nurses in the context of racial and ethnic health and healthcare disparities in the United States. By providing culturally and linguistically appropriate services, nurses may influence access to and utilization of care, quality of care, and patient outcomes, especially among racially and ethnically diverse patients. We also discuss some barriers to cultural competence among the nursing profession.

Figure 3. Rationale for Cultural Competence Education for the Nursing Profession

The need for culturally competent nurses is especially relevant in the context of racial and ethnic health and healthcare disparities.

Diverse racial and ethnic groups

- Experience unequal burdens of disease morbidity and mortality
- Receive a lower quality of healthcare services
- Confront cultural and linguistic barriers to accessing health care

Nurses

- Spend more time in direct patient care than other healthcare professionals
- Are employed in diverse settings across the healthcare system
- Are responsible for and to other members of the health service team
- Advocate for patients and their families within the healthcare system
- Do not reflect the racial and ethnic diversity of the U.S. population

Nurses may help improve access to health care, quality of care, and patient outcomes for all patients and especially those experiencing racial and ethnic health and healthcare disparities.

Racial and Ethnic Health and Healthcare Disparities

The U.S. population is increasing in diversity. Non-White and/or Hispanic ethnic and racial groups currently comprise approximately 35 percent of the total U.S. population (U.S. Census Bureau, 2003a). As of 2002, Hispanics have become the largest minority group in the United States, numbering 38.8 million. Among the race groups, Asians have the highest growth rate at 9 percent (U.S. Census Bureau, 2003b).

With this increasing diversity of the U.S. population, healthcare providers need to concentrate on the escalating problem of racial and ethnic health and healthcare disparities. Health disparities are unequal burdens of disease morbidity and mortality rates experienced by diverse racial and ethnic groups as compared to the dominant group (Baldwin, 2003). The health and policy arenas have documented extensively the longstanding problem of racial and ethnic health disparities. Recent studies documented an association between health and an individual's socioeconomic status (SES), environmental factors, ethnicity, and/or gender (Geiger, 2001; Lillie-Blanton et al., 2001; National Institutes of Health, 2001;

Rutledge, 2001; Smedley et al., 2002; Stapleton, 2001). Heart disease, diabetes, and cancer are three diseases that disproportionately affect racially and ethnically diverse groups. For example, heart disease death rates are more than 40 percent higher for African Americans than for Whites. Hispanics living in the United States are almost twice as likely to die from diabetes as are non-Hispanic Whites. Hispanics also have higher rates of high blood pressure and obesity than non-Hispanic Whites. The rate of diabetes for American Indians and Alaska Natives is more than twice that for Whites. The Pima of Arizona have one of the highest rates of diabetes in the world (U.S. Department of Health and Human Services, 2000). The death rate for all cancers is 30 percent higher for African Americans than for Whites; for prostate cancer, it is more than double that for Whites. African-American women have a higher death rate from breast cancer despite having a mammography screening rate that is nearly the same as the rate for White women. Asians and Pacific Islanders, on average, have indicators of being one of the healthiest population groups in the United States. However, there is great diversity within this population group, and health disparities for some specific segments are quite marked. Women of Vietnamese origin, for example, suffer from cervical cancer at nearly five times the rate that White women do (U.S. Department of Health and Human Services, 2000).

Racial and ethnic disparities in health care may be a contributing factor to racial and ethnic health disparities in health outcomes and status. Healthcare disparities “are defined as racial or ethnic differences in the quality of health care that are not due to access-related factors or clinical needs, preferences and appropriateness of intervention” (Smedley et al., 2002, p. 4). Causes of these disparities in health care include provider variables such as provider bias or discrimination as well as patient variables such as mistrust of the healthcare system or refusal of treatment (Baldwin, 2003). According to an Institute of Medicine (IOM) report on racial and ethnic health disparities, “a large body of published research reveals that racial and ethnic minorities experience a lower quality of health services, and are less likely to receive even routine medical procedures than are White Americans” (Smedley et al., 2002, p. 5). Also, racially and ethnically diverse patients feel that their race affects the healthcare process and the health outcomes. In one qualitative study of African Americans, patients stated that healthcare providers’ preconceived assumptions such as the person’s race, living location, and SES affect the quality of care that a person receives (Fongwa, 2002). Van Ryn and Fu (2003) suggest that provider behavior and bias contribute to racial and ethnic disparities in care. They assert that limited resources have been devoted to this aspect of healthcare disparities, perhaps because provider bias is uncomfortable to contemplate (van Ryn and Fu, 2003). Ashton and colleagues found that the effects of provider racial bias and of patient preferences on racial and ethnic healthcare disparities appear to be a small, but suggest that poor provider-patient communication is a cause of disparities (Ashton et al., 2003). More detail on racial and ethnic healthcare disparities is provided in the Access to Care and Quality of Care sections below.

In response to these dramatic disparities, the Government and other health care organizations have implemented a number of major initiatives to improve the health of non-White populations (U.S. Department of Health and Human Services, 2001). For example, Healthy People 2010 established a public health agenda with two overarching goals—to improve health and to eliminate health disparities. Disparity reduction focuses on six key areas shown to affect racial and ethnic groups differently at different stages of life: infant mortality, diabetes, cardiovascular disease, cancer screening and management, HIV/AIDS, and child and adult immunization (U.S. Department of Health and Human Services, 2000).

Likewise, the Minority Health and Health Disparities Research and Education Act of 2000, signed into law on November 22, 2000, as P.L. 106–525, creates a National Center on Minority Health and Health Disparities (NCMHD) at the National Institutes of Health (NIH) (National Conference of State Legislatures, 2001). Congress established the NCMHD to work in collaboration with other NIH Institutes and Centers to “foster, coordinate, and assess the progress of all NIH-sponsored research activities involving minority health and other health disparities” (National Institutes of Health, 2002). Priorities for the center include developing a national research agenda on health disparities, promoting and supporting research activities in minority and medically underserved communities, collaborating with NIH research

partners to sponsor activities involving minority health and health disparities, and assessing, tracking, and monitoring the results of NIH minority health and health disparities research programs (National Institutes of Health, 2002).

Educating nurses about culturally and linguistically appropriate services is a key step toward the elimination of racial and ethnic health and healthcare disparities.

Nurses: The Frontline of Health Care

The American public consistently identifies nursing as one of the most honorable and ethical professions (Carroll, 2003). Nurses are seen as being more approachable than other healthcare providers (Luker et al., 1998).

The need for continuing cultural competency education is especially relevant to the nursing profession as nurses spend more time in direct patient care, the diversity of the nursing population does not reflect the diversity of the communities they serve, and healthcare organizations are recruiting foreign nurse graduates in response to widespread nursing shortages.

Various studies have shown that nurses spend more time with patients than other healthcare providers (Han and Arnold, 2001; Rudy et al., 1998; Zupancic and Richardson, 2002). Likewise, studies have shown that nurses spend the majority of their time (50 percent to 85 percent, depending on the specialty) in direct patient care, including patient education and communication with the patient’s family (Harrison and Nixon, 2002; Holley and McGuirl, 2000; Kane et al., 2001; Skilbeck and Seymour, 2002).

Nurses also work in a variety of settings and specialties across the healthcare system. The distribution of registered nurses (RNs) by employment setting is shown in Figure 4. According to the National Sample Survey of Registered Nurses conducted by the Human Resources and Services Administration (HRSA) at the U.S. Department of Health and Human Services (DHHS), the majority of RNs in 2000 worked in the hospital setting (59.1 percent), followed by public/community health setting (18.3 percent), ambulatory care (9.5 percent), nursing homes/extended care facilities (6.9 percent), and nursing education (2.1 percent) (Spratley et al., 2000).

Figure 4. Distribution of Registered Nurses by Employment Setting, 2000

Nurses are employed in a variety of healthcare settings and specialties.

Employment Setting	Percentage of Registered Nurses Population
Hospital	59.1
Public/Community Health	18.3
Ambulatory Care	9.5
Nursing homes/extended care facilities	6.9
Nursing education	2.1

Source: Adapted from Spratley E, Johnson A, Sochalski J, Fritz M, Spencer W. *The Registered Nurse Population: Findings from the National Sample Survey of Registered Nurses*. U.S. Department of Health and Human Services, Health Resources and Services Administration, Bureau of Health Professions, Division of Nursing; 2000.

Although nurses spend more time with patients, the racial and ethnic makeup of the nursing population does not reflect the diversity of the U.S. population. According to the National Sample Survey of Registered Nurses, non-Hispanic Black and Hispanic nurses were underrepresented in the total RN population, while non-Hispanic White and American Indian populations were over represented. Comparison of the RN population to the U.S. population in 2000 is shown in Figure 5. In 2000, 86.6 percent of the total RN population was non-Hispanic White, compared to 71.8 percent of the U.S. population in 2000. Non-Hispanic Black RNs made up 4.9 percent of the RN population, compared to 12.2 percent of the 2000 U.S. population. Hispanics made up 11.4 percent of the U.S. population in 2000, but only 2.0 percent of the RN population. Asians/Pacific Islanders made up 3.7 percent of the RN population, slightly lower than their 3.9 percent makeup of the U.S. population in 2000. The American Indian/Alaska Native RN population was at 0.5 percent, higher than their U.S. population of less than 0.1 percent

(Spratley et al., 2000). Few of the nurses providing care are from racially and ethnically diverse populations, thereby creating a further gap between healthcare providers and healthcare recipients.

Figure 5. Comparison of Registered Nurse Population to General U.S. Population by Race and Ethnicity, 2000

The racial and ethnic diversity of the nursing population does not reflect that of the general population.

Racial or Ethnic Group	Percentage of Registered Nurse Population, 2000	Percentage of General U.S. Population, 2000
Non-Hispanic, White	86.6	71.8
Non-Hispanic, Black	4.9	12.2
Asian or Pacific Islander	3.7	3.9
American Indian or Alaskan Native	0.5	0.07
Hispanic	2.0	11.4

Source: Adapted from Spratley E, Johnson A, Sochalski J, Fritz M, Spencer W. *The Registered Nurse Population: Findings from the National Sample Survey of Registered Nurses*. U.S. Department of Health and Human Services, Health Resources and Services Administration, Bureau of Health Professions, Division of Nursing; 2000.

In response to nursing shortages, healthcare organizations, especially in large urban settings, have (1994). These highly skilled foreign nurses tend to complement rather than displace local labor; however, the nonimmigrant status of many of these nurses may create a vulnerable workforce (Glaessel-Brown, 1998). We mention FNGs not as a source of cultural incompetence, but as another layer of diversity in the healthcare system.

According to the National Sample Survey of Registered Nurses in 2000, approximately 4 percent of the nursing population received their basic nursing training outside the 50 States and the District of Columbia. More racial and ethnic minorities received their initial nursing education outside of the United States. Only 1.3 percent of White, non-Hispanic nurses graduated from such programs. Almost 7 percent of Hispanic, and 6 percent of non-Hispanic, Black nurses fit in this category. Conversely, 55.4 percent of Asians and 30.7 percent of Native Hawaiian or Pacific Islanders received their education outside the United States (Spratley et al., 2000). From 1988 to 1996, the number of FNGs increased 51 percent, compared with a 26 percent overall increase in nurses. The majority of FNGs come from the Philippines, Canada, the United Kingdom, and India (Glaessel-Brown, 1998). In a study of the recruitment and employment of FNGs in the New York City Health and Hospitals Corporation, more than 90 percent of H-1 visa nurses had baccalaureate degrees compared to one-third of U.S. nurses. Also, 86 percent of FNGs had been employed more than 3 years at that organization, indicating that foreign nurses have higher retention rates and may be more attractive to some employers, for example urban hospitals with high turnover rates (Pizer et al., 1994). The employment of foreign nurse graduates may lead to the need for continued education about culture for both domestically and foreign educated nurses, not only for assessing patients but also for professional relationships with colleagues from different cultural backgrounds.

Because of these characteristics of the nursing profession, nurses have a unique opportunity to help improve access to care, quality of care, and health outcomes for patients, especially those patients with racial and ethnic health and healthcare disparities.

Access to Care

Barriers in access to health care are economic, geographic, social, linguistic, and cultural (Baldwin, 2003). Figure 6 highlights some of the barriers to accessing health care. These types of barriers encompass a wide variety of specific impeding factors. However, much of the literature on access to health care focuses on access to health insurance (American Institutes for Research, 2002). Overall, 31 percent of non-White Americans ages 16 to 84 are uninsured, compared with 14 percent of White Americans in the same age group. Although non-White and White adults have comparable rates of employment, non-White adults (56 percent) are less likely than White adults (66 percent) to receive health insurance through their

employers (Commonwealth Fund, No date). Even for people with similar health insurance coverage, disparities include differences in the source of primary care (Commonwealth Fund, No date; Lillie-Blanton et al., 2001). Non-White adults are less likely to have a regular provider than White adults (Commonwealth Fund, No date). These examples accentuate the fact that social, cultural, and language barriers to access outside of insurance coverage are numerous.

Figure 6. Cultural and Linguistic Barriers to Accessing Health Care

Racial and ethnically diverse patients experience cultural and linguistic barriers to accessing health care.

- Non-White adults are less likely than White adults to receive health insurance through employers.
- Non-White adults are less likely than White adults to have a regular healthcare provider.
- Patients with inadequate health literacy report worse health status.
- Spanish-speaking Latinos are significantly less likely than non-Latino Whites to have had a physician visit, flu shot, or mammogram in the preceding year.
- Fear may deter illegal immigrants from accessing care.
- History of racism may create mistrust toward physicians and hospitals.

Literacy and language barriers may impede access to adequate health care at several points, from having health insurance to receiving basic and preventive care to accessing specialty services (Cooper et al., 2002; Dreger and Tremback, 2002; Grantmakers in Health, 2003; Parikh et al., 1996; Supples and Smith, 1995). Results from the 1992 National Adult Literacy Survey suggest that approximately half of the American adult population experiences difficulties with functional literacy—using reading, writing, speaking, and computational skills in everyday life (Kirsch et al., 1993).

Healthy People 2010 defines health literacy as “the degree to which individuals have the capacity to obtain, process, and understand basic health information and services needed to make appropriate health decisions” (U.S. Department of Health and Human Services, 2000). The average American reads at a seventh-grade level and may not be able to understand sophisticated medical terminology (Dreger and Tremback, 2002). Many low-literacy individuals may be ashamed of their reading difficulties and try to hide their low-literacy from their families. Additionally, low-literacy patients have acknowledged avoidance of health care because they are ashamed of their reading difficulties (Parikh et al., 1996). Patients with inadequate health literacy report worse health status and have less understanding about medical conditions and treatment (Ad Hoc Committee for the AMA Council on Health Literacy for the Council on Scientific Affairs and American Medical Association, 1999).

With the increasing diversity of the population, there is an increase in the number of languages spoken in the United States. According to the 2000 U.S. Census, 17.9 percent of the population spoke a language other than English at home. Of those who spoke another language at home, the majority spoke Spanish (59.9 percent), followed by other Indo-European languages (21.3 percent) and Asian and Pacific Islander languages (14.8 percent). In a nationwide telephone study of uninsured adults, Spanish-speaking Latinos were significantly less likely than non-Latino Whites to have had a physician visit, flu shot, or mammogram in the preceding year. In comparing non-Latino Whites with English-speaking Latinos, no differences in utilization were found, indicating the importance of language (Fiscella et al., 2002). Once patients get into the system, literacy and language barriers may compromise comprehension of diagnosis, treatment instructions, and plans for followup care (Grantmakers in Health, 2003). One study found that 60 percent of English-speaking patients at a public hospital could not understand a standard consent form (Dreger and Tremback, 2002). In a study of diabetes patients’ diabetes-related knowledge and behaviors, 14 percent of Spanish-speaking respondents received instruction about diabetes in English alone (Lipton et al., 1996). “The nurse’s fundamental task is to ensure effective communication” (Dreger and Tremback, 2002, p. 5), and patients are less likely to comply with treatment if they do not understand it. Without this communication, patients with low literacy and language barriers may not be able to access health care.

Language access problems interact with social class and biases as well as cultural differences. For example, although not documented with nurses and other healthcare providers, speaking a primary

language other than English or having an accent may activate prejudice in many English speakers (Lippi-Green, 2000; Urciuoli, 1996). Healthcare providers may be unaware of their own biases (Pope, 2004).

Linked to language are cultural differences that also may present barriers in access to health care. Cultural differences affect health and health behaviors and can vary within groups of the same race and ethnicity. Cultural and personal differences that may affect access to health care include family structure, patient preferences and expectations of treatment, patient involvement in decisionmaking, personal health beliefs, and beliefs about the benefits of alternative medicine (Cooper et al., 2002). Among immigrant groups, intraethnic variations may include the individual's level of adaptation to the dominant American culture, which depends on citizenship or refugee status, the circumstances of immigration, and the length of time the family has lived in the United States. These differences affect individual health practices and the ability to navigate the American health system. Social networks and use of folk healers may impact a person's decision to seek health care.

History can have a tremendous influence on creating barriers of mistrust toward physicians and hospitals for racially and ethnically diverse groups who have historically experienced racism, as the legacy of the Tuskegee University experiment demonstrates. Funded by the U.S. Government, the Tuskegee study observed Black men with syphilis to study long-term complications of the disease while allowing the study participants to believe that they were being treated. Intergenerational transmission of healthcare experiences and attitudes based on stories of such extreme discrimination are powerful influences (Watts, 2003). Fear may also be a powerful barrier for groups who are illegal immigrants (Ell and Castaneda, 1998).

Although strategies to increase access to health insurance are important and necessary to decrease disparities, the provision of culturally competent care by nurses and other providers may decrease cultural and language barriers to accessing health care.

Quality of Care

In today's changing healthcare environment, healthcare organizations are under increasing pressure and scrutiny to ensure quality of care for their patients. It is important for all practitioners and organizations to understand that providing quality care includes cultural competence (Canales and Bowers, 2001). If nurses are not culturally competent, there is a potential for misdiagnosis, unnecessary suffering, and harmful complications (Donnelly, 2000).

Recently, the Institute of Medicine convened a national committee of experts to develop a framework for a National Health Care Quality Report on the quality of health care in the United States (Institute of Medicine, 2001). According to the framework, healthcare quality consists of four components: safety, effectiveness, patient centeredness, and timeliness. Two of these components, safety and patient centeredness, can be used to illustrate the necessity of cultural competence to quality care.

The IOM report refers to patient safety as "avoiding injuries to patients from care that is intended to help them" (Institute of Medicine, 2001, p. 44). Lack of culturally competent care can result in a patient's misunderstanding of the treatment plan, which, in turn, can cause harm to the patient. For example, a patient may not take a medication correctly due to a miscommunication, compromising the patient's safety. So, the nurse must be able to communicate treatment plans effectively to patients with limited English proficiency or of diverse cultural backgrounds through culturally and linguistically appropriate services. Medical errors may also result from a lack of linguistically appropriate care. In a study examining the accuracy of medical interpretation by nurses, one-third of noncomplicated cases and two-thirds of complicated cases experienced communications problems that resulted in errors or significant omissions in the medical chart (Elderkin-Thompson et al., 2001).

The relationship between the clinician and the patient is central to patient-centered care. Patient-centered care is based on a partnership between practitioners, patients, and their families and takes into account the patient's needs and preferences (Institute of Medicine, 2001, p. 50). Patient centeredness is "furthered when patients receive information in their own language, when the clinicians have greater

awareness of potential communication difficulties, and most importantly, when care is provided taking into account the context of the patient's cultural beliefs and practices" (Institute of Medicine, 2001, p. 52). Cultural competency is a measure of quality in nursing care because the match between a patient's expectations of care and the care received will play a substantial role in compliance to a treatment plan. Patients have different expectations of quality care (Salimbene, 1999). As the population becomes increasingly diverse, culturally competent healthcare practitioners, bilingual practitioners, and language access services are becoming a requirement for high quality care (Chin, 2000).

Patient satisfaction is an indicator of quality of care for many hospitals and managed care organizations (Dingman et al., 1999; Tzeng et al., 2002; Wolf et al., 2003; Yellen, 2003). Patient satisfaction may be most closely connected to patient satisfaction with the quality of nursing care. The performance of nursing staff, including caring behaviors, contributes to patients' perceptions of the quality of the hospitalization experience (Dingman et al., 1999; Wolf et al., 2003). Creating a caring environment for patient care could improve patient outcomes (Wolf et al., 2003). In addition to caring behaviors, nurse communication may be linked to patient satisfaction. In an ambulatory surgery department, communication with the nurse was significantly associated with patient satisfaction. Hispanic patients reported lower patient satisfaction than White patients, suggesting a lack of communication with the nurse (Yellen, 2003).

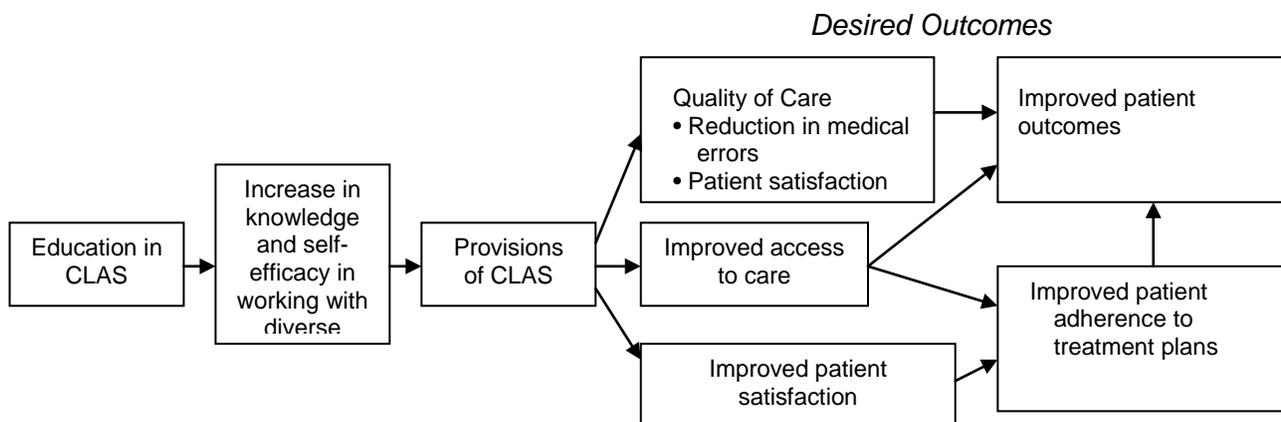
Improved Patient Outcomes

Research on the link between culturally and linguistically appropriate services and improved patient outcomes is just beginning to emerge. While there is evidence that cultural competency should help reduce racial and ethnic healthcare disparities, health systems have little evidence about which cultural competency techniques are effective and less evidence on when and how to implement these techniques (Brach and Fraser, 2000). Anderson and colleagues could not determine the effectiveness of five interventions addressing the National Standards for Culturally and Linguistically Appropriate Services (CLAS) because of the lack of comparative studies using the selected outcome measures (Anderson et al., 2003). In one integrative review, Kehoe and colleagues found that culturally relevant healthcare interventions improved health outcomes for patients with diabetes mellitus, drug addiction, sexually transmitted infections, and other health problems (Kehoe et al., 2003).

Figure 7 depicts a proposed pathway of how the provision of culturally and linguistically appropriate services may affect patient outcomes. This model is not based on empirical evidence, but describes a possible pathway for the impact of CLAS on patient health outcomes. Further research and evaluation of the connection between intervention and outcome is needed. Also, other variables affecting patient outcomes (such as health insurance availability or patient demographic variables) are not shown in this model.

Figure 7. Impact of Culturally and Linguistically Appropriate Services on Patient Outcomes

This conceptual model depicts a possible pathway describing the impact of CLAS on patient outcomes, based on discussion with expert panel members and nursing literature.



Cultural competency education for nurses has been shown to be effective in increasing knowledge (Napholz, 1999; Ryan et al., 2002; Smith, 2001) and self-efficacy (Smith, 2001; St. Clair and McKenry, 1999). However, not all training in CLAS is equally effective (Brach and Fraser, 2000). Bandura and colleagues proposed that self-efficacy is the most important prerequisite for behavioral change, because it affects how much effort is invested in a given task and what level of performance is attained (Bandura, 1986). Potentially, increases in knowledge and self-efficacy may facilitate nurses' provision of CLAS.

Provision of linguistically appropriate care has the potential to reduce medical errors. For example, accurate interpretation could reduce the number of communication problems that may result in significant errors or omissions (Elderkin-Thompson et al., 2001). Language services also may improve access for those patients with lower literacy or with limited English proficiency.

Provision of CLAS additionally may improve patient satisfaction with service and followup (Anderson et al., 2003). Anderson and colleagues reviewed studies evaluating interventions to increase the cultural competence in healthcare systems according to the first two themes of the CLAS standards. One study evaluated cultural competency training of mental health counselors (non-nurses). Clients of the intervention group counselors reported greater satisfaction with the interaction independent of the race of the counselor. Also, those assigned to the intervention group returned for more followup sessions (Anderson et al., 2003).

As nurses become more knowledgeable and have a higher self-efficacy in caring for diverse cultural groups, there may be a reduction in medical errors resulting from better communication, improved access to care, and improved patient satisfaction resulting in better adherence to recommended treatments. Nurses may have the potential to improve patient outcomes by providing CLAS but further empirical research is needed.

Kehoe suggested that further research in outcome studies should address long-term intervention effects, what constitutes a health outcome (e.g., changes in physiological indicators versus patient satisfaction), and isolating which intervention aspects are effective. Hahn and Cella (2003) also recommend further research to understand the causal pathways linking diversity and health outcomes. Even though further research is needed to demonstrate a direct link between cultural competence and clinical outcomes, culturally competent services have the potential to increase access, improve the quality of care, and improve patient satisfaction, leading to better outcomes for culturally diverse groups.

Figure 8. A Note on the Measurement of Cultural Competence

Measurement of healthcare providers' level of cultural competence is an important step for linking the provision of CLAS to patient health outcomes.

- Researchers have developed various measures to assess healthcare students' and professionals' knowledge, awareness, and skills related to cultural competency. Appendix C briefly describes selected measures.
- All measures are self-reported perceptions or behaviors.
- Most measures appear in a Likert-type format.
- Most measures have been assessed in nursing student populations. Reliability and validity data have been reported for some measures.
- Measures do not assess patient perceptions of cultural competency of care received.

Barriers to Achieving a Culturally Competent Work Force

While culturally and linguistically appropriate services are an important part of competent nursing care, many potential barriers exist to achieving a culturally competent work force. Lack of diversity in the nursing profession may be a potential barrier to care. Also, surveys of undergraduate and graduate nursing programs show that current nursing education does not adequately meet the needs for culturally competent care in terms of providing skills and knowledge to assess diverse patient groups (Bond et al., 2001; Chevannes, 2002; Garity, 2000; Weaver, 2001). Lack of exposure to a particular cultural group may inhibit the provision of culturally and linguistically appropriate care. One study found significant positive relationships between comfort level and amount of experience for all racial and sexual identity groups (Eliason, 1998). Nurses and nursing students may feel discomfort caused by a lack of knowledge, skills, or exposure to the cultural group; disapproval or negative attitudes toward group members; threatened by group members (i.e., the fear of becoming HIV positive); or guilt, sympathy, or pity (Eliason and Raheim, 2000; Jones et al., 1998a; Leonard, 2001). Leonard also identifies racism, bias and ethnocentrism, stereotyping, and differences in perceptions and expectations as barriers to cultural competence (Leonard, 2001).

In addition to these barriers to cultural competence, there are special considerations for FNGs with regard to cultural competency. Ryan asserts that four areas must be addressed for international nurses: socialization to the professional role, acquisition of language and other communication skills, development of workplace competence (both clinical and organizational), and availability of support systems and resources within the organization (Ryan, 2003). Even though the majority of nurses are from English-speaking countries, foreign nurse graduates may experience American language issues and complications. Likewise, international nurses may experience differences with the diversity of patients' cultures in the United States as well as the dominant American nursing culture. Behaviors in relation to communication and respect may cause conflict in the work force. For example, in a qualitative study of the adjustment of Korean nurses to American hospitals, the Korean nurses had to overcome the language barrier, accept American nursing practice, adopt the style of U.S. problemsolving strategies, and adopt the style of U.S. interpersonal relationships (Yi and Jezewski, 2000).

Policies and Laws Promoting CLAS

This subsection provides an overview of the laws and policies that influence culturally and linguistically appropriate services. We briefly discuss Federal and State laws, Medicare and Medicaid policies, and immigration laws for FNGs.

Federal and State Laws

A number of Federal and State laws include requirements for culturally and linguistically appropriate services in health care, with the majority focusing on language access (highlighted in Figure 9). The most noted of the Federal laws is Title VI of the Civil Rights Act of 1964.

Figure 9. Federal and State Laws Affecting Culturally and Linguistically Appropriate Services
Federal and State laws promote the provision of CLAS.

Federal Laws and Policies

- Title VI of the Civil Rights Act of 1964
- Americans with Disabilities Act of 1990
- Minority Health and Health Disparities Research and Education Act of 2000
- Office of Minority Health's Cultural and Linguistic Access Standards
- Medicare
- Medicaid

State Laws and Policies

- Language access laws
- State civil rights laws
- Tort liability
- English-only laws

Source: Perkins J, Youdelman M, Wong D. *Ensuring Linguistic Access in Health Care Settings: Legal Rights and Responsibilities*. 2nd ed. Los Angeles, CA: National Health Law Program; 2003.

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

HHS-funded health programs were required to provide patients with limited English proficiency (LEP) access to services equal to that of English speakers. However, the regulation was vague and is difficult to comply with and enforce. On August 30, 2000, OCR issued a policy guidance to provide clarity and guidance to physicians and other recipients of Federal funds on the regulation as it applies to LEP patients (Office for Civil Rights, 2000). However, a U.S. Department of Justice (DOJ) memorandum dated July 8, 2002, required the departments of the Federal Government to increase consistency with regards to the existence of LEP policies. In response, the HHS reissued its LEP policy guidance using the DOJ template on August 8, 2003 (U.S. Department of Health and Human Services, 2003). In this guidance, all recipients of Federal financial assistance from HHS are required to provide to LEP persons meaningful access to their programs and activities. To determine their obligation to provide LEP services, recipients must make an individual assessment that balances the following four factors.

Four Factor Analysis Determining Obligations to Provide LEP Services

- Number or proportion of LEP persons eligible to be served or likely to be encountered
- Frequency with which LEP individuals come in contact with the program
- Nature and importance of the recipient’s program, activity, or service to people’s lives
- Resources available to the recipient and costs

The intent of the guidance “is to suggest a balance that ensures meaningful access by LEP persons to critical services while not imposing undue burdens on small business, small local governments, or small nonprofits.” The greater the number or proportion of LEP persons or the more frequent the contact with LEP persons, the more likely that providing language services is necessary. Greater importance or urgency of the program would also support the need for more immediate language services. A recipient’s resources and costs to provide language services would have an impact on the services it might provide. Recipients may want to document their application of the four-factor analysis by recording the number of LEP persons from a particular language group served or by verifying the level of resources and costs that would be incurred to provide language services. After applying the four-factor analysis, a recipient may conclude

that providing different language assistance services, or none at all, is appropriate for different types of programs or activities.

Another key constituent for language access services is people with disabilities. The Americans with Disabilities Act (ADA) of 1990 provides for language accommodations for individuals who are deaf or hard of hearing when they access health care (American with Disabilities Act of Americans with Disabilities Act of 1990, 1990). The ADA extended the reach of Federal law beyond federally funded programs and into the private offices of physicians, dentists, and other individual practitioners (American with Disabilities Act of Americans with Disabilities Act of 1990, 1990). In addition to removing architectural barriers, healthcare facilities may be required to provide auxiliary aids such as telecommunication devices and interpreters for hearing-impaired patients (Harris, 1999; U.S. Department of Justice, 2003; Wood, 2002).

The Minority Health and Health Disparities Research and Education Act, discussed earlier, became effective on October 1, 2000, establishing the National Center on Minority Health and Health Disparities to facilitate the work of the National Institutes of Health to address and reduce health disparities (National Conference of State Legislatures, 2001; National Institutes of Health, 2002).

As discussed in the Introduction, the Office of Minority Health issued 14 national standards on culturally and linguistically appropriate services in health care. The standards represent the first national standards for cultural competence in health care. The 14 standards are guidelines for all recipients of Federal funds. They follow three general themes: culturally competent care (standards 1–3), language access services (standards 4–7), and organizational supports (standards 8–14). The final CLAS standards were issued in the *Federal Register* on December 22, 2000 (*Federal Register* 65(247), 80865–80879), and the final report, *National Standards for Culturally and Linguistically Appropriate Services in Health Care*, was published in March 2001.

In addition to these Federal laws, a number of States have also enacted laws that require providers to offer language assistance to LEP persons in many healthcare and other service settings. Forty States have enacted one or more laws imposing interpretation requirements for a specific service or medical condition. State civil rights laws may also sanction language access requirements for healthcare providers. In addition, State court-developed common law provides another source of potential protection for LEP patients. Patients may use tort law principles to address instances in which the lack of communication created a barrier to adequate care. Lack of sufficient informed consent is a common basis for medical malpractice claims (Perkins et al., 2003).

English-only laws at the State level may threaten access to healthcare services for LEP patients. At least 25 States have enacted laws that make English the official State language. However, these laws do not exempt State governments from complying with the Federal Title VI obligations and agency guidance (Perkins et al., 2003). Figure 28 in Appendix D highlights States that enacted laws making English the official State language. Appendix D also shows a detailed summary of State law requirements addressing language and cultural needs in health care.

Medicare and Medicaid Policies

Medicare provides health coverage for people over age 65, people with end-stage renal disease (permanent kidney failure), and people of any age with certain other disabilities (Centers for Medicare and Medicaid Services, 2003a). Hospitals participating in Medicare may seek reimbursement for providing bilingual services to inpatients. However, the reimbursement policy is limited and does not provide for explicit billing for these services, but includes them in hospital overhead costs (Perkins et al., 2003).

Medicaid, jointly funded by Federal and State governments, provides medical assistance for certain individuals and families with low incomes and resources. Medicaid policies vary among the States (Centers for Medicare and Medicaid Services, 2003b). The Centers for Medicare and Medicaid Services have informed States that Federal reimbursement for language services is available for Medicaid and State Children's Health Insurance Program enrollees (Health Care Financing Administration, 2000). Regulations

require State Medicaid programs to operate in a manner consistent with Title VI of the Civil Rights Act (Perkins et al., 2003). States' approaches to ensuring culturally competent services to Medicaid beneficiaries vary widely, primarily as a result of differences among States' demographics and healthcare delivery systems.

Immigration Policy and Credentialing for Foreign Nurse Graduates

Foreign nurse graduates enter the United States using two visa categories: nonimmigrant (e.g., F, J, or H) or immigrant (permanent resident). Nonimmigrant visa options (e.g., H-1A, H-1B, H-1C, H-2B, or TN) for nursing are limited. Because of the nursing shortage, Congress established the H-1A visa category with the Immigration Relief Act of 1989. This visa classification is no longer available as the program expired in 1995. In 1999, Congress passed the Nursing Relief for Disadvantaged Areas Act, establishing the complex H-1C visa classification. The H-1C classification imposes restrictions on the types of facilities that may petition FNGs, requires a greater number of attestations to the U.S. Department of Labor, sets a 500-visa annual cap, and does not recognize FNGs from Canada. Because of these restrictions, the H-1C visa is not frequently used (U.S. Citizenship and Immigration Services, 2003b). The North American Free Trade Agreement (NAFTA) in 1994 permitted Canadian and Mexican nurses to enter the United States for up to 1 year under a TN visa. Under the agreement, Mexican professionals have a maximum quota for the first 10 years; Canadian nurses do not (Xu et al., 1999). Securing immigrant visas for FNGs typically involve three main steps: (1) the employer must establish that there is a shortage of workers sufficiently skilled to provide the services, (2) the employer then files the I-140 form at the geographically appropriate service center, and (3) after approval, the applicant becomes eligible to apply for an immigrant visa (U.S. Citizenship and Immigration Services, 2003b).

¹ A *tort* is a wrong committed by one person against another. The injured person may recover monetary damages from the person who caused the injury, but tort is not necessarily a violation of criminal law. The tort of negligence, one type of tort, does not require proof of intent of injury. Because healthcare providers do not intend to injure their patients, medical malpractice is considered to be a type of negligence and is primarily a matter of State law (Harris, 1999).

In 2003, the Bureau of Citizenship and Immigration Services published the final rules required under section 343 of the Illegal Immigration Reform and Immigration Responsibility Act of 1996. Taking effect in 2004, these final rules require foreign-educated nurses and other healthcare professionals who are seeking nonimmigrant visas, NAFTA status, or immigrant visas to obtain a visa screen certificate as part of the visa application process. Previously, only those nurses seeking permanent occupational visas were required to obtain a visa screen certificate from the Commission on Graduates of Foreign Nursing Schools (CGFNS) (Commission on Graduates of Foreign Nursing Schools, 2003; U.S. Citizenship and Immigration Services, 2003a; U.S. Citizenship and Immigration Services, 2003b).

The CGFNS, established as a private, independent, nonprofit organization in 1977 by the American Nurses Association (ANA) and the National League for Nursing (NLN), evaluates and tests FNGs before they enter the United States to ensure that they are eligible and qualified to meet licensure requirements in the United States (i.e., to pass the National Council Licensure Examination for Registered Nurses [NCLEX-RN]) (Commission on Graduates of Foreign Nursing Schools, 1999; Xu et al., 1999). The CGFNS administers several services for international healthcare professionals. The Certification Program, administered by the CGFNS, has three parts: a credentials review of the nurse's education, registration, and licensure; the CGFNS Qualifying Exam; and an English-language proficiency exam. After successfully completing the three parts, an applicant is awarded a CGFNS certificate. The Credentials Evaluation Service of the CGFNS analyzes international credentials in comparison to U.S. standards. The International Consulting and Educational Service, a division of the CGFNS, is a team of experts that provides information on international standards, education, and licensure or registration for healthcare professionals. The International Commission on Healthcare Professions, a division of the CGFNS, administers VisaScreenTM: Visa Credentials Assessment to ensure that healthcare professionals' credentials

meet the minimum Government eligibility standards. Applicants who successfully complete VisaScreen receive a VisaScreen certificate. Finally, the International Consultants of Delaware, Inc., the newest division of the CGFNS, is a credentialing agency that evaluates foreign educational documents and provides their U.S. equivalents (Commission on Graduates of Foreign Nursing Schools, 1999).

Standards and Guidelines Supporting CLAS

Standards and guidelines are imposed by and on different types of organizations. Nursing schools and hospitals are both accredited organizations. Accreditation demonstrates an organization's commitment to excellence. The standards upon which accreditation is based are developed by nonpartisan third-party organizations.

Standards and guidelines governing the implementation, instruction, and promotion of cultural competency strengthen organizational and individual commitment to providing high quality care. Standards and guidelines not only provide a foundation and support for organizations already participating in culturally competent practices, but also encourage the adoption of these practices in nonparticipating organizations. The development of a standard requiring cultural competency education and practices can lead to cultural competency training and awareness in organizations that previously would have not used cultural competency. The enforcement of standards to develop and train nurses to be culturally competent, even if seen as an imposition, is a necessity to broaden cultural competency across organizations and disciplines.

Accreditation Standards

Standards for nursing school accreditation are developed by the National League for Nursing Accreditation Commission (NLNAC). The commission accredits all types of nursing education programs, diploma, associate's degree, and baccalaureate, under the auspices of the U.S. Department of Education. One of the goals of the commission is to "foster educational equity, access, opportunity, and mobility, and preparation for employment based upon type of nursing education." Educational equity can be interpreted as equity across diverse types of nursing students (National League for Nursing Accreditation Committee and Inc, 2004).

Hospitals, the sector in which the majority of nurses are employed, must meet the standards set by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO). The JCAHO standards for 2004 include a standard directly related to culturally and linguistically appropriate services. Standard HR.2.10 requires that organizations include cultural diversity and sensitivity training as part of employee orientation and on an ongoing basis as needed (Joint Commission on Accreditation of Healthcare Organizations, 2004).

In addition to its importance at the provider level, cultural competency is important at the access and payment levels, as patients routinely interact with insurance providers, billing clerks, claims representatives, and similar staff during the course of their illness or treatment. It is just as important for these healthcare entities to be culturally competent. To ensure the best possible experience within the healthcare delivery system, the National Committee for Quality Assurance places standards for accreditation on managed care organizations. An example is requiring managed care organizations to provide materials and publications in non-English languages that are spoken by at least 10 percent of their membership (National Committee for Quality Assurance, 2001).

Code of Ethics for Nurses

Ethical considerations may provide guidelines for practicing nurses. The ANA's *Code of Ethics for Nurses* explains the ethical obligations and duties of individuals who enter the nursing profession (American Nurses Association, 2001). The code consists of nine provisions—the first three describe the fundamental values and commitments of the nurses, the next three focus on the boundaries of duty, and the last three address duties beyond individual patient encounters. Figure 10 lists these provisions and offers suggestions for how they overlap with culturally and linguistically appropriate services.

In addition to the ANA's *Code of Ethics for Nurses*, nurse researchers explore ethical considerations of providing culturally competent nursing care. For example, Ray (1994) presents a framework and model of transcultural nursing ethics. The dynamic model consists of four foundations—transcultural caring dynamics, principles, transcultural context, and universal source. This model incorporates caring, biomedical and traditional ethics, anthropological contexts, and spirituality and religious morality (Ray, 1994).

Figure 10. Code of Ethics for Nurses and CLAS

CLAS is grounded in nursing principles that already exist such as the ANA's Code of Ethics for Nurses.

Provision	Relation to CLAS
1. The nurse, in all professional relationships, practices with compassion and respect for the inherent dignity, worth, and uniqueness of every individual, unrestricted by considerations of social or economic status, personal attributes, or the nature of health problems.	<ul style="list-style-type: none"> • Nurses take into account the needs and values of every individual patient. • Nurses deliver health care without prejudice. • An individual's lifestyle, value system, and religious beliefs should be considered in planning health care with and for each patient. • Patients have the moral and legal right to determine what will be done with their own person. • Nurses maintain compassionate and caring relationships with colleagues and treat colleagues with respect.
2. The nurse's primary commitment is to the patient, whether an individual, family, group, or community.	<ul style="list-style-type: none"> • Any plan of care must reflect the uniqueness of the patient. • Nurses seek to resolve conflict, but the nurse's commitment lies with the patient.
3. The nurse promotes, advocates for, and strives to protect the health, safety, and rights of the patient.	<ul style="list-style-type: none"> • Nurses safeguard the patient's right to privacy. • Nurses should be active participants in the development of policies and review mechanisms designed to promote patient safety, reduce the likelihood of errors, and address both environmental system factors and human factors that present increased risk to patients. • Nurses must be alert and take action regarding any instances of incompetent, unethical, illegal, or impaired practice by any member of the healthcare team.
4. The nurse is responsible and accountable for individual nursing practice and determines the appropriate delegation of task consistent with the nurse's obligation to provide optimum patient care.	<ul style="list-style-type: none"> • Individual registered nurses are responsible for the nursing care their patients receive. • Individual nurses are responsible for assessing their own competence. • When the needs of the patient are beyond the qualifications and competencies of the nurse, consultation and collaboration must be sought from qualified nurses, other healthcare professionals, or other appropriate services. • Nurses functioning in management or administrative roles have a responsibility to provide appropriate orientation to staff and assist less experienced nurses.

<p>5. The nurse owes the same duties to self as to others, including the responsibility to preserve integrity and safety, to maintain competence, and to continue personal and professional growth.</p>	<ul style="list-style-type: none"> • Nurses are required to have knowledge of current scopes and standards of nursing practice, changing issues, concerns, controversies, and ethics. • Nurses have the responsibility to remain consistent with both their personal and professional values.
<p>6. The nurse participates in establishing, maintaining, and improving healthcare environments and conditions of employment conducive to the provision of quality health care and consistent with the values of the profession through individual and collective action.</p>	<ul style="list-style-type: none"> • Nurses are responsible for contributing to a moral environment that encourages respectful interactions with colleagues, support of peers, and identification of issues that need to be addressed.
<p>7. The nurse participates in the advancement of the profession through contributions to practice, education, administration, and knowledge development.</p>	<ul style="list-style-type: none"> • Nurses should advance their profession by contributing in some way to the leadership, activities, and viability of their professional organizations. • Nursing professionals should engage in scholarly inquiry to identify, evaluate, refine, and expand the body of knowledge that forms the foundation of its discipline and practice.
<p>8. The nurse collaborates with other health professionals and the public in promoting community, national, and international efforts to meet health needs.</p>	<ul style="list-style-type: none"> • Nurses are committed to promoting the health, welfare, and safety of all people. • Nurses have the responsibility to be aware of broader healthcare concerns such as lack of access to health care, violation of human rights, and inequitable distribution of nursing and healthcare resources. • Through support of and participation in community organizations and groups, the nurse assists in educating the public, facilitates informed choice, and identifies conditions and circumstances to foster healthy lifestyles.
<p>9. The profession of nursing, as represented by associations and their members, is responsible for articulating nursing values, maintaining the integrity of the profession and its practice, and shaping social policy.</p>	<ul style="list-style-type: none"> • Nurses can work individually or collectively through political action to bring about social change.

Source: American Nurses Association. *Code of ethics for nurses with interpretative statements*. Washington, DC: Author; 2001.

Evidence-Based Nursing Practice

Evidence-based nursing (EBN) guidelines may offer another solution to providing culturally and linguistically appropriate services. EBN practice combines individual nurses' clinical expertise with current external clinical evidence from systematic nursing research to make decisions about the care of individual patients. EBN practice assumes that sufficient research has been published on the topic, the nurse has skill in accessing and critically analyzing research, and the nurse is able to implement changes based on EBN. EBN differs from evidence-based medicine because nurses consider acceptability to patients and cost effectiveness in addition to treatment effectiveness in the clinical decision-making process (Health Sciences Library, No date).

EBN practice solves problems encountered by nurses via the following four steps: (1) clearly identify the issue or problem, (2) search the literature for relevant research, (3) evaluate the research evidence using established criteria regarding scientific merit, and (4) choose interventions with the most valid evidence (Evidence-Based Health Care Project and University of Minnesota, 2001; Melnyk and Fineout-Overholt, 2002).

EBN can act as a guideline with individual clinical experience to provide quality care to patients. Increased reliance upon evidence-based protocols may decrease racial and ethnic healthcare disparities by decreasing uncertainty and minimizing individual provider discretion (Richardson et al., 2003).

Professional Nursing Organizations

Professional nursing associations act as a resource and support system for nurses. These groups, particularly those groups founded around a common ethnic bond, have demonstrated a commitment to cultural competency. Organizations such as the National Association of Hispanic Nurses, the National Black Nurses Association, the Asian and Pacific Islander Nurses Association, and the National Alaska Native American Indian Nurses Association provide professional support for diversity in the nursing field. Appendix E lists Web sites of the various nursing associations and their mission statements. Also, many of these organizations produce journals or other publications surrounding CLAS.

The American Nurses Association, the largest of all nursing associations, has the mission of "advancing the nursing profession through fostering high standards of nursing practice, promoting the economic and general welfare of nurses in the workplace, projecting a positive and realistic view of nursing, and lobbying the Congress and regulatory agencies on healthcare issues affecting nurses and the general public" (American Nurses Association, 2004). The ANA issued a position statement in which they explain that "nurses need to understand how cultural groups understand life processes, how cultural groups define health and illness, what cultural groups do to maintain wellness, what cultural groups believe to be the cause of illness, how healers cure and care for members of cultural groups, and how the cultural background of nurses influences the way in which care is delivered" (American Nurses Association, 1991). Workplace diversity was one of the top 10 areas of concern in the ANA's *Nursing's Agenda for the Future*. The ANA expects diversity to be accomplished through having diverse leadership, an increase in the number of diverse nursing students, a focus on recruiting and retaining diverse nurses, and an increase in funding and policy for diversity programs (American Nurses Association, 2002). This commitment to cultural competency encourages association members to learn more about the provision of culturally and linguistically appropriate care.

Educational and Professional Organizations

Several educational and professional organizations also are interested in cultural competency. The Web site Minoritynurse.com offers online resources for minority nurses. It provides career advice and discusses educational opportunities. Acting as a clearinghouse for nurses from diverse backgrounds, Minoritynurse.com also has links to other nursing associations, current research opportunities, and a discussion forum. Another Web site of interest is DiversityRx.org. This site provides information for increasing cultural competency in all aspects of healthcare delivery. An overview of the models and

practices used in language access services, links to Federal and State laws related to culturally competent care, and networking opportunities for those interested in health care are all on the site. Figure 11 provides addresses and descriptions of selected Web sites related to culturally competent care.

Figure 11. Web Sites Related to Culturally and Linguistically Appropriate Services

Web sites with information regarding cultural competence are available for the public domain.

Organization:

Center for Health Families and Cultural Diversity, University of Medicine and Dentistry of New Jersey
<http://www2.umdnj.edu/fmedweb/chfcd/index.htm>

Date Accessed:

1/5/2004

Description:

The site has a description of the mission and services of the center as well as links to cross-cultural health Web sites.

Organization:

Cross Cultural Health Care <http://www.xculture.org/>

Date Accessed:

1/5/2004

Description:

The site has information for interpreters and links to trainings offered by Cross Cultural Health Care.

Organization:

Diversity Rx <http://www.diversityrx.org>

Date Accessed:

1/9/2004

Description:

Diversity Rx promotes language and cultural competence to improve the quality of health care for minority, immigrant, and ethnically diverse communities. Diversity Rx is supported by the National Conference of State Legislatures, Resources for Cross Cultural Health Care, and the Henry J. Kaiser Family Foundation of Menlo Park, CA.

Organization:

MinorityNurse.com <http://minoritynurse.com/>

Date Accessed:

1/5/2004

Description:

This site provides resources and employment advancement links for minority nurses.

Organization:

National Center for Cultural Competence, Georgetown University
<http://www.georgetown.edu/research/gucdc/nccc/>

Date Accessed:

1/5/2004

Description:

This site provides information on cultural competency models and theories, a resource database, and a source for cultural competency products.

Organization:

Office of Minority Health, HHS <http://www.omhrc.gov/>

Date Accessed:

1/5/2004

Description:

This site is the main site for the Office of Minority Health, serving as a gateway to all of the resources and services offered by the office.

Organization:

The Center for Cross-Cultural Health [http:// www.crosshealth.com](http://www.crosshealth.com)

Date Accessed:

1/5/2004

Description:

The center, an independent nonprofit organization, provides information and resources for providers who want to become more culturally competent.

Organization:

The Provider's Guide to Quality and Culture <http://erc.msh.org/quality&culture>

Date Accessed:

1/5/2004

Description:

The site provides information on health disparities, different cultural groups, and what it means to be a culturally competent organization.

Organization:

Transcultural C.A.R.E. Associates <http://transculturalcare.net>

Date Accessed:

3/10/2004

Description:

Transcultural C.A.R.E. Associates is a private consultation service that focuses on clinical, administrative, research, and educational issues in transcultural health care and mental health.

Organization:

Transcultural Nursing Society <http://www.tcns.org/>

Date Accessed:

3/10/2004

Description:

This site's format is based on a discussion board system. Sections are available to both members and nonmembers of the organization. Only current members can post messages on the board.

The provision of culturally and linguistically appropriate care by healthcare providers is a potential method to reduce racial and ethnic health and healthcare disparities. Because nurses spend more time in direct patient care than other healthcare professionals, nurses may help to improve access to health care, quality of care, and patient outcomes, especially for those patients with racial and ethnic health disparities. Federal and State laws, Medicare and Medicaid policies, and immigration policies promote the provision of culturally and linguistically appropriate services by healthcare providers. Standards and guidelines of accrediting organizations, professional nursing associations, evidence-based practice, and consumer advocacy groups also support cultural competence. With this context and rationale for cultural and linguistic services, we will now explore the three themes of the CLAS standards in more detail.

SECTION III. THREE THEMES OF THE CLAS STANDARDS AND NURSING

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

Culturally Competent Care

The theme of culturally competent care is addressed by the first three CLAS standards (see Figure 1) and, for the purpose of this report, refers to the culturally competent services delivered by individual nurses to patients and their families. Many of the materials reviewed for this section provide conceptual frameworks and key aspects of culturally competent care that can be used in developing curriculums for training nurses and other healthcare practitioners. The main themes of culturally competent care are discussed in this section.

The resources gathered for this section represent the majority of the information we collected, found mainly in peer-reviewed journal articles and Web sites from professional organizations. Summaries of some of these cultural competence frameworks or approaches are given in Appendix F.

Our review of the materials we gathered on culturally competent care identified seven themes: caring and the nurse-patient relationship, skill-centered and fact-centered approaches to acquiring cultural competence, transcultural nursing, bias and racism, the acquisition of cultural competence as a developmental process, understanding alternative sources of care, and communication with patient cultural assessment tools.

Caring: The Nurse-Patient Relationship

Nursing theorists and researchers have defined caring as a fundamental value for nursing care (Dingman et al., 1999). However, the concept of caring remains elusive in the field of nursing as there is no consensus regarding the definition of caring. Most literature in this field—both qualitative and quantitative—seeks to describe elements of caring (Paley, 2001). These elements encompass cultural expectations of care, the nurse-client therapeutic relationship, and patient-centered care.

Leininger (1988) defines care as the essence of nursing and a powerful instrument to help clients recover from illness or unfavorable human life conditions (Leininger, 1988). Pacquiao and colleagues (1999) explored the definition of care through an ethnographic study of home care patients served by multidisciplinary healthcare providers. Four themes emerged defining care: care is respectful of valued lifeways and consistent with personal and cultural values; care is congruent with perceived needs and attentive to the unique needs of the individual; care promotes trust because it is responsive, competent, and consistent; and care transforms intangible qualities into concrete acts that make a difference in people's lives (Pacquiao et al., 1999, p. 114–116). Ray explored the idea of caring as an act of spiritual or divine love (Ray, 1997).

Different cultures have different expectations of care (Leininger, 1988). Provision of culturally and linguistically appropriate services by nurses seeks to meet the different cultural expectations of care. Not only do patients differ in their expectations of care, but studies have shown that nurses and patients differ in their perceptions of care. To provide effective care, nurses need to be aware of potential differences (Wichowski et al., 2003). Patients place emphasis on care that recognizes them as unique individuals (Radwin, 2000; Schmidt, 2003; Williams, 1998). In a qualitative study of oncology patients, patients appreciated being treated as a partner in the decision-making process and when nurses respected their knowledge, skills, and abilities (Radwin, 2000). Caring should not be artificial or strained: “The challenge to the nurse is to not offer comments that are politically correct (words from the mouth), but to offer

comments that reflect true caring (words from the heart)” (Campinha-Bacote and Munoz, 2001, p. 11).

Caring may not be realized if a therapeutic nurse-patient relationship is not developed (Cortis, 2000). This relationship is a dynamic, interactive, and interpersonal process that brings clients and nurses into defined care situations with quality healthcare outcomes as the primary goal. The nurse-patient relationship is a therapeutic tool that can enhance treatment approaches and generate positive health outcomes. Developing this positive therapeutic relationship requires self-reflection, a nonjudgmental attitude, and trust. Self-reflection allows nurses to be aware of their own attitudes, beliefs, and expectations. A nonjudgmental attitude is especially necessary when nurses and clients have different ideas about their care. Trust can be enhanced by established credibility and maintaining confidentiality (Bischko, 1998).

Nursing researchers also have discussed patient-centered care (Hagenow, 2003; Lauver et al., 2002). Lauver and colleagues define patient-centered care as “a respect for and integration of individual differences when delivering patient care” (Lauver et al., 2002, p. 248). They then distinguish four kinds of patient-centered interventions, used especially in health education: personalized, targeted, tailored, and individualized.

Four Types of Patient-Centered Interventions

- **Personalized interventions** invoke the name of a person or a single characteristic.
- **Targeted interventions** match characteristics of a group of people who share sociodemographic characteristics or behavioral characteristics.
- **Tailored interventions** are customized to characteristics that a person expresses.
- **Individual interventions** are highly customized to a particular individual and that person’s situation (Lauver et al., 2002).

Although tailored and individual interventions are customized to the individual patient, the interventions remain structured because of clearly delineated procedures or protocols. However, content delivery to the patient is made more meaningful as it is based on the patient’s unique characteristics and situation (Lauver et al., 2002). Hagenow proposes two challenges to patient-centered care: the provider’s focus and the organization’s culture. Provider focus must change from business functions to the patient. Organizational culture must change to be more patient-focused (Hagenow, 2003).

As part of culturally competent services, nurses may have to alter their focus of caring from the individual to the person as a member of a family. The nursing profession may need to change from the client-nurse model to the client-nurse-family model to allow for differences in cultural preferences (Covington, 2001). The client, his or her family, and the nurse bring cultural heritage, personal and professional knowledge, formal and informal knowing, and personal knowing to the nursing interaction (Engebretson and Littleton, 2001).

Skill-Centered and Fact-Centered Approaches

Methods to teach nurses about cultural competence attempt to balance a skill-centered approach with a fact-centered approach (Burchum, 2002; Campinha-Bacote, 1999; Engebretson and Littleton, 2001; Giger and Davidhizar, 2003; Purnell, 2002; Warren, 1999). In the skill-centered approach, methods focus on the content and structure of the nurse-client interaction (Engebretson and Littleton, 2001; Purnell, 2002). Dissemination of knowledge about cultural groups can be accomplished by teaching healthcare professionals how to study an individual’s cultural beliefs and practices (Jones et al., 1998a). The fact-centered approach describes attributes of specific cultural groups (Galanti, 2003). Appendix G provides summaries of articles using this approach and focusing on particular cultural groups.

Dreher and MacNaughton (2002) take issue with providing information on specific cultural groups and propose that it is an ecological fallacy to suggest that all individuals are the same in a certain culture. Cultural competence is nursing competence and can be defined as the “capacity to be equally therapeutic with patients in any social context or cultural background.” As such, these techniques should be used with all patients (Dreher and MacNaughton, 2002, p. 185). In one qualitative study, Latina doctoral-prepared nurse educators stated that they did not teach about different cultures specifically, but focused on teaching how to connect with anyone perceived as different from oneself (Canales and Bowers, 2001). In an integrative review, Kehoe and colleagues (2003) found that the design of a culturally relevant intervention did not require specific knowledge of a particular ethnic or cultural group, but of cross-cultural process principles. Figure 12 describes a cultural sensitivity and awareness checklist that could be used with all patients. Many of the models reviewed include constructs of cultural knowledge as well as skill (Burchum, 2002; Campinha-Bacote, 1999; Salimbene, 1999; Warren, 1999).

Figure 12. Cultural Sensitivity and Awareness Checklist

Healthcare providers could use a checklist with all patients to ensure provision of CLAS.

Focus	Instruction
Communication method	Identify the patient’s preferred method of communication. Arrange for an interpreter if needed.
Language barriers	Identify potential language barriers (verbal and nonverbal). List possible compensations.
Cultural identification	Identify the patient’s culture. Find resources about that culture.
Comprehension	<i>Double-check:</i> Does the patient and/or family understand the current situation?
Beliefs	Identify religious/spiritual beliefs. Make appropriate support contacts.
Trust	<i>Double check:</i> Does the patient and/or family appear to trust the caregivers? Watch for both verbal and nonverbal cues. If not, seek advice.
Recovery	<i>Double-check:</i> Does the patient and/or family have misconceptions or unrealistic views about the caregivers, treatment, or recovery process?
Diet	Address culture-specific dietary considerations.
Assessments	Conduct assessments with cultural competence in mind.
Healthcare provider bias	Examine and recognize your biases and prejudices.

Source: Seibert PS, Stridh-Igo P, Zimmerman CG. A checklist to facilitate cultural awareness and sensitivity. *J Med Ethics* 2002;28(3):143–146.

Published literature describing facts of different cultural groups often presents a caveat regarding making stereotypes or assumptions about an individual’s cultural practices. For example, Giger and Davidhizar (2003) write, “To provide culturally appropriate and competent care, it is important to remember that each individual is culturally unique and as such is a product of past experiences, cultural beliefs, and cultural norms.” Zoucha and Husted (2000) argue that a patient’s culture is only a useful tool for caring for a patient if the individual person is made the primary focus of care. Culturally competent care should not reinforce stereotypes, but should respect individual variations within cultures. Figure 13 highlights the difference between stereotyping and generalizing regarding cultural differences.

Figure 13. Differences Between a Stereotype and a Generalization

Culturally competent care focusing on the individual should not reinforce stereotypes.

A stereotype and a generalization may appear similar, but function differently.

- A **stereotype** is an ending point. No attempt is made to learn whether the individual in question fits the statement. Stereotyping patients can have negative results.
- A **generalization** is a beginning point. It indicates common trends, but further information is needed to ascertain whether the statement is appropriate for a particular individual.

Generalizations may be inaccurate when applied to specific individuals. Anthropologists do apply generalizations broadly and look for common patterns, beliefs, and behaviors that are shared by a group. It is important to acknowledge the differences between individuals. An example is the assumption that Mexicans have large families. If I meet Rosa, a Mexican woman, and I say to myself, "Rosa is Mexican; she must have a large family," I am stereotyping her. But if I think Mexicans often have large families and wonder whether Rosa does, I am making a generalization.

Source: Galanti G. *Caring for Patients from Different Cultures*. 3rd ed. Baltimore, MD: University of Pennsylvania Press; 2003.

Transcultural Nursing

Transcultural nursing can be defined as "a formal area of study and practice focused on comparative culture care (caring) values, beliefs, and practices of diverse and similar cultures in order to provide culturally congruent nursing care that contributes to the health and well-being of individuals, family groups, community groups, and institutions" (Leininger, 1994a, p. 23). Leininger, a nurse anthropologist, developed the field of transcultural nursing in the mid-1950s, but it was not until recently that the field of nursing began to acknowledge how cultural beliefs and values may influence the health and health outcomes of culturally diverse patients (Outlaw, 1994). The field of transcultural nursing uses Leininger's Theory of Culture Care Diversity and Universality (see Appendix F) with the ethnonursing research method (Leininger, 1996; Leininger, 1997; Leininger, 1988). Ethnonursing refers to "a qualitative nursing research method focused on naturalistic, open discoveries, and largely inductive modes to document, describe, explain, and interpret informants' worldview, meanings, symbols, and life experiences as they bear upon actual or potential nursing phenomena" (Leininger, 1997, p. 42). This theory's goal is to provide "culturally congruent care," a term coined in the 1960s by Leininger. The theory in combination with the ethnonursing research method has been used to study more than 100 different Western and non-Western cultures (Leininger Information Pack, 2002).

The Transcultural Nursing Society, established by Leininger in 1974, serves as the official organization of the discipline and certifies professional nurses as clinical specialists in transcultural nursing. Leininger also established the *Journal of Transcultural Nursing* to provide a forum for healthcare professionals to advance the knowledge of culturally congruent healthcare delivery (Leininger Information Pack, 2002).

Bias and Racism

Although bias, ethnocentrism, and racism prevent cultural competence, nursing literature focusing on these issues has been limited (Harris and Cummings, 1996; Puzan, 2003), and few cultural competence training programs or courses address these issues directly (Eliason, 1999; Vaughan, 1997).

Van Ryn and Fu (2003) suggest that provider behavior and bias contribute to racial and ethnic disparities in care. They assert that limited resources have been devoted to this aspect of healthcare disparities, perhaps because provider bias is uncomfortable to contemplate. Bias, either positive or negative, prevents objective consideration of an issue or person. Biases help people determine acceptable and unacceptable behaviors and may occur before or after meeting a patient. For example, stereotypes of

certain groups may lead to bias. Also, a patient's behavior may lead to labeling him or her as a "problem patient." Bias does not just refer to racial groups, but also gender, sexual orientation, socioeconomic status (SES) group, or the individual patient behavior. Once a nurse develops a negative bias toward a patient, the nurse may avoid caring for that patient. The label rather than the uniqueness of the patient becomes the focus of the interaction. The following strategies may help nurses care for "problem patients" and reduce bias: provide opportunities for patients to talk about themselves, ask patients to assist in their care, hold patient care conferences to gather input from other staff members, and request staff development to address the topics of labeling patients and stereotyping (Erlen and Jones, 1999).

The idea of "racism" triggers tension that can prevent nurses from reflecting on the meaning of the word and how it may appear in day-to-day life (Harris and Cummings, 1996). Acknowledging racism and racist behaviors may be distressing to nurses because it directly conflicts with stated professional values and ethics. Nonetheless, racism is especially important to discuss because it may be the heart of why health disparities exist (Kendall and Hatton, 2002).

Barbee (1993) discusses four reasons why racism goes unacknowledged in nursing:

- The emphasis to treat all clients the same
- The individual orientation that misses the social, economic, or political structures in society that impact health
- A preference of faculty in nursing schools for homogenous student bodies
- The need to avoid conflict

Barbee describes three ways racism manifests itself in the nursing field today: (1) through denial, by avoiding the term, (2) through the "colorblind" perspective, by viewing race as irrelevant, and (3) through "aversive" racism, by practicing subtle discriminatory behaviors (Barbee, 1993; Eliason, 1999; Kendall and Hatton, 2002).

Individual racism refers to those actions of an individual person against a particular group based on the belief that the group does not deserve the rights and privileges of other groups. Patients and families may demonstrate behaviors related to individual racism (Harris and Cummings, 1996). Prejudice may be the biggest barrier to cultural communication (Taylor, 1998). Individual racism may not be overt. For example, Eliason (1999) recounts ways that she treated African Americans differently. At first, she labeled the differences as "sympathy," but came to realize the racism inherent in that attitude (Eliason, 1999).

Institutional racism refers to the practices of an institution that limit the rights or opportunities of a particular group (Harris and Cummings, 1996). Racially and ethnically diverse groups have historically experienced racism by the healthcare system, as the legacy of the Tuskegee University experiment demonstrates (Watts, 2003). Few African Americans were admitted to the first nursing training schools in the late 19th century, and few resources were provided to establish hospitals and nursing training programs for African Americans. Professionally, the American Nurses Association (ANA) did not admit African-American nurses until after World War II (Andrews, 2003). Likewise, community racism and competition for resources today may create barriers to health care for ethnically diverse groups (Supples and Smith, 1995).

In a discussion on racism, power dynamics and White privilege in American society are not often openly discussed. A marker of White privilege is the authority and ability to specify and validate the rules and regulations of everyday interaction (Puzan, 2003). McIntosh identifies some of the daily effects of White privilege. These conditions are listed in Appendix H (McIntosh, 1988). "Whiteness" or "acting White" is required to assimilate into the nursing establishment, including adhering to acceptable patterns of communication, appropriate attitudes toward authority, and geographic location of healthcare services. Among curriculums focusing on cultural diversity, "understanding cultural differences continues to imply an understanding of deviations from normative whiteness" (Puzan, 2003, p. 197).

As the concept of racism and resulting discrimination is sensitive, a gradual progression of self-exploration may be the most appropriate method for facilitating discussion on the subject. One university course reviewed focused on issues of discrimination in health care (Abrums and Leppa, 2001). This course began with the least threatening topic of the culture of nursing and moved to a discussion about White, middle-class Americans. This discussion highlighted to White, middle-class students that cultural descriptions do not clearly explain intracultural differences. The course then explored other health belief systems and experiences of race, class, gender, sexual orientation, and disability. Standard course evaluations have been high (Abrums and Leppa, 2001).

Harris and Cummings (1996) offered a method for exploring diversity in a multicultural environment. The first step would be for the workgroup to acknowledge differences and agree to share information as part of a multicultural exchange. Next, the group may want to engage in activities to understand the culture of the patient population. As the group becomes more comfortable with its own diversity and the diversity of its patient populations, the group may want to define a mechanism for ensuring that troublesome incidents are discussed. For example, nurses could use the word “ouch” to signal to coworkers that they perceive racism in staff or patient interactions. The signal can trigger a private discussion to lead to new insights about behavior (Harris and Cummings, 1996).

Process of Cultural Competence

Attributes of cultural competency can be best described as a process or journey, not an outcome (Burchum, 2002; Campinha-Bacote, 1997; Campinha-Bacote and Campinha-Bacote, 1999). Becoming culturally competent is a process that requires major changes in the attitudes, beliefs, behaviors, and communication style that each person has developed throughout his or her lifetime. As a result, it cannot be accomplished in a single training session (Salimbene, 1999). The process requires healthcare providers to see themselves as *becoming* culturally competent rather than *being* culturally competent (Campinha-Bacote, 1999).

To begin this process, nurses need the desire to learn about culture. Campinha-Bacote (1999) describes cultural desire as “the motivation of healthcare providers to ‘want to’ engage in the process of cultural competence.” The cultural competency process starts by first exploring the provider’s culture (Barnes et al., 2000; Burchum, 2002; Campinha-Bacote, 2003b; Engebretson and Littleton, 2001; Leininger, 1994b; Salimbene, 1999; Warren, 1999).

Ethnocentrism may be expressed by an ignorance of or a lack of tolerance for differences. Unchecked ethnocentrism may negatively affect a nurse’s interactions with clients. However, recognizing the presence of ethnocentrism can serve as a warning to develop knowledge of and tolerance of differences (Harris and Cummings, 1996). Assessing one’s own culture is a first step to recognizing differences and avoiding stereotypes (Meleis, 1999).

In addition to the nurse’s individual culture, healthcare providers should acknowledge the “healthcare provider” culture. Figure 14 shows some beliefs and practices associated with Western medicine (Spector, 2003). Western medicine has historically reflected European values and traditions (Winn and Riehl, 2001). Leininger, the founder of transcultural nursing, asserts that it is essential for nurses to understand their own culture to provide sensitive and understanding care to others. As such, she characterized the culture of the nursing profession in the United States in the early 1980s. Although she distinguished four “tribes,” or subcultures, of the nursing profession, all of these tribes share common values and practices within the dominant American nursing culture. Leininger defines the American nursing profession as valuing “independence, autonomy, being self-reliant, depending upon high technologies, empowerment of women, their desire for power and being professional nurses” (Leininger, 1994b, p. 22).

Figure 14. Healthcare Provider Culture

As part of the “healthcare provider” culture, nurses need to be aware of cultural differences in expectations of nursing care.

Aspect	Description
Beliefs	<ul style="list-style-type: none"> • Standardize definitions of health and illness • Omnipotence of technology
Practices	<ul style="list-style-type: none"> • Maintenance of health and the prevention of disease through mechanisms such as the avoidance of stress and use of immunizations • Annual physical examinations and diagnostic procedures such as Pap smears
Habits	<ul style="list-style-type: none"> • Charting • Constant use of jargon • Use of a systematic approach and problem-solving methodology
Likes	<ul style="list-style-type: none"> • Promptness • Neatness and organization • Compliance
Dislikes	<ul style="list-style-type: none"> • Tardiness • Disorderliness and disorganization
Customs	<ul style="list-style-type: none"> • Professional deference and adherence to the “pecking order” found in autocratic and bureaucratic systems • Hand washing • Employment of certain procedures attending birth and death
Rituals	<ul style="list-style-type: none"> • Physical examination • Surgical procedure • Limiting visitors and visiting hours

Source: Spector RE. *Cultural Diversity in Health and Illness*. 6th ed. Upper Saddle River, NJ: Prentice Hall Health; 2003.

Nurses need to be aware of their cultural expectations and differences when providing care to patients from cultures different from their own. After examining these personal biases and prejudices, nurses can seek the skills and knowledge needed to assess their patients’ cultures. The process continues with each encounter with culturally diverse clients. As nurses become more understanding and aware of other cultures, they become culturally competent (Campinha-Bacote, 1999).

Complementary and Alternative Medicine

Complementary and alternative medicine (CAM) is becoming more popular in the United States due to people’s dissatisfaction with healthcare providers, side effects of drugs or treatment, high health costs, and lack of control in their healthcare practices (Cuellar et al., 2003). People of all backgrounds use CAM (Leonard, 2001). The most common types of CAM are herbs, chiropractic, relaxation techniques, vitamins, spirituality, massage, acupuncture, Chinese medicine, guided imagery, homeopathy, and chelatin. The most common conditions for using CAM are arthritis, back pain, heart disease, allergies, depression, and diabetes (Cuellar et al., 2003).

During a health history, the nurse should ask about health beliefs and practices, including the use of herbs or medicines. Biomedical and traditional ethnic healing beliefs and practices may be combined. Although routinely asking about the use of CAM is important, determining the compatibility of CAM with biomedical treatments is also critical. Web sites that may offer some information about CAM are listed in Figure 15.

Figure 15. Web Sites for Information About Complementary and Alternative Medicine

Nurses may access information on CAM from several Internet sources.

Web site:

National Center for Complementary and Alternative Medicine (NCCAM) <http://www.nccam.nih.gov>

Date Accessed:

1/8/2004

Description:

The NCCAM, part of the National Institutes for Health, is dedicated to exploring complementary and alternative healing practices in the context of rigorous science, training CAM researchers, and disseminating authoritative information to the public and professionals.

Web site:

Continuum Center for Health and Healing <http://www.healthandhealingny.org>

Date Accessed:

1/8/2004

Description:

The Continuum Center for Health and Healing, an initiative of Beth Israel Medical Center, provides fully integrative care, employing safe and effective conventional and complementary therapies in a specially designed healing environment. The center's vision is comprehensive, including clinical services, educational offerings, research studies, and outreach efforts.

Web site:

The Richard and Hinda Rosenthal Center for Complementary and Alternative Medicine
<http://www.rosenthal.hs.columbia.edu/>

Date Accessed:

1/8/2004

Description:

The Center for CAM Research in Aging and Women's Health, funded by the NCCAM, operates under the auspices of the Richard and Hinda Center for Complementary and Alternative Medicine. The center's research program includes a spectrum of research methodologies and approaches, including survey research, clinical trials, basic science, ethnobotanical studies, and information science research. The work to date has focused primarily on women's health and aging, with an emphasis on botanical remedies from traditional systems of medicine.

Web site:

HolisticOnline.com http://www.holistic-online.com/herb_home.htm

Date Accessed:

1/8/2004

Description:

The objective of HolisticOnline.com is to provide people with the information that they need to make an intelligent decision on how to take care of themselves. HolisticOnline.com provides information covering all fields of CAM.

Web site:

Alternative Link <http://alternativelink.com/ali/home/>

Date Accessed:

3/22/2004

Description:

Alternative Link developed a set of integrative healthcare codes and related coding solutions that fill gaps in older coding systems and the national health information infrastructure.

In one study of faculty and nursing students, graduating nursing students expressed interest in learning about CAM, but did not want to practice most of these therapies personally. Massage, imagery, and touch therapy may have higher acceptance by nursing students and faculty as clinical skills to be included in the curriculum. Lack of evidence is cited as a barrier to integrating CAM therapies into nursing practice (Halcon et al., 2003).

Patient Cultural Assessment Tools: Guidelines to Communication

Many nurses may find that intercultural communication is difficult. The following reasons may explain the difficulty in communication (Taylor, 1998). The above sections discuss these reasons in more detail.

Reasons Why Intercultural Communication Is Difficult

- Assumed similarity
- Ethnocentrism/denial of difference
- Anxiety or tension regarding conflict
- Prejudice
- Stereotyping
- Comfort with the familiar

Several tools have been developed to aid with communication during the interaction between the patient and the healthcare provider. Cultural assessment tools have been developed specifically for nurses to use with every patient, not just those who are from a different cultural group. For example, the Purnell Model for Cultural Competence—with 12 domains—can be used as a framework for conducting a cultural assessment (Purnell, 2002; Warren, 2001). The Giger and Davidhizar Transcultural Assessment Model and Theory use the six phenomena of Giger's and Davidhizar's model as indicators to assess a patients' cultural beliefs during the client-nurse interaction (Culturediversity.org, 2003; Davidhizar and Giger, 2001). Leininger's Acculturation Health Care Assessment Tool for Cultural Patterns in Traditional and Nontraditional Lifeways provides qualitative indicators to obtain an informant's orientation to traditional and nontraditional ways of life (Leininger, 1991); however, Leininger's tool may be more appropriate for qualitative studies of different cultures. Pacquiao developed a cultural care tool following through from the assessment to diagnosis to planning, implementation, and evaluation of interventions for patients (Pacquiao, In press). Also, Spector (2003) and Andrews and Boyle (2003) have developed tools for assessing a patient's culture (Andrews and Boyle, 2003; Spector, 2003).

Kleinman (1980), a psychiatrist and medical anthropologist, developed an explanatory belief model to assess the patients' cultural beliefs. These open-ended questions are depicted in Figure 16.

Several medical providers have developed mnemonic cultural assessment tools. These tools and other cultural competence models are described in Appendix F.

Healthcare providers may also use more conversational approaches to assessing a patient's cultural beliefs. For example, the healthcare provider may open with a conversational remark such as "Tell me about yourself and your family." Another approach would be to frame the question in the context of other clients such as, "I know another client who thought that so-and-so was wrong. Do you think that?"

(Campinha-Bacote, 2003c).

Figure 16. Kleinman’s Explanatory Belief Model

These eight questions elicit a patient’s belief model regarding the health condition

1. What do you call the problem? What names does it have?
2. What do you think causes the problem?
3. Why do you think it started when it did?
4. What do you think the illness does? How does it work?
5. How severe is the illness? Will it have a short or long course?
6. What frightens you most about this sickness?
7. What are the chief problems this sickness causes?
8. What kind of treatment do you think would be best for this problem?

Source: Kleinman A. *Patients and Healers in the Context of Culture*. Berkeley, CA: University of California Press; 1980.

Culturally competent care is one aspect of CLAS. Culturally competent care requires support by the organization at large and depends on the ability to understand and communicate. For many lower-literacy patients or those patients who do not speak English, communication can be a major barrier to health care. The next section focuses on the issues related to creating language access services for limited English proficiency (LEP) or lower-literacy patients.

Language Access Services

Providing language access services in healthcare settings to LEP patients is the second theme of the CLAS standards. Standards 4 through 7 (see Figure 1) represent the set of CLAS standards that are guidelines for providing appropriate language access services for LEP patients so that they can have equal access to healthcare services.

In this section, we address issues related to the nurse’s role in ensuring appropriate linguistic services for people with LEP and lower literacy. Even though we did not collect information about services for the hearing impaired, we acknowledge that addressing the language access needs for all people is essential to providing culturally and linguistically appropriate services. Using information from the sources we reviewed on language access services, we discuss these four prominent themes: language access strategies, cost of language services, working with interpreters, and patient education and patient-related materials.

Language Access Strategies

The nurse’s fundamental task is to ensure effective communication of the information by “simplifying the message, verifying the patient’s comprehension of what is being explained or taught, and conveying respect and concern to help the patient deal with the stigma of having limited literacy skills” (Dreger and Tremback, 2002, p. 5). Though Federal laws and policies encourage recipients of Federal funds to provide language access services, and interpretation and language service resources are available for providers, sustainable funding for these services is not always available (Grantmakers in Health, 2003).

The main resources to ensure language access include oral communication (e.g., professional interpreters, family or friends, the AT&T language line) and multicultural aids (e.g., signs, appointments, phrase sheets for staff and patients, foreign language patient education materials and videos) (Duffy and Alexander, 1999; Gravely, 2001; Rivero-Kempf, 1999). In an Australian study, nurses used a variety of strategies and resources for communicating with LEP patients: charts, family members, signs and body language, and bilingual nurses (Cioffi, 2003). Descriptions of communication strategies for LEP patients as well as their strengths and limitations are shown in Figure 17.

Assessment of a patient’s command of English is the responsibility of the healthcare provider. The following cues may indicate a patient’s lack of understanding (Enslein et al., 2002).

Indicators of Patient’s Lack of Understanding

The client:

- States that he or she speaks little or no English
- Requests an interpreter
- Nods or says “yes” to all questions
- Incorrectly uses the negative case (e.g., use double negatives)
- Reads or speaks a language other than English at home or with friends
- Has a brief residence in the United States
- Is unable to explain or demonstrate key information

Once the provider has assessed the need for an interpreter, the provider is responsible for selecting the best available interpreter (Enslein et al., 2002).

Figure 17. Strategies for Communicating with LEP Patients

Each communication strategy for LEP patients has advantages and disadvantages for the healthcare interaction.

Strategy	Description	Strengths	Limitations
Professional and trained interpreters on staff	Provider employs and trains interpreters who are available for languages that are most frequently represented in the particular patient population	<ul style="list-style-type: none"> • Available during operating hours • Consistent personnel fosters rapport and trust with clients and healthcare providers 	<ul style="list-style-type: none"> • Not a feasible, cost-effective alternative for small organizations • Not all languages covered
Untrained interpreters	Provider employs anyone who declares to be bilingual and provides interpretation services, including healthcare providers or office staff	<ul style="list-style-type: none"> • Availability 	<ul style="list-style-type: none"> • May not have sufficient knowledge of medical terminology or proficiency in English and the other language • Potential to omit, add, condense, or substitute information
On-call interpreters	Provider maintains a list of interpreters of various languages who are willing to interpret as need arises	<ul style="list-style-type: none"> • Covers a broader variety of languages 	<ul style="list-style-type: none"> • May be trained or untrained • Dependent on the availability of the interpreter at the time one is needed
Bilingual staff	Healthcare staff or support staff are temporarily used as the need arises to interpret for patients with whom they would otherwise have no contact	<ul style="list-style-type: none"> • Availability 	<ul style="list-style-type: none"> • Inconsistent availability • Conflict of duties • May create resentment in staff member or coworkers • Usually untrained • Inconsistent ability
Family members or friends	Family or friends who accompany the patient to the provider are used as interpreters	<ul style="list-style-type: none"> • Availability 	<ul style="list-style-type: none"> • Untrained • Usually unfamiliar with specialized vocabulary • May interfere with family dynamics, confidentiality, or

			revelation of sensitive information
Telephone interpretation services	Interpretation available over the telephone	<ul style="list-style-type: none"> • Covers multiple languages • Available 24 hours a day, 7 days a week • Interpreters usually have training in interpretation and may have familiarity with healthcare terminology • May have rapid access 	<ul style="list-style-type: none"> • Speakerphone needed for easiest use • Requires prior arrangement by agency to establish an account • Nurses and clients may feel awkward during encounter • Providers may feel a lack of control over the interaction with patient • Cost may be extensive depending on frequency and length of time in session
Patient education materials	Bilingual and lower-literacy materials such as signs, appointments, phrase sheets, patient education materials, and videos	<ul style="list-style-type: none"> • Provides additional sources of information that could be taken home • Lower-literacy materials improve understanding 	<ul style="list-style-type: none"> • Cost of translating materials • Translated materials may or may not be accurate or available • Populations may not be able to read or write in their own language • Forms may only be translated into one language (usually Spanish)
Online translation services	Internet Web sites that translate typed statements into other languages	<ul style="list-style-type: none"> • Immediate 24 hours a day availability 	<ul style="list-style-type: none"> • Requires a computer with Internet access • Requires the client to be able to read and to type responses • Complicated sentences may not translate effectively

Source: Adapted from Enslein J, Tripp-Reimer T, Kelley LS, Choi E, McCarty L, Tang JH, et al. (2002). Evidence-based protocol: interpreter facilitation for individuals with limited English proficiency. *J Gerontol Nurs* 2002;28:5–13 and Perkins J, Youdelman M, Wong D. *Ensuring Linguistic Access in Health Care Settings: Legal Rights and Responsibilities*. 2nd ed. Los Angeles, CA: National Health Law Program; 2003.

Cost of Language Services

A recent report from the Office of Management and Budget estimates that language access services would add an extra 0.5 percent to the cost of an average healthcare visit. This estimate covers interpretation costs for LEP patients for emergency room visits, inpatient hospital visits, and outpatient physician visits. This estimate does not include costs to nonphysician providers such as physical or occupational therapists, chiropractors, or mental health professionals, except psychiatrists. Also, this estimate does not cover fixed-cost translations of hospital signs and forms. The Office of Management and Budget also did not account for steps already taken by many healthcare facilities to address LEP issues

(Office of Management and Budget, 2002). Youdelman and Perkins describe promising programs and practices for providing language services in a variety of healthcare settings. Their report also address current funding sources for these services (Youdelman and Perkins, 2002).

Working with Interpreters

Interpretation is “the processing of oral language in a manner that preserves the meaning, tone, and register of the original language without adding or deleting anything” (Enslein et al., 2002, p. 6). Interpretation can be simultaneous or sequential, proximate or remote. Interpretation that occurs while the person is talking is simultaneous interpretation (e.g., the United Nations uses simultaneous interpretation) (Duffy and Alexander, 1999). Interpretation that takes place after the speaker finishes is known as sequential or consecutive interpretation (Duffy and Alexander, 1999; Enslein et al., 2002). With proximate interpretation, the interpreter is in the room. Remote interpretation occurs over the telephone, audio hookup, or video conference (Duffy and Alexander, 1999). Although interpreters may be professionals, bilingual staff, or family members and friends, most providers agree that professional, bilingual trained interpreters should be used when possible to ensure accurate and effective communication (Duffy and Alexander, 1999; Enslein et al., 2002; Poss and Beeman, 1999). The AT&T language line uses a telephone interpreter service and may offer professional interpretation in less populous languages (Rivero-Kempf, 1999).

Although interpretation ensures adequate communication with LEP patients, the process of an interpretation session may create problems for all parties involved. For example, nurses reported the following difficulties with interpretation: finding interpreters for less populous groups or during nights and weekends, feeling awkward during phone interpretation, spending longer periods of time in a session, and having concerns about the accuracy of the interpretation (Cioffi, 2003). In addition, during an interpretation session, nurses may find that the interpreter experiences fatigue, changes the patient’s or provider’s statements, or refuses to translate certain portions of interaction (Poss and Beeman, 1999). Untrained interpreters may commit the following five errors: omission, addition, condensation, substitution, and role exchange (Vasquez and Javier, 1991 from McLeod, 1996).

Understanding the potential barriers and difficulties, nurses may take steps to ensure smoother and more effective communication. Before a session, healthcare providers should review the content of the session with the interpreter, clarify the role of the interpreter, explain the need for precise interpretation, and encourage the interpreter to ask questions to clarify information (Enslein et al., 2002). Guidelines for working with interpreters during a session are shown in Figure 18.

Figure 18. Guidelines for Working with Interpreters

While working with interpreters, nurses can take steps to ensure smoother and more effective communication.

- Allow extra time for the encounter. Everything will be said at least twice, so it may take two or three times longer than a standard interview
Use bilingual trained and professional interpreters whenever possible.
- Do not use patients' children as interpreters.
- Face the *patient* and speak directly to the *patient*. Placing the patient, healthcare provider, and interpreter in a triangular relationship may be the most conducive to communication. The interpreter should be considered a member of the healthcare team.
- Speak slowly and clearly. It is not necessary to raise your voice and shout.
- Use short, simple sentences with fewer than 16 basic words.
- Use simple language. Avoid metaphors, slang, idioms, and jargon.
- Use active rather than passive voice.
- Avoid subjunctive mood ("would" or "could").
- Use nouns rather than pronouns so the referent will be clear.
- Explain all medical terms in simple language.
- Watch the *patient* during the translation to allow observation of nonverbal cues. The interpreter may help the provider understand these nonverbal messages.
- Try not to interrupt the interpreter.
- The time required for translation may be longer than it takes the provider to say something.
- Allow the interpreter to ask questions to clarify what the patient says.
- Allow time for patients to ask questions and seek clarification.
- If the interpreter seems to answer for the patient, inquire about this.
- Use diagrams, pictures, and translated written materials to increase understanding.
- Always ask patients to repeat instructions back to you to be certain they were understood.
- Learn some basic words and phrases in the patients' language. Knowing how to introduce yourself or ask how the patient is feeling in his or her own language is generally well received.
- Some patients who request an interpreter may understand English well. The patient may understand any comments made to other providers or to the interpreter.
- Document the name of the interpreter in the progress notes.

Sources: Adapted from Poss JE, Beeman T. Effective use of interpreters in health care: guidelines for nurse managers and clinicians. *Semin Nurse Manag* 1999;7:166–171 and Enslin J, Tripp-Reimer T, Kelley LS, Choi E, McCarty L, Tang JH, et al. Evidence-based protocol: interpreter facilitation for individuals with limited English proficiency. *J Gerontol Nurs* 2002;28:5–13.

Patient Education and Patient-Related Materials

Patient education is an important component of nursing care because patients and families often must manage healthcare needs at home (Garity, 2000). Patient education encompasses both formal education and informal explanations. In a qualitative study assessing surgical patients' perceptions of nursing care, patients emphasized the more informal explanations offered by nursing staff during the delivery of care rather than formal education as important to care (Schmidt, 2003).

Nurses are required to provide information to all patients, but providing information to LEP and

lower-literacy patients is especially important as those patients are more vulnerable to miscommunication (Dreger and Tremback, 2002). Language barriers and literacy problems may exist even for well-educated patients (Yeo et al., 2000). Hahn and Cella (2003) recommend implementing routine literacy screening when prescribing complicated medical regimens and providing followup to ensure comprehension and compliance. Price and Cordell (1994) offer a four-step approach to patient teaching: healthcare providers should (1) assess their own cultural beliefs, (2) develop a teaching plan, (3) implement the plan, and (4) evaluate the success of the teaching-learning process. Figure 19 lists strategies to improve literacy for all patients and specifically for LEP or lower-literacy patients.

Figure 19. Provider Strategies for Improving Health Literacy

Assessing health literacy is an important aspect of patient education.

For All Patients

- Demonstrate active learning
- Use open-ended questions
- Clarify any discrepancies
- Ask patients to restate information
- Acknowledge and reassure
- Allow silences

For LEP or Lower-Literacy Patients

- Assess client's needs and level of understanding
- Find an appropriate time to educate the patient
- Present one idea at a time
- Use uncomplicated sentences
- Use concrete examples
- Evaluate the change in client's knowledge, ability, or attitude

Sources: Adapted from Dreger V, & Tremback T. Optimize patient health by treating literacy and language barriers. *AORN J* 2002;75:280–93 and Price JL, Cordell B. Cultural Diversity and Patient Teaching. *J Contin Educ Nurs* 1994;25:163–6.

Printed materials may help nurses educate patients about a particular health concern. Written materials should be simplified for lower-literacy patients (Hahn and Cella, 2003). The availability of many resources on the Internet has made finding patient education materials easier for nurses. McCarty and colleagues analyzed more than 75 multicultural health sites available on the Internet to identify the most useful sites for healthcare providers (McCarty et al., 2002). Selected Web sites are shown in Figure 20. Universal problems among health education Web sites included difficulties in printing materials, lack of material evaluation, uncertain quality of translation, and the lack of stability in Web sites.

When using written patient educational materials, it is important to consider the following (McCarty et al., 2002; Scala-Foley et al., 2003).

Considerations When Using Patient Education Materials

- Materials focus on the desired topic
- Reading level is designed to be between fourth and sixth grades
- Format includes illustrations and photographs
- Readability is easiest with 14 to 16 point font, capital and lowercase letters, no italics, and plenty of open space
- Text is broken into clear sections
- Key messages are repeated
- Active voice is used
- Glossary or text defines unfamiliar terms
- Sources of additional information such as a toll-free number are included

Figure 20. Selected Multicultural Patient Education Materials Web Sites

The availability of multicultural resources on the Internet makes it easier for nurses to find patient education materials.

Source:

- American Academy of Child and Adolescent Psychiatry
- <http://www.aacap.org/publications/factsfam/index.htm>

Date Accessed:

- 12/22/03

Description:

- Educate parents about psychiatric disorders affecting children.
- More than 80 topics available in English, Spanish, German, French, Polish, and Icelandic.
- Copies may be duplicated and distributed free.

Source:

- Association of Asian Pacific Community Health Organizations
- <http://www.aapcho.org>

Date Accessed:

- 12/22/03

Description:

- The organization seeks “to promote advocacy, collaboration and leadership that improves the health status and access of Asian Americans, Native Hawaiians and Pacific Islanders within the United States, its territories and freely associated states, primarily through our member community health clinics.”
- Patient education materials are available on a variety of topics such as cancer, diabetes, thalassemia, and tuberculosis and are available in Chinese, English, Hmong, Korean, Lao, Tagalog, Samoan, Vietnamese, and Ilocano.
- Most materials are available for a fee.

Source:

- Multicultural Health Communication Service, NSW Department of Health, Australia
- <http://www.mhcs.health.nsw.gov.au>

Date Accessed:

- 12/22/03

Description:

- This site provides information and services to help health professionals communicate with non-English speaking communities.
- Patient education materials are available in more than 40 languages on more than 240 topics (not all topics available in all languages).
- Brochures can be downloaded free.

Source:

- MultiLingual-Health-Education.net
- <http://www.multilingual-health-education.net/faq.asp>

Date Accessed:

- 12/22/03

Description:

- MultiLingual-Health–Education.net is a nonprofit alliance of Canadian health agencies that provides translated materials for public use.

- More than 40 topics covered in English, French, Farsi, Hindi, Punjabi, Korean, Spanish, Chinese, Japanese, Vietnamese, Darshan, Italian, and Tagalog.

Source:

- New York Online Access to Health (NOAH)
- <http://www.noah-health.org/index.html>

Date Accessed:

- 12/22/03

Description:

- The goal of NOAH is to provide “access to high quality full-text consumer health information in English and Spanish that is accurate, timely, relevant and unbiased.”
- The site contains more than 50 topics with multiple subtopics in English and Spanish.
- Links and brochures can be accessed free.

Source: Adopted from McCarty LJ, Enslein JC, Kelley LS, Choi E, Tripp-Reimer T. Cross-cultural health education: materials on the World Wide Web. *J Transcult Nurs* 2002;13:54–60.

If the patient speaks a language other than English, the materials need to be translated. Translation is defined as “the conversion of one written language into another language” (Enslein et al., 2002, p. 6). There are three different methods of translation: one-way translation (translates original text into the second language), translation by committee or consensus (two or more bilingual individuals translate the materials independently, then agree on the translation), and back translation (two translators work independently, one to translate into the foreign language and the other to translate back to the original language). The latter method is the most costly, but considered to be the most reliable (Duffy and Alexander, 1999). Although translated written materials is one of the most prevalent forms of communication with LEP patients, certain problems may exist (Perkins et al., 2003).

Problems with Translated Written Materials

- Inadequate use of translated materials
- No translation of individual patient care instructions and medication regimens
- Limited availability and questionable accuracy of translated materials
- Translation of forms into only one language (usually Spanish)
- Considerations of literacy level of LEP patients
- Special software requirements for certain languages (e.g., Arabic, Chinese)

In addition to patient education materials, providers need translated tools to assess the patient’s medical history or current condition. Translated tools have been found to be an acceptable equivalent of the original (Dunckley et al., 2003). For example, translation and back translation into Spanish of a pediatric pain assessment tool allowed Spanish-speaking children to describe pain as needed (Van Cleve et al., 2001). However, cross-cultural equivalence is more difficult to determine. Also, ethnically diverse communities may not be familiar with clinical tools that use multiple choice, timescales, or Likert responses (Dunckley et al., 2003).

Organizations that serve diverse populations have the challenge of implementing extensive linguistic services. However, ideally these language services are just one part of a healthcare organization’s overall plan to increase cultural competence. In the next section, we discuss the main themes associated with implementing cultural competence at the organizational level.

Organizational Supports

The third theme of the CLAS standards, addressed in standards 8 through 14 (see Figure 1), is organizational support for cultural and linguistic competence. The recommendations cover many issues related to developing and implementing cultural and linguistic competence at the organizational level, including strategic planning, self-assessment and evaluation, management information systems, community partnering, complaint/grievance structures, and notification of the public.

Kerr and colleagues applied Cross et al.’s 1989 cultural competency developmental continuum (see Appendix F) to an organization rather than an individual. Every organization exists at a stage along the cultural competency continuum, progressing from cultural destructiveness to cultural incapacity to cultural blindness to cultural precompetence to cultural competence to cultural proficiency (Kerr et al., 2001). Definitions of these terms are shown in Figure 21.

Figure 21. Stages of the Cultural Competency Developmental Continuum

Cross et al.’s 1989 cultural competency developmental continuum may be applied at an organizational level.

Terms	Definitions
Cultural destructiveness	Organizations at this stage display attitudes, policies, structures, and practices destructive to cultures and consequently individuals.
Cultural incapacity	Organizations at this stage of the continuum do not intentionally seek to be culturally destructive but simply lack the capacity to effectively respond to culturally, ethnically, racially, and linguistically diverse groups.
Cultural blindness	At this stage, organizations provide services with the expressed philosophy of being unbiased. These organizations see all people as the same and operate under pretense that culture, race, ethnicity, and nationality do not make a difference.
Cultural precompetence	At this stage, organizations realize their weaknesses in providing support to culturally, ethnically, racially, and linguistically diverse groups. A genuine desire exists to deliver quality services and demonstrate a commitment to civil and human rights.
Cultural competence	Organizations demonstrate a genuine acceptance and respect for cultural differences. A clear understanding exists of the similarities and differences among cultural, ethnic, and racial groups, including numerous subgroups and within

	group differences.
Cultural proficiency	Culture is an integral or core part of the organization.

Source: Kerr MJ, Struthers R, Huynh WC. Work force diversity: implications for occupational health nursing. *AAOHN J* 2001;49:14–20.

Organizational efforts, through implementation of the CLAS standards and training programs, work to achieve cultural proficiency. From our review of the literature, the following five themes emerged for this section: commitment at every level of organization, recruiting and retaining diverse nursing students and staff, integrating foreign nurse graduates, training and professional development programs, and techniques for organizational assessment.

Commitment at Every Level of Organization

Implementing culturally and linguistically appropriate services requires commitment at every level of the organization (Bess et al., 2003; Frederick and Frederick, 1995). The constant demand on healthcare providers for quality improvement drives the need for organizational cultural competence. This increased interest in quality improvement at all levels of the organization is especially relevant in the area of nursing and nursing management (Frederick and Frederick, 1995).

Organizational commitment to the goal of cultural competency leads to a similar commitment and goal in individual employees. Organizational supports create an environment that develops client trust, which leads to better outcomes, including adherence and followup (Anderson et al., 2003). Cultural competency has an impact not only on the way that nursing staff interact with patients, but also on the way that nurses interact with each other and their supervisors.

To become culturally competent, organizations should assess needs and potential conflicts within all levels of their organization. Kerr and colleagues created a checklist of accomplishments for organizations to achieve cultural competency, found in Figure 22.

Figure 22. Checklist for Cultural Competence Development

Organizations can promote CLAS at all levels of healthcare provision.

- Convene a cultural competence committee, workgroup, or task force within the organization.
- Ensure that the organization's mission statement commits to cultural competence as an integral component of all its activities.
- Determine the racially, ethnically, culturally, and linguistically diverse groups served by the organization.
- Determine what percentage of the population served by the organization is affected by the following six health disparities: cancer, cardiovascular disease, infant mortality, diabetes, HIV/AIDS, and child and adult immunizations.
- Conduct a comprehensive organizational cultural competence self-assessment.
- Conduct an assessment of staff to determine their perceived development needs that will enable them to provide culturally and linguistically appropriate services.
- Convene focus groups to solicit consumer input on professional or staff development needs related to culturally and linguistically appropriate services.
- Network and dialog with other organizations about culturally competent delivery systems.
- Seek resources from federally and privately funded technical assistance centers.
- Convene "brown bag" lunches to engage organizational personnel in discussions and activities related to cultural and linguistic competence.
- Identify and include budgetary expenditures each fiscal year for resource development and professional development.
- Gather and categorize resource materials related to health care and culturally diverse groups.
- Build and use a network of natural helpers, community informants, and other "experts" who have knowledge of the diverse groups served by the organization.
- Network with advocacy organizations concerned with specific healthcare and social and economic issues impacting racially, ethnically, culturally, and linguistically diverse communities.
- Consider the culture of the hospital setting prior to implementation
- Use a culturally competent instructor
- Offer training on a voluntary basis
- Teach using creative and nonthreatening experiential exercises
- Provide a positive learning experience

Source: Adapted from Kerr MJ, Struthers R, Huynh WC. Work force diversity: implications for occupational health nursing. *AAOHN J* 2001;49:14–20.

To attain cultural competency at an organizational level, managers should recognize the demographics and diversity of their patients and their staff to foresee possible problems and opportunities for improvement. Difficulties in communication and cultural understanding experienced by nurses about medical and social practices of patients may lead potentially to adverse health outcomes (Rutledge, 2001). Likewise, diverse nursing groups in the workplace may lead to interstaff difficulties such as language and communication barriers, different approaches to carrying out nursing duties, and differences in training backgrounds, particularly regarding psychosocial skills; poor teamwork; formation of nationality "cliques"; lack of assertiveness to ask questions or get clarity; different nomenclature for equipment, supplies, or tasks; different standards of care; fear of embarrassment; and blaming behaviors to protect individuals from criticism (Frederick and Frederick, 1995). Nursing leaders should identify and solve these problems to provide quality improvement for patients and retain a diverse nursing staff with a shared managerial vision and commitment. Staff interaction through ongoing staff education, collaborative practice alliances, unit-based quality improvement programs, and standardized quality improvement forms may promote organizational cultural competence quality improvement (Frederick and Frederick, 1995). To provide quality improvement to the patient, organizations can employ a culturally diverse staff that reflects the communities served, provide interpreters who speak the client's language, train nurses about the clients they serve, and post signage and create instructional literature consistent with the language needs of the populations served (Anderson et al., 2003).

Figure 23. Organizational Strategies To Enhance Cultural Competence

Strategies to incorporate cultural competence should be applied for employees and for patients.

For Employees

- Provide staff education
- Encourage collaborative practice alliances
- Establish unit-based quality improvement programs
- Create standardized quality improvement forms

For Patients

- Employ a culturally diverse nursing staff, reflecting communities served
- Provide interpreters for LEP clients
- Train nurses about communities served
- Post signage and create instructional materials in appropriate languages

Sources: Adapted from Anderson LM, Scrimshaw SC, Fullilove MT, Fielding JE, Normand J. Culturally competent healthcare systems. A systematic review. *Am J Prev Med* 2003;24: 68–79 and Frederick B, Frederick L. Quality improvement with a culturally diverse staff: implications for nurse managers. *Semin Nurse Manag* 1995;3:137–42.

Recruiting and Retaining Diverse Nursing Students and Staff

Various methods to recruit minority nurses to specific nursing fields have been described in the published literature (Bennett et al., 2003; Boutain and Olivares, 1999; Rew, 1996). Not only do workplace organizations need to be culturally competent, but also institutions of higher learning need to adopt culturally competent practices, especially regarding the retention and education of a diverse student body. Programs may assign mentors to culturally diverse students (Bennett et al., 2003; Boutain and Olivares, 1999; Rew, 1996), offer scholarships for diverse students (Bennett et al., 2003), or alter class schedules for working students (Bennett et al., 2003; Boutain and Olivares, 1999). For example, Bennett and colleagues described a program at the University of California at San Francisco that sought to increase the ethnic diversity and number of gerontological and advanced nursing practice nurses from Laguna Honda Hospital in San Francisco. The program assigned a faculty member to assist students, provided advanced nurses as mentors, developed a “peer leader” program, extended the curriculum from 2 to 3 years, and provided financial support in the form of scholarships to ensure completion by students (Bennett et al., 2003).

Once enrolled, culturally diverse students encounter unique experiences in nursing school, resulting in the need to support these students. Experiences of culturally diverse students and faculty are described in the Curriculums and Training section. Barriers currently exist in nursing schools for the retention of culturally diverse students. One barrier to retention of diverse students in nursing programs includes the attitude of and interactions with faculty, especially regarding cultural and socioeconomic issues (Rew, 1996). Such barriers may be reduced or eliminated through a variety of methods, including faculty education (Rew, 1996) and support groups for diverse students (Stokes, 2003). Nursing faculty members have to be equipped with the awareness, knowledge, and skills to work with students of diverse backgrounds. At the University of Texas at Austin, faculty prepared to mentor students from disadvantaged backgrounds through a program called Pathways, which is used to affirm the diversity of nursing students (Rew, 1996). The Pathways program promotes interaction between faculty and students in a supportive environment. Using travel as a metaphor, diversity is seen as a road, learning as the landscape, and a student’s education and choices as a pathway. At the University of Indiana, diverse student groups participate in “Gatherings” three times a semester (Stokes, 2003). Acting as a support group for students, each “Gatherings” meeting begins with open-ended questions about student life that spark discussion. Students have had a very positive reaction to these groups, feeling that they received both academic and social support from students in situations similar to their own. These groups involved students in varying years of degree completion, so new students were able to learn from others who had formerly been in their position, and older students were able to share their experiences and knowledge.

Foreign Nurse Graduates

Given the nursing shortage, foreign nurse graduates (FNGs) are increasingly employed in healthcare settings. In one study, the recruitment and employment strategies of the New York City Health and Hospitals Corporation were examined for efficacy at reducing costs and increasing longevity of nurses through the recruitment of FNGs. Pizer and colleagues found that even though recruiting costs are higher than those for recruiting domestic nurses, the FNGs stayed at the organization longer and worked more overtime hours (Pizer et al., 1994).

American healthcare organizations can recruit FNGs from their country of origin or from the pool of FNGs already living here but not practicing as nurses. FNGs may choose to work in the United States as a result of the wages, professional advancement opportunities, technological advancements, and safe working environment offered in juxtaposition to their native country (Kline, 2003). The process of “importing” nurses is often seen as controversial, but the ethical implications can be rectified through using reputable recruiting organizations, respecting the home country’s wishes, and providing emotional support for the nurse throughout the process and during assimilation (Gamble, 2002). One program to reach nurses already living in the United States includes the Chicago-Mexico nurse initiative. This initiative identifies and helps professional nonpracticing nurses from Mexico who are already living in the Chicago area obtain and utilize Illinois State licensure (Smith, 2003). Assistance is provided in taking the NCLEX–RN and finding a job. The process of recruiting and assimilating FNGs into an organization requires special attention and considerations.

Recruitment and retention programs for FNGs differ across organizations. Once FNGs are hired by an organization, their acclimation as employees regards not only working with patients, but also interacting with coworkers and supervisors. FNGs are significantly younger and more likely to be unmarried than domestic nurses (Pizer et al., 1994). Also, since FNGs usually have less seniority, they are more likely to work on evening and night shifts and work overtime (Pizer et al., 1994). Given the different demographics of the FNG population, the processes used to acculturate and assimilate FNGs may be different from those used to train and retain domestically educated nurses. The assimilation to the U.S. “nursing culture” is a concern for international nurses. Flynn and Aiken (2002) found that there is no difference between international nurses and U.S. nurses in the degree to which they value a professional nursing environment.

To create a positive, professional working environment and to help FNGs adjust to a new workplace, four areas should be addressed: socialization to the professional nursing role, acquisition of language and other communication skills, development of workplace competence (both clinical and organizational), and availability of support systems and resources within the organization (Ryan, 2003). A variety of programs can address these areas. For example, Ryan describes a buddy program for international nurses developed to even extend into the community, showing nurses how to use public transportation, find ethnic grocery stores, etc. Although the program has yet to be evaluated, anecdotal responses have been positive (Ryan, 2003). Preceptor programs may also be a potential method to orient new FNG employees. Those with LEP can be assigned to a preceptor with a knowledge of or interest in the new employee’s language (Fahje et al., 2001).

Training and Professional Development

Organizations are not only responsible for ensuring a culturally competent work environment for a diverse nursing staff, but all nurses within the organization should have training and support to implement the CLAS standards. One way to approach organizational cultural competency is to consider the provider as a cultural broker who understands both the biomedical model and the patient’s background (Shaw-Taylor and Benesch, 1998). Not only do the nurses offer a traditional medical role, but they also provide an understanding and incorporation of the patient’s background. To achieve this within the organization, nurses must be educated to fulfill this role in addition to their standard nursing duties.

Organizations conduct employee education in different fashions, all requiring a high level of organizational commitment. New employee orientations are the most common ways that nurses are first exposed to cultural competency in the workplace (Fahje et al., 2001). Training should follow some guidelines: it should consider the culture of the hospital setting prior to implementation, be taught by a culturally competent instructor, be offered on a voluntary basis, offer creative and nonthreatening experiential exercises, and provide a positive learning experience (Campinha-Bacote et al., 1996). Different educational exercises, such as “cultural bingo,” can be used to present issues in a training environment. One successful model that can be employed in a hospital setting to train nurses includes “train-the-trainer” programs. Peer nurses can lead staff educational programs, making the discussed issue more relevant to the organization. A unique method of providing culturally competent nursing education is an “immersion” program and the development of a sister hospital relationship for practicing nurses (Jones et al., 1998b). Nurses are immersed in another culture during a 2-week visit to another country, providing a salient experience to show the importance of cultural competency. Sister hospital relationships also provide nurses with the opportunity to interact with other professionals in a setting where emotional involvement contributes to the learning experience.

Organizational Assessment

Given the large amount of training and effort by organizations to teach cultural competency, organizations want to know if their efforts are producing results. Measurement of knowledge transfer is not always easy. Flavin evaluated a home health nurse education and training program that consisted of a panel presentation by local cultural and ethnic experts, a videotaped behavior modeling session combined with skill practice, and a modified cultural assimilator technique. Flavin (1997) found positive results in reactions and behavioral skills; the results, however, were not statistically significant. Given the newness of the field and the increasing number of organizations participating in cultural competency training programs, the ability to measure the effects, especially with patient outcomes, will be realized in the future.

At the organizational level, the ability to measure cultural competency is still in the development stages. Given the qualitative nature of cultural competency and the multiplicity of interactions between providers and patients, quantitative measures at the organizational level may come from a variety of sources. Examples of quantitative data that can be gathered include Equal Employment Opportunity complaints filed, cultural awareness-based health outcomes (such as infant birth weight or immunization rates), retention rates of minority nursing employees, the level of interpreter services offered, and the number of programs an organization uses (Shaw-Taylor and Benesch, 1998). Siegel and colleagues developed performance measures of cultural competency to be used in mental health organizations, although these measures could be adopted and used by any organization. Three factors of the organization can be assessed through these measures: the organization’s approach to developing culturally competent services, the availability of culturally competent services, and access to culturally competent services (Siegel et al., 2004). These measures can be found in Figure 24.

Figure 24. Organizational Performance Measures of Cultural Competency

Measuring an organization’s cultural competence contributes to understanding the link between provision of CLAS and patients’ health outcomes.

Availability of Culturally Competent Services

Factor and Indicators	Measures	Data Sources
Cultures represented on staff	Number of cultures and languages on staff	Personnel records or management information system (MIS)
Staff trained in cultural competency	Percentage of staff completing cultural competency training	Personnel records or MIS
Treatment adapted to cultural groups	Number of service types adapted to cultures	Clinical record, case records, MIS

Availability of Cultural Competency Instruments

Factor and Indicators	Measures	Data Sources
Intake and assessment	Cultural competency instruments available and cultural competency assessments used	Checklist, MIS

Access to Culturally Competent Services

Factor and Indicators	Measures	Data Sources
Cultures in treatment	Utilization rates	MIS
Linguistic capacity	Number of languages or dialects available at first point of contact, number of trained translators/interpreters available, number of in-language clinicians/staff	Personnel records, MIS, staff activity logs
Consumer/family education activities	Information is available that respects cultural values, reflects literacy levels, and is in different formats; information is available in the language of the community; material is reviewed by local experts; family education and support groups are available	Checklist
Transportation	Available from residential areas to culturally competent provider; agency provides transportation	Bus schedule, bus stop locations, checklist
Agency provides mobile services in the community	Outreach, screening, crisis services, etc., are available in the community	Checklist, MIS
Convenient hours for culturally competent services	Culturally competent services are available on evenings/weekends	Checklist/consumer satisfaction survey

Source: Siegel C, Davis-Chambers E, Haugland G, Bank R, Aponte C, McCombs H. Performance measures of cultural competency in mental health organizations. *Adm Policy Ment Health* 2004;28:91–106.

Weech-Maldonado and colleagues did a survey of hospitals to measure them on six performance scales related to cultural competence, including scales for planning, stakeholder satisfaction, diversity training, human resources, healthcare delivery, and organizational change. In the hospitals surveyed, the highest performance scores were in the areas of planning activities and the lowest were recorded in human resources activities and organizational change indicators (Weech-Maldonado et al., 2004). These findings show many areas for improvement in the cultural competency of organizations. In a review of interventions to improve cultural competence in healthcare systems, Anderson and colleagues were unable

to draw any conclusions about effectiveness due to the fact that there were no studies for comparison or studies did not use the following outcomes measures: client satisfaction with care, improvements in health status, and inappropriate racial or ethnic differences in use of health services or received and recommended treatment (Anderson et al., 2003).

Although the themes of culturally competent care, language access services, and organizational supports are presented separately, these three themes are interdependent. Culturally competent care requires language access services for LEP and lower literacy patients and support by the organization at large. Similarly, language access services should be delivered in a culturally appropriate manner. Organizational supports ensure that nurses provide consistent culturally and linguistically appropriate services on an ongoing basis. The three themes are ultimately parts of the interrelated and overall construct of cultural competence.

SECTION IV. CURRICULUMS AND TRAINING

For this section, we conducted a content analysis of several curriculums used in nursing schools across the United States to determine whether they cover common core concepts and competencies, use common teaching techniques, and conduct evaluations of their curriculums. Before discussing findings from the content analysis, we present issues surrounding cultural competence in the literature from nursing school curriculums and from trainings in healthcare organizations.

Nursing Schools

To understand what professional nurses need to learn related to cultural competency, it is important to examine what nursing schools are teaching to nursing students. This section is presented under four headings: results of nursing school curriculum surveys, the lack of diversity in nursing education materials, experiences of racially and ethnically diverse students, and the benefits of international learning experiences.

Nursing School Curriculum Surveys

Surveys of nursing school curriculums have found limited incorporation of cultural content. However, response rates for these surveys were low and may not adequately describe how nursing schools currently are integrating cultural content.

Ryan and colleagues (2000) surveyed all baccalaureate and higher degree National League for Nursing (NLN) schools of nursing in the United States, with a 36 percent response rate (Ryan et al., 2000). Results of the survey are shown in Figure 25. Although the majority of schools incorporated transcultural nursing (TCN) definitions into classes, few programs had a formal course on transcultural nursing. The majority of programs did not feel faculty were prepared to teach TCN, and the majority of respondents expressed an interest in participating electronically in selected modules (Ryan et al., 2000).

Figure 25. Percent of NLN Nursing Schools Incorporating Transcultural Nursing
Nursing schools were more likely to incorporate definitions of TCN into the curriculum than offer a course focusing on TCN.

Concept	Baccalaureate (%)	Graduate (%)	Both (%)
Incorporated TCN definitions	92	75	DNA
Incorporated TCN units or modules	67	51	DNA
Offered formal courses on TCN	43	26	DNA
Program did not have specific faculty earmarked for TCN	DNA	DNA	98
Program did not have sufficient faculty prepared in TCN	DNA	DNA	78
Expressed interest in participating electronically in selected modules	DNA	DNA	67

DNA = Data Not Available from source

Source: Ryan M, Carlton KH, Ali N. Transcultural nursing concepts and experiences in nursing curricula. *J Transcult Nurs* 2000;11:300–7.

Two additional studies assessed cultural content in nursing programs. Grossman and colleagues (1998) surveyed deans and directors of nursing programs in Florida with a 51 percent response rate (Grossman et al., 1998). Of those responding, 31 percent ranked the goal of promoting cultural diversity as high importance, 65 percent ranked it as moderate importance, and only 4 percent ranked it as low importance. Respondents identified the following critical issues related to cultural diversity: lack of cultural knowledge, sensitivity, and awareness; academic problems and educational deficits; and a lack of minority staff to serve as role models. About one-half of programs integrated cultural content throughout the curriculum. Continued needs related to cultural diversity included access to information such as statistics, strategies, and success stories; development of a core curriculum; educational materials designed for learning styles of minority students; and cultural workshops and programs (Grossman et al., 1998). The second study, in which Weaver explored educational experiences of 40 professional Native American nurses, found that 35 percent of programs contained no cultural content and 17 percent contained minimal cultural content (Weaver, 2001).

Nursing Education Materials

In addition to the lack of cultural content in nursing programs, nursing students may also see a lack of diversity represented in nursing education materials. In an assessment of photographs in textbooks, Curry found males and minorities underrepresented as nurses, women and ethnic minorities underrepresented as patients, and female patients underrepresented in cardiovascular and respiratory chapters while over-represented in reproductive chapters (Curry, 2001). Byrne and colleagues identify six categories of bias in instructional materials (Byrne et al., 2003).

Categories of Bias in Instruction Materials

- Invisibility or omission
- Stereotyping
- Imbalance and insensitivity
- Unreality (e.g., not mentioning racism or discrimination)
- Isolation (nondominant groups presented physically or visually separate from other groups)
- Linguistic bias (e.g., primitive, exotic, negative connotations for Black, or labeling people as their race)

The “Byrne Guide for Inclusionary Content” may help nurse educators evaluate and create instructional materials that include culturally diverse groups (Byrne et al., 2003).

One study examined linguistic bias in multiple-choice nursing exams, as nonnative English speakers often do poorly on multiple-choice tests (Bosher, 2003). Clearly written, appropriate, nonbiased questions allow students an equal opportunity to do well on multiple-choice exams.

Experiences of Racially and Ethnically Diverse Faculty and Students

Because of the lack of racial and ethnic diversity in the nursing profession, there has been a national effort to recruit and retain diverse nursing students. However, qualitative studies conducted with racially and ethnically diverse students demonstrate that students continue to feel racism and isolation in their education experiences. In one study, undergraduate nursing students expressed that similar people tended to migrate together on campus. These students also felt that cultural events focusing on one particular group promote “cultural enclaves” rather than cohesion (Yearwood et al., 2002).

In a qualitative study of women of color in nursing doctoral programs, participants expressed that racism in their everyday experiences in nursing school—usually unrecognized by the Euro-American faculty and peers—drained students of their energy (Hassouneh-Phillips and Beckett, 2003). Students expressed frustration with the lack of diversity in doctoral classes, Eurocentric curriculums, and lack of interest in diverse cultures by Euro-American faculty and peers. These students also stressed the role of faculty mentors (Hassouneh-Phillips and Beckett, 2003).

Struggles encountered by Native American professional nurses during their education included culture shock, stereotyping, isolation, and assumptions about cultural identity. Most of these nurses did not get support with these struggles as students. Those nurses who did find support received it from student groups or informal peer groups (Weaver, 2001). Native American graduate nursing students felt isolated from the main student body, especially when students' values conflicted with academic behavioral values. Researchers argued for additional support and continued dialog about cultural issues (Dickerson et al., 2000).

International and Community-Based Nursing Experiences

Research also illustrates the benefit of short-term international experiences in increasing cultural competence of nursing students and faculty. In one quantitative study, nursing students who completed a short-term international clinical experience had statistically significant higher achievement in cultural self-efficacy than those who remained in the United States. Students who traveled internationally were able to overcome their ethnocentrism and were able to integrate the patients' cultural practices and beliefs into Western healthcare practices (St. Clair and McKenry, 1999).

Two additional qualitative studies demonstrate that international experiences may aid in the process of cultural competency. Nursing students participating in an international learning experience in Nicaragua reported gains in knowledge, understanding, personal growth, and interpersonal connections that may help these nurses provide culturally competent care to people from diverse cultural backgrounds (Kollar and Ailinger, 2002). Nursing students who completed a short-term immersion experience in Guatemala expressed increased awareness of being "other," recognized that they had knowledge and skills to provide care, and challenged students to assess their view of the world (Walsh and DeJoseph, 2003).

Although not an "international" experience, one immersion technique had nursing students living and working on the Rosebud Reservation in South Dakota for 2 weeks to gain firsthand experience of a different culture (Pickrell, 2001). Community-based education may also help nursing students become more culturally competent (Staats, 2003; Yu and Godfrey, 2000).

Training Opportunities in Healthcare Organizations

With the increasing diversity of the U.S. population and the limited information on cultural competence previously offered by many nursing schools, healthcare organizations may have to fill that gap by offering cultural competency training for nursing employees. Because cultural diversity is broader than a patient's ethnic background, medical centers with predominately European nursing staff and few ethnically diverse patients still need cultural competency training (Campinha-Bacote et al., 1996). Donnelly recommends that healthcare institutions and nurse services administration conduct cultural competency training during new employee orientation as well as ongoing staff development (Donnelly, 2000). Effective training should be continual, occurring multiple times during the course of employment (Donnelly, 2000; Salimbene, 1999).

Health professionals in England identified the following training needs for cultural competence: communication skills, understanding cultural differences, the nature of ethnicity and burden of disease, sharing with other professionals, and what services patients want from healthcare providers. Nonetheless, healthcare providers identified challenges of sustaining learning when training take place apart from practice (Chevannes, 2002). Campinha-Bacote and colleagues offer the recommendations in Figure 26 for cultural competency trainings (Campinha-Bacote et al., 1996).

As with nursing students, cultural immersion and international exchange for employed nurses are other possible methods to develop a culturally competent workforce. In a collaboration between the University of Texas, the Parkland Health and Hospital System, and the Greater Dallas Chamber of Commerce, nursing staff and faculty participated in a 1-week Spanish-language immersion program in Mexico. Also, American and Mexican nursing staff and faculty can participate in a 2-, 4-, or 8-week exchange with a "sister" hospital in Mexico (Jones et al., 1998b).

Figure 26. Recommendations for Cultural Competency Trainings

Because of the sensitive issues surrounding cultural diversity, trainings should consider the needs of the healthcare provider.

- Consider the culture of the hospital setting prior to implementation
- Use a culturally competent instructor
- Offer training on a voluntary basis
- Teach using creative and nonthreatening experiential exercises
- Provide a positive learning experience

Source: Campinha-Bacote J, Yahle T, Langenkamp M. The challenge of cultural diversity for nurse educators. *J Contin Educ Nurs* 1996;27:59–64.

Training for Foreign Nurse Graduates

Foreign nurse graduates (FNGs) may need additional training in cultural competency to aid in their adjustment to the American nursing workforce. Yi and Jezewski (2000) point out that adjustment of Korean nurse graduates is based on support from coworkers and the administration. Pacquiao (2002) offers that professional development and occupational socialization for foreign nurse graduates should foster biculturalism.

Two programs used mentors to assist FNGs' adjustment. In a new employee orientation, administrators assigned preceptors interested in the new employee's language or culture to help facilitate orientation (Fahje et al., 2001). Another program used a buddy system to help FNGs adjust to a new workplace. Participants used the buddy system not only in the hospital but also in the community (Ryan, 2003).

One program described conducting focus groups with Filipino nursing staff to identify specific behaviors to be addressed by the minority workforce, their supervisors, and their peers. These groups now act as an advisory board for diversity training (Hellman and Baker, 1996). Another program used Leininger's Sunrise Model (see Appendix F) as a way to facilitate the assimilation of FNGs (Bola et al., 2003).

Curricular Analysis

In our review of curriculums and training, we gathered information from the published literature, the participants of the Transcultural Nursing Conference, and curriculums available on the Internet. Although the majority of information gathered came from published literature describing university courses, we also obtained responses from a brief survey via e-mail of participants in the September 2003 Transcultural Nursing Conference. They shed light on how universities or healthcare organizations incorporate cultural diversity training, whether organizations use specific models or teaching methods, and what kinds of assistance people need in their training efforts. When able, respondents sent syllabuses or journal references. Of the 130 participants, we had valid e-mail addresses (excluding students, international participants, and retired professionals) for 85 participants. Of these 85 people, 23 responded to our questions. Descriptions of health organization trainings may be underrepresented in this analysis. Selected courses and programs from the published literature and e-mail survey are presented in Appendix I.

Common Core Concepts

Of the courses reviewed, we identified the following common core concepts: examining one's own cultural beliefs, exploring the influence of culture on health and health behaviors, learning information for specific cultural groups, using a theoretical approach, and integrating concepts into university curriculums. Figure 27 highlights these common core concepts and shows links to sections in this document for further descriptions.

Figure 27: Common Core Concepts of Curriculums Analysis

The curricular analysis identified five common core concepts; page numbers are shown for those core concepts described in more detail in this report.

Core Concepts

- Cultural self-examination
- Describe relationship between cultural and health
- Provide group information versus skills used in any cultural encounter
- Use a theoretical approach
- Integrate into nursing school curriculum

Described in Section

- Process of Cultural Competence (p.34)
- -
- Skill-Centered and Fact-Centered Approaches (p.30)
- Appendix F (p.F-1)
- -

Most programs began with or incorporated an examination of one's own culture (Abrums and Leppa, 2001; Campinha-Bacote et al., 1996; Clinton, 1996; Gebru and Willman, 2003). After assessing one's own personal and cultural biases, the courses explored other ideas and cultural groups.

All programs reviewed presented information on the relationship between culture and health; perspectives differed, however, depending on the program. For example, Abrums and Leppa's (2001) course focused on discrimination and oppression in health care. Other programs explored culture and health from a transcultural nursing perspective (Amerson, 2001; Gebru and Willman, 2003; Jeffreys, 2002).

The programs reviewed presented information about specific cultural groups while stating that practitioners should not stereotype (Amerson, 2001; Clinton, 1996; Gebru and Willman, 2003; Jeffreys, 2002; Matzo et al., 2002; Wendler and Struthers, 2002). Almost all programs presenting information talked about African-American and Latino American groups (Clinton, 1996; Jeffreys, 2002; Kardong-Edgren, 2003; Matzo et al., 2002; Wendler and Struthers, 2002). Other cultural groups discussed included Asian Americans (Clinton, 1996; Jeffreys, 2002; Matzo et al., 2002; Wendler and Struthers, 2002), Arab Americans (Clinton, 1996), Jewish Americans (Clinton, 1996), Native Americans (Clinton, 1996; Matzo et al., 2002; Wendler and Struthers, 2002), different age groups (Gebru and Willman, 2003; Jeffreys, 2002), and homosexual and bisexual people (Jeffreys, 2002). Two programs reported discussing the dominant Euro-American culture (Abrums and Leppa, 2001; Clinton, 1996).

Most programs in the published literature used a theoretical approach to learning about culture. Literature commonly cited the following cultural competency models: Leininger's Theory of Culture Care Diversity and Universality (Amerson, 2001; Chrisman, 2003; Gebru and Willman, 2003; Jeffreys, 2002), Campinha-Bacote's *A Culturally Competent Model of Care* (Campinha-Bacote et al., 1996; Chrisman, 2003), the Purnell Model for Cultural Competence (Jeffreys, 2002; Kardong-Edgren, 2003), and Giger and Davidhizar Transcultural Assessment Model (Amerson, 2001; Smith, 2001). Interestingly, healthcare organizations reported using the Giger and Davidhizar Transcultural Assessment Model more frequently than university programs. Descriptions of specific models are provided in Appendix F.

Finally, the majority of nursing programs identified by Ryan and colleagues as well as our survey of TCN participants indicate that nursing schools incorporate cultural concepts throughout the curriculum rather than requiring students to take a separate TCN course. Several programs offered a separate elective course for those students interested in nursing and culture.

Teaching Methods

The majority of courses used a combination of lecture and discussion. Several programs used case studies, audiovisual materials such as films and videos, and Internet resources. Shearer and Davidhizar (2003) suggested the use of role play to increase cultural competence. Methods used depended on the availability and cost of materials, participant's comfort level, and community resources.

Figure 28. Teaching Methods Used in Cultural Competency Courses

Teaching methods used in cultural competency programs may depend on the target audience or the availability of materials.

- Lecture
- Discussion
- Case Studies
- Role play
- Videos
- Internet
- Community experience

Evaluation

Although the ideal would include evaluations for all programs, this ideal is not always possible. A few programs from universities and healthcare organizations reported evaluation results.

Most universities require a standard evaluation for each class, the instructor, and the class' ability to meet stated objectives. These evaluations may not assess a student's level of cultural competence, but can offer an idea of how students received the course. Two programs reviewed found that their evaluations were consistently high (Abrums and Leppa, 2001; Wendler and Struthers, 2002). Winn and Riehl suggest some additional evaluation components for nursing schools (Winn and Riehl, 2001).

Potential Evaluation Components for Nursing Schools

- Students assess their clinical experience with regard to transcultural nursing concepts
- Recent graduates provide input on the applicability of the program's content to entry-level practice
- Input from employers of recent graduates regarding transcultural nursing skills should be the final piece of evaluation

Many healthcare organizations may lack resources for conducting an extensive evaluation. One program reported that its major evaluation method was to observe the participation of the learners in the discussion and case studies (Amerson, 2001). Likewise, another program distributed a posttraining questionnaire and found that 90 percent of participants rated the program as good to excellent (Campinha-Bacote et al., 1996).

In a two-group intervention study, 94 registered nurses (RNs) were randomly assigned to an 8.5-hour "culture school" or nursing informatics class. Using the Cultural Self-Efficacy Scale, the evaluation study found that culture school participants demonstrated significantly more cultural self-efficacy and cultural knowledge. These improvements remained 3 weeks after the intervention (Smith, 2001). The Cultural Self-Efficacy Scale and other cultural competence measures are cited in Appendix C.

These evaluation show that students and professional nurses are open to receiving information about culture and that cultural competency trainings may increase cultural knowledge and self-efficacy.

SECTION V. CONCLUSION

As is evident from this environmental scan, a growing body of information is available related to nursing and cultural competence. Information was gathered from five sources to obtain a broad perspective: published literature, medical and nursing schools, Federal and State agencies, public and private health care, and consumer and advocacy groups. Below, we review areas for further research and the implications for the creation of curricular modules that have the standards for culturally and linguistically appropriate services (CLAS) as a framework.

What Are the Gaps in Knowledge?

Although much information is available, further research is needed in several key areas: linking CLAS and patient outcomes, evidence-based nursing (EBN) practice and CLAS, effective intervention aspects, and patient definitions of CLAS.

Further evidence is needed to strengthen the claim that cultural competency affects patient health outcomes. As a starting point in assessing this claim, measurements of providers' and organizations' cultural competency need to be assessed for reliability and validity. Patient outcomes need to be defined (e.g., changes in physiological indicators versus patient satisfaction) (Kehoe et al., 2003). Also, further research needs to be conducted on the pathways linking CLAS and patient outcomes (Hahn and Cella, 2003).

One potential way to determine the impact of CLAS on patient outcomes would be to rank existing literature according to a hierarchy of evidence, as in EBN practice—reviewing articles using accepted criteria and presenting a summary with details of study design, sample size, power, and effects (Pope, 2004). However, in a review of cultural competency interventions, Anderson and colleagues found that there were too few comparative studies to determine intervention effects (Anderson et al., 2003). Perhaps a first step in defining evidence-based practice would be to conduct studies comparing the cultural competency of practitioners who have undergone cultural competency training to the cultural competency of those who have not.

Further research is needed to determine which aspects of cultural competency interventions for healthcare providers are effective. Research could seek to answer such questions as: what content is critical to a cultural competency curriculum, which teaching methods are the most effective in conveying information, when and how often does the training need to be conducted, and how should the intervention be evaluated? In addition to these questions, further research could determine the effectiveness of current cultural assessment tools, models, frameworks, and theories in the field of nursing.

Understanding CLAS from a patient perspective also needs to be further examined in the nursing literature. Culturally competent care seeks to match patient expectations of care with nursing care. As part of this process, patients could be involved in defining quality care and evaluating the provision of CLAS by healthcare providers.

What Did We Learn?

Much information has been written pertaining to the three areas of CLAS and relevant to teaching core aspects of cultural competence to nurses. Several themes emerged for each of the three major CLAS areas. In the first area, culturally competent care, the main themes for consideration as content for the development of the curricular modules are caring and the nurse-patient relationship, skill-centered and fact-centered approaches, transcultural nursing, bias and racism, the process of cultural competence, complementary and alternative medicine, and patient cultural assessment tools. In the area of language access services, the prominent themes are language access strategies, cost of language services, working with interpreters, and patient-education and patient-related materials. The main themes related to organizational supports for cultural competence that may be important core knowledge for enhancing nurses' capacity for institutional change are a strong commitment to cultural competence at every level of the organization, recruitment and retention of diverse nursing students and staff, foreign nurse graduates,

training and professional development, and organization assessment.

In the curricular analysis, we identified five core concepts common to most curriculums: cultural self-examination, relationship between culture and health, balance between providing group information versus providing skills that could be used in any cultural encounter, use of a theoretical approach, and integration into the nursing school curriculum. Teaching methods used included lecture, discussion, case studies, role play, videos, Internet, and community or international experiences.

Few programs reported evaluation results. Those programs that did used standard university evaluation forms, participant observation, or posttraining questionnaires to evaluate the training. Overall, evaluations showed that nursing students and professional nurses are open to receiving information about culture and that cultural competency trainings may increase cultural knowledge and self-efficacy.

Concluding Thoughts

The information available provides a sufficient basis to begin defining modules for cultural competency for nurses. However, recommendations from the National Project Advisory Committee and consensus building members, insight from the three expert concept papers commissioned for this project, and the results of the initial focus groups with practicing nurses will be essential information for designing the curricular modules. Despite the need for further research, this environmental scan shows that much information and many resources are available that address all three areas of the CLAS standards.

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APPENDIX B. SEARCH TERMS

We searched for combinations of the following terms in PubMed, CINAHL, and EBSCO databases. We limited articles to those written in English in the past 5 years and searched for articles about the U.S. healthcare system. When searches yielded many results, we limited the search to review articles.

- Communication
- Communication barriers
- Critical Race Theory
- Cultural bias
- Cultural competence
- Cultural diversity
- Cultural diversity—education
- Cultural sensitivity
- Cultural values
- Curriculum development
- Education, nursing
- Education, nursing, continuing
- Ethnic groups
- Evidence-based practice
- Faculty, nursing
- Foreign groups
- Foreign nurses recruitment
- Health beliefs
- Healthcare delivery
- Interpretation
- Language
- Language services
- Learning environment
- Licensure
- Minority groups
- Nursing
- Nursing models, theoretical
- Nursing organization
- Nursing shortage
- Nursing workforce diversity
- Personnel recruitment
- Personnel retention
- Professional development
- Racism
- Student experiences
- Student recruitment
- Student retention
- Teaching methods
- Therapeutic relationship
- Transcultural nursing
- White power

APPENDIX C. MEASURES OF CULTURAL COMPETENCE

Name of Measure	Description
Cultural Awareness Scale (Rew et al., 2003)	Rew and colleagues developed a Cultural Awareness Scale to measure outcomes of a program to promote multicultural awareness among nursing faculty and students. Five subscales were developed from a literature review on cultural awareness: general educational experience, cognitive awareness, research issues, behaviors/comfort with interactions, and patient care/clinical issues. The original scale contained 37 items using a 7-point Likert response format.
Cultural Self-Efficacy Scale (CSES) (Bernal and Froman, 1993, from St. Clair and McKenry, 1999)	The CSES is a 26-item, 5-point Likert response scale used to assess students' cultural self-efficacy. Two factors accounting for 90 percent of total item covariation are self-efficacy in general cultural skills (such as distinguishing ethnicity from culture) and self-efficacy in specific cultural skills (such as understanding role differentiation or beliefs about health). Internal consistency of the CSES was $\alpha = .97$ in the Bernal and Froman study and $\alpha = .80$ in the St. Clair et al. study.
Ethnic Attitude Scale (EAS) (Rooda, 1993, from Bond et al., 2001)	The EAS-Part I is a Likert-type self-administered questionnaire consisting of three vignettes describing three ethnic groups (Anglo, African-American, and Hispanic). The scale assumes behavior is positively associated with an individual's level of confidence. Respondents are asked to respond to 20 questions designed to measure attitudes toward providing care to each group. Higher scores indicate a more positive attitude.
Ethnic Competency Skills Assessment (ECSA) (Ho, 1992, from Napholz, 1999)	The ECSA, a self-report instrument, measures self-perceived cultural competency skills. The ECSA consists of 23 items and uses a 5-point Likert response format. The instrument takes about 10 to 15 minutes to complete. The higher the score, the greater the cultural competency.
Inventory for Assessing the Process of Cultural Competence Among Healthcare Professionals—Revised (IAPCC–R) (Campinha-Bacote, 2003a)	The IAPCC, developed by Campinha-Bacote in 1997, is based on her model of cultural competence. In 2002, Campinha-Bacote developed the IAPCC–R, in which she added five additional questions to the IAPCC to measure the fifth construct of cultural desire. The IAPCC–R, a self-administered tool, consists of 25 items that measure the five cultural constructs of desire, awareness, knowledge, skill, and encounters. Five items address each one of these constructs. The IAPCC–R uses a 4-point Likert scale, and completion time is approximately 10 to 15 minutes. Scores indicate whether a healthcare professional is operating at a level of cultural proficiency, cultural competence, cultural awareness, or cultural incompetence. Higher scores depict a higher level of competence. The

	IAPCC–R can be purchased from Transcultural Care Associates.
Multicultural Counseling Inventory (Sodowsky et al., 1994, from Pope-Davis et al., 1994)	This inventory was developed to measure self-reported multicultural competency. The inventory has four subscales: skills, knowledge, awareness, and relationship. The Multicultural Counseling Inventory consists of 40 items in a 4-point Likert scale format. Higher subscale scores indicate greater self-perceived multicultural competence in the respective subscale areas.
Oklahoma Racial Attitudes Scale (Eliason, 1998)	The Oklahoma Racial Attitudes Scale contains 50 statements about race issues rated on a 5-point Likert scale. The statements measure overt and subtle manifestations of racism. Higher scores indicate greater racial awareness.
Self-Examination in Transcultural Issues (Davis, 1994)	This tool is a 44-item multiple-choice questionnaire that measures levels of understanding of trans-cultural issues. Respondents answer questions on specific aspects of particular ethnic or cultural groups such as beliefs, practices, and diseases inherent to those groups. Tabulated scores result in the following categories: transculturally gifted, above average, below average, and retarded.
Transcultural Questionnaire (Bernal and Froman, 1987, from Bond et al., 2001)	The Transcultural Questionnaire is a 30-item Likert-type self-efficacy scale that measures the respondent's level of confidence in caring for different ethnic groups. Jones and Bond (1998) modified it for use with African-American, Anglo, and Hispanic cultures. Respondents rate their perceived level of confidence in three areas: knowledge of cultural concepts, knowledge of cultural patterns for each group, and skills in performing selected activities with culturally different patients.
Transcultural Self-Efficacy Tool (TSET) (Jeffreys, 2000)	The TSET contains 83 items, a 10-point rating scale (1 = not confident to 10 = totally confident) and three subscales—Cognitive (25 items), Practical (30 items), and Affective (28 items). Scoring involves subscale calculations of self-efficacy strength (SEST) and self-efficacy level (SEL). SEST scores are calculated by totaling subscale item responses and dividing by the total number of subscale items, resulting in the mean score. SEL refers to the number of items students perceive with more than 20 percent confidence.

APPENDIX D. STATE LANGUAGE LAWS

Figure 29. States Enacting Laws Making English the Official Language

- Alabama, 1991
- Alaska, 1998
- Arizona, 1996 (declared unconstitutional)
- Arkansas, 1996
- California, 1997
- Colorado, 1996
- Florida, 1991
- Georgia, 1996
- Hawaii, 1993 (recognizing English and Hawaiian)
- Illinois, 1993
- Indiana, 1996
- Kentucky, 1996
- Mississippi, 1991
- Missouri, 1991, 1999 (recognizing “fluency in English is necessary for full integration into our common American culture for reading readiness”)
- Montana, 1995
- Nebraska, 1920
- New Hampshire, 1995
- North Carolina, 1994
- North Dakota, 1989
- South Carolina, 1996
- South Dakota, 1995
- Tennessee, 1991
- Utah, 2001
- Virginia, 1993
- Wyoming, 1996
- The Commonwealth of Puerto Rico declared Spanish and English to be official languages in 1990.

Source: Perkins J, Youdelman M, Wong, D. *Ensuring Linguistic Access: Legal Rights and Responsibilities*. 2nd ed. Los Angeles, CA: National Health Law Program, 2003.

Permission to include this information has been obtained from the authors and the National Health Law Program.

Source: Jane Perkins, Mara Youdelman & Doreen Wong, *Ensuring Linguistic Access: Legal Rights and Responsibilities*, 2nd edition (2003), available from National Health Law Program, <http://www.healthlaw.org/>.

State	Provision	Requirement
Alaska	Alaska Stat. § 47.30.735 and 745	During 30- and 90-day involuntary commitment hearings, patients have the right to an interpreter.
	Alaska Stat. § 47.30.860	When practicable, notices and documents served on mental patients must be explained in a language understood by the patient or the patient's adult designee.
	Alaska Stat. § 47.30.855	Patient rights must be explained in languages understood by mental patients.
	Alaska Stat. § 47.30.675	All applicants for voluntary treatment must receive an explanation of rights in languages that they understand.
Arizona	Arizona Administrative Code § R9-21-305(B)(9)	Case management services employed by the Department of Health Services must assess communication skills of each eligible mentally ill client, including clients' abilities to read, hear, understand and speak English.
Arkansas	Arkansas Statutes § 20-16-904	Woman's Right to Know Act of 2001—requires all printed materials to be in English and every language spoken by 2% of the population and to include information on adoption alternatives, description of the 2-week fetus, and risks of abortion.
	Health and Human Services Regulations 016 01 CARR 055 (Div. of Youth Services) § 5012	Residential facilities admitting juveniles shall have written policy and procedure that new juveniles receive written orientation materials and rules in their own language, assist juvenile in understanding materials.
	0116 19 CARR 011 (Div. of Aging and Adult Services)	Division must establish a telephone service that has a list of interpreters available to assist LEP clients in obtaining information.
California	22 California Code of Regulations § 98211(c)	Recipients of state funds may not discriminate against ethnic minorities by failing to provide alternative communication services for individuals who are unable to read, speak or write in the English language, except when the state determines that such a requirement would place an undue burden on the recipient. Alternative means of communication include, but are not limited to, interpreter services and written materials.
	California Health and Safety Code § 1259	General acute care hospitals must provide language assistance services for language groups that comprise 5% or more of the facility population. Acute care hospitals must develop policies on the provision of interpreter services to LEP patients and must review these policies on an annual basis. To the extent possible as determined by the hospital, these policies must ensure the availability of interpreter services 24 hours a day to LEP patients who are part of a language group that comprises at least five percent of the population of the geographic area served by the hospital. Hospitals also must (1) post foreign language notices that advise patients and their families of the availability of interpreters, the procedure for obtaining an interpreter, and directions on how to make complaints to state authorities about interpreter services; (2) notify their employees of their commitment to provide interpreters to all patients who request them; (3) prepare and maintain a list of qualified interpreters; (4) identify and record their patients' primary languages in hospital records, (5) review standardized forms to determine which should be translated, (6) consider

		providing non-bilingual staff with picture and phrase sheets from communication with LEP patients, and (7) consider establishing community liaison groups to enable LEP communities to ensure the adequacy of interpreter services. State licensing agencies are empowered to enforce these requirements through administrative sanctions.
	California Welfare and Institutions Code §§ 5804, 5868	County mental health demonstration programs and children's mental health programs must make provisions for staff with necessary linguistic skills to remove barriers to mental health care for non-English speaking patients.
	22 California Code of Regulations § 73501	Intermediate Care Facilities must use interpreters and other methods to ensure adequate communication between staff and patients.
	California Welfare and Institutions § 14552(e)	An adult day care provider serving a "substantial number" of participants of a particular racial group, must employ staff of that particular racial or linguistic group at all times. The term "substantial number" is not defined.
	22 California Code of Regulations § 70707	Hospitals must post notice of patients' rights in English and Spanish.
	California Welfare and Institutions Code § 16946(h)(1)(D)	Counties must provide public notice of availability of county funded emergency, urgent care, and non-urgent clinical services in Spanish and English.
	22 California Code of Regulations § 97520.15	Post-surgical recovery care demonstration project must post notice of patients' rights in prominent places in English and "any other language prevalent to the area."
	9 California Code of Regulations § 862, 22 California Code of Regulations §§ 70577, 71507, 72453, 73399, 77099 and 79313	Mental health treatment facilities must post notice of patients' rights in English and Spanish.
	22 California Code of Regulations §§ 79111, 79113	Chemical dependence recovery hospitals must post notice of patients rights in English or the predominant California Welfare and Institutions Code § 5325 (individuals subjected to involuntary mental health treatment must receive an explanation of their rights in a language and modality that is accessible to them.
	California Health and Safety Code § 1568.02(c)(4)	Residential care facilities for persons with chronic, life-threatening illness must demonstrate ability to provide linguistic services for non-English speaking patients as a condition of licensure
	22 Code of California Regulations §§ 72528, 73524	Nursing facilities must obtain informed consent from non-English speaking patients for use of psychotherapeutic drugs, physical restraints, or devices that may lead to loss of ordinary body function through use of an interpreter who is fluent in English and patients' language
	17 California Code of Regulations § 6824(b)(3)(B)	Medicaid beneficiaries who cannot understand English must be informed "appropriately" of the program
	22 California Code of Regulations § 54401	Adult day care centers must include ethnic and linguistic staff as indicated by participant characteristics.
	California Government Code § 11513(d)	States must make available certified interpreters to non-English speaking individuals upon request to interpret at administrative hearings.
	California Welfare and Institutions Code § 7290 et seq.	State and local agencies must provide bilingual services to non-English speaking persons. Local agencies must provide services for languages spoken by substantial numbers of non-English speaking persons, defined as 5

		percent or more of the population served by a state or local facility. Both state and local agencies must employ sufficient bilingual persons, who are proficient in both the English language and the foreign language spoken by clients, to ensure that non-English speaking persons enjoy the same level of services enjoyed by English speaking persons. Every two years, state agencies must conduct surveys of local offices to determine the number of bilingual employees and the number and percentage of non-English speaking persons served by each office, broken down by language.
	California State Department of Social Services Manual § 21-115 (May 1, 1990)	Local social service offices must employ a percentage of bilingual employees that is proportional to the percentage of non-English speaking clients served by the office.
	22 California Code of Regulations § 70707	Hospitals must post notice of patients' rights in English and Spanish.
	9 California Code of Regulations § 862, 22 California Code of Regulations §§ 70577, 71507, 72453, 73399, 77099 and 79313	Mental health treatment facilities must post notice of patients' rights in English and Spanish.
	California Welfare and Institutions Code § 16946(h)(1)(D)	Counties must provide public notice of availability of county funded emergency, urgent care, and non-urgent clinical services in Spanish and English.
	22 California Code of Regulations § 97520.15	Post-surgical recovery care demonstration project must post notice of patients' rights in prominent places in English and "any other language prevalent to the area."
	22 California Code of Regulations §§ 79111, 79113	Chemical dependence recovery hospitals must post notice of patients' rights in English or the predominant language of the community and must explain these rights in a language or medium that the patient understands.
	California Welfare and Institutions Code § 4503	State hospitals and community care facilities must post notice of the rights of developmentally disabled persons in Spanish and English.
	California Health and Safety Code § 1599.74	Department of Health Licensing is to translate enumerated patient rights into Spanish, Chinese, and every other language spoken by 1% or more of the state's nursing home population. Nursing facilities must give translated versions to non-English-speaking patients upon admission.
	California Welfare and Institutions Code § 14007.5(j)	Medicaid beneficiaries who cannot understand English must be informed "appropriately" of the Early Periodic Screening Diagnosis and Treatment program.
	California Welfare and Institutions Code §§ 4710.8(d) and 4712(k)	State or service delivery agency must provide non-English speaking claimants with interpreters at fair hearings and informal meetings challenging decisions regarding services for developmentally disabled.
	16 California Code of Regulations § 1003	Dental health experimental programs must post notices describing the nature and intent of the program in English and a second language if warranted by the needs of the local community.
	22 California Code of Regulations § 79799	Correctional facilities must post notice of rights of inmate-patients in English and Spanish.
	California Welfare and Institutions Code § 14191, 22 California Code of Regulations §§ 51305.4, 70707.4	Local health departments are directed to make family planning pamphlets and circulars available in languages spoken by 10% or more of the county's population.
	California Welfare and Institutions Code § 5325	Physicians and hospitals performing voluntary, non-emergency sterilizations on Medi-Cal beneficiaries must provide informed consent forms in English and Spanish.

	California Health and Safety Code § 124300	Individuals subjected to involuntary mental health treatment must receive an explanation of their rights in a language and modality that is accessible to them.
	California Health and Safety Code § 1568.02(c)(4)	Residential care facilities for persons with chronic, life-threatening illness must demonstrate ability to provide linguistic services for non-English speaking patients as a condition of licensure.
	22 Code of California Regulations §§ 72528, 73524	Nursing facilities must obtain informed consent from non-English speaking patients through use of an interpreter who is fluent in English and patients' language for the use of psychotherapeutic drugs, physical restraints, or devices that may lead to loss of ordinary body function.
	California Welfare and Institutions Code § 10746	Informational materials about state administration of public assistance must be produced in both English and Spanish.
	17 California Code of Regulations 6824(b)(3)(B)	Local offices must explain Medicaid alien eligibility rules in a language that is understood.
Colorado	Colorado Revised Statutes § 26-4-703(d)(3)	Directing the Department of Health Services to consider the special cultural and linguistic needs of patients in developing a Medicaid waiver.
Connecticut	Regulations of Connecticut State Agencies § 17-134d-41	Coordinating, Assessment and Monitoring Agencies that provide assessment and case management services for patients receiving long term care or community based services recipients must provide or access necessary services for non-English speaking and bilingual individuals.
	Connecticut General Statutes § 19a-490i	Each acute care hospital to (1) develop and annually review a policy on the provision of interpreter services to non-English-speaking patients; (2) ensure, to the extent possible, the availability of interpreter services to patients whose primary language is spoken by a group comprising not less than five per cent of the population residing in the geographic area served by the hospital; (3) prepare and maintain a list of qualified interpreters; (4) notify hospital staff of the requirement to provide interpreters to non-English-speaking patients; (5) post multilingual notices of the availability of interpreters; (6) review standardized forms to determine the need for translation for use by non-English-speaking patients; (7) consider providing hospital staff with picture and phrase sheets for communication; and (8) establish liaisons to non-English-speaking communities in the geographic area served by the hospital.
Delaware	16 Delaware Code § 5161	Mental health hospitals and residential centers must display patient rights in English and Spanish and must provide a list of rights to each patient.
District of Columbia	D.C. Stat. § 7-703.01	Residents in long term care facilities must be provided with written notice in the appropriate language of their rights vis-à-vis ombudsman.
	Code of D.C. Regulations § 22-3410	Each mental health rehabilitation services provider shall make language interpreters available as needed.
	Code of D.C. Regulations §22-3411	Each Code Service Agency shall provide materials on how to access crisis/emergency services, writing at the 4 th grade level and printed in English and Spanish or other language conducive to facilitating communication.
	Code of D.C. Regulations § 22-3801	Prior to admission, rights and responsibilities of mental health community residential facility resident must be explained in orally and in writing in a language the resident can understand.
	Code of D.C. Regulations § 22-4405.2-5	Required notices of the availability of health services to all members of the community must be posted in English,

		Spanish, and any other language spoken by 10% or more of the households in the service area.
	Code of D.C. Regulations § 31-2711(a)	Establishing the Office of Interpreter Services to facilitate the use of interpreters in administrative, judicial, and legislative proceedings.
Florida	Florida Stat. § 381.026(4)(b)(7)	A patient in a health care facility who does not speak English has the right to be provided an interpreter if the facility has a person readily available who can interpret on behalf of the patient.
	Florida Stat. § 381.0038	The Department of Health shall establish an AIDS education program containing components to reach non-English speakers and other minorities.
	Florida Stat. § 393.11, 12 Florida Administrative Code § 59A-3.207	A petition for involuntary admission to residential services provided by the developmental services program of the Department of Children and Family Services or to appoint a guardian advocate for a person with developmental disability shall be given verbally and in writing in the language of the client and in English.
	Florida Stat. §627.419(8)	If an insurer advertises a policy in a language other than English, the advertisement shall not be construed to modify or change the policy written in English. The advertisement must disclose that the policy written in English controls in the event of a dispute.
	Florida Stat. § 641.54	Every HMO must provide to subscribers, on request, their policies for addressing the needs of LEP subscribers. Each hospital offering emergency services must post notices in English and Spanish stating patient's rights to receive such services.
	Florida Stat. §§ 636.015, 641.305 and 641.421	Prepaid limited health service organizations, HMOs, and prepaid health clinics that negotiate contracts in languages other than English, must provide non-English speaking members with written translations of their contract. These translations must be identical to the English language versions, approved in advance by the Department of Insurance, and certified as accurate.
	Florida Admin. Code. § 64F-10.003	Each primary care provider of family health services must post translated signs or provide written information to each applicant and client describing methods for determining financial eligibility, where it is likely that more than 5% of applicants for primary care will be LEP.
Hawaii	Hawaii Revised Statutes Annotated § 321-301	Establishing state sponsored bilingual health education aide program to assist in the provision of health education and public health services to non-English speaking and limited English-speaking persons.
	Hawaii Revised Statutes Annotated § 334-13	Establishing a bilingual mental health division within the Department of Health to provide outreach, education, case finding, screening, referral, consultation, crisis stabilization, community support, and client advocacy.
Illinois	20 Illinois Compiled Stat. 2310/2310-210	Advisory Panel on Minority Health is established, in part, to address reduction of communication barriers for non-English speaking residents and improve data collection and reporting on minority health.
	20 Illinois Compiled Stat. 2310/2310-255	Recognizes lack of access to childhood immunizations by LEP families; establishes permanent, temporary or mobiles sites for immunizing children in places where high-risk families live.
	20 Illinois Compiled Stat. 2310/2310-345	Requires publication in Spanish of a pamphlet outlining early detection and treatment of breast cancer.
	210 Illinois Compiled Stat. 87/15 et seq., 77 Illinois Administrative Code § 250.265	Access to information regarding basic health care services is an essential right; communication barriers must be

		removed by proper arrangements for interpretation. To accomplish this, health care facilities may take one or more of the following steps to provide services to language groups constituting 5% or more of the population of the service area: (1) review policies on the use of interpreters, including the availability of staff interpreters; (2) adopt and review annually new policies for providing language assistance, that shall include procedures for providing, to the extent possible as determined by the facility, an interpreter whenever a communication barrier exists, except where the patient, after being informed of the availability of the interpreter, chooses to use a family member or friend who volunteers to interpret; (3) prepare lists of qualified interpreters; (4) identify and track language needs; (5) notify employees of the commitment to provide interpreters; (6) review standardized forms to determine which should be translated; (7) develop community liaison groups to obtain feedback about interpreter policies; (8) provide non-bilingual staff with phrase and picture sheets to assist them in communicating; (9) post notices advising patients of the availability of interpreter services.
	305 Illinois Compiled Stat. 5/5-19	To support "Healthy Kids Program," Department shall use accepted methods of informing persons who are illiterate, blind, deaf, or cannot understand English, including but not limited to public service announcements and advertisements in foreign language media.
	59 Illinois Administrative Code § 112.20	Mental health and developmental disability facilities must notify non-English speaking patients and their guardians of the right to challenge diagnoses of mentally retardation and resulting placement and treatment.
	405 Illinois Compiled Statutes 5/3-204	The Department of Public Health is required to publish and distribute pamphlets to women on reproductive health issues in English and Spanish.
	20 Illinois Compiled Statutes 2310/55.66	Patients admitted to mental health facilities who do not understand English must receive an explanation of their legal rights in their primary language "within a reasonable time before any hearing is held."
	89 Illinois Administrative Code §§ 302.30(c) and 308.30(b)	In delivering social services to children and their families, the Department of Children and Family Services shall ensure compliance with Title VI of the Civil Rights Act of 1964 and any other state or federal laws that prohibit discrimination in service delivery on account of the inability to speak or comprehend the English language.
	89 Illinois Administrative Code § 140.461	Federally qualified health centers must comply with federal and state laws and regulations governing the provision of adequate notice to persons who are unable to read or understand the English language.
	89 Illinois Administrative Code § 716.200(d)(2)	Providers contracting with the Department of Rehabilitative Services to provide case management services to persons with AIDS must agree to comply with Title VI of the Civil Rights Act of 1964 and any other state or federal laws that prohibit discrimination in service delivery on account of the inability to speak or comprehend the English language.
	89 Illinois Administrative Code § 1200.10(d)(1)	Information, forms, and applications distributed by the Division of Specialized Care for Children shall be available in English and Spanish.
Iowa	Iowa Admin. Code § 441-86.13-.15	When 10% or more of the enrollees in Medicaid Healthy and Well Kids plan speak a language other than English, the plan must provide written materials in that language (to be informed by third party administrator tracking enrollment).

	Iowa Admin. Code § 441-88.71	Contractors under Plan for Behavioral Health shall provide enhanced outreach to beneficiaries with special needs, including LEP.
	Iowa Admin. Code § 481-57.35	Steps shall be taken to translate residents' rights and responsibilities for LEP residents in residential care facilities.
	Iowa Admin. Code § 481-63.33	Steps shall be taken to translate residents' rights and responsibilities for LEP residents in residential care facilities for the mentally retarded.
	Iowa Admin. Code § 481-65.25	Steps shall be taken to translate residents' rights and responsibilities for LEP residents with mental illness in ICFs.
Kansas	Kansas Stat. § 65-6710	Woman's Right to Know materials will be printed in English and Spanish and include information on adoption alternatives, description of the 2-week fetus, and risks of abortion.
	Kansas Administrative Regulations § 28-4-550(h)(1)(A) and (w)	Informed consent for services under part H of the Individuals With Disabilities Education Act (IDEA) must be obtained from parent(s) in their native language.
Kentucky	Kentucky Rev. Stat. § 214.650	Because access to health care and sustaining individuals infected with HIV/AIDS is top priority for care coordinators, the Cabinet must urge access to Spanish-speaking interpreters to provide prevention, treatment, and service efforts.
Louisiana	40 Louisiana Revised Statutes § 1299.35.6.B(2)(4)	Specified oral information and written materials about abortion and abortion alternatives must be provided to the patient at least 24 hours before the procedure is performed. If an interpreter is necessary to explain this information, the State of Louisiana shall bear the costs.
	La. Rev. Stat. § 2018.2(D)(3)	In making grants for community-based AIDS prevention programs, the Department of Health and Hospitals will give priority to (among others) racial and ethnic minorities who are engaged in high-risk behaviors, including persons whose primary language is not English.
	La. Rev. Stat. § 28:52	Mental health patients admitted voluntarily must be informed of rights and responsibilities; appropriate provisions should be made to supply information to LEP persons.
	La. Rev. Stat. § 28:53	Mental health patients admitted on an emergency basis must be informed of rights and responsibilities; appropriate provisions should be made to supply information to LEP persons.
	La. Rev. Stat. § 40:31.22	Person admitted to a facility for treatment of active tuberculosis shall be informed of rights and responsibilities; appropriate provisions should be made to supply information to LEP persons.
	La. Rev. Stat. § 46:447.2	The Department of Health shall develop a program such that all pregnant women have access to appropriate health care; to include staff development to improve cultural sensitivity and interpersonal skills and training in providing assistance to women with low literacy skills or who are LEP.
Maine	5 Maine Revised Statutes § 51	State must provide qualified interpreters or utilize a professional telephone-based interpretation service when a non-English person is subject of a proceeding before an agency or a court.
Maryland	Code of Md. Regs. § 10.09.08.06	Maryland Qualified Health Centers must assure access to language interpretation is a substantial portion of the population served is LEP.
	Code of Md. Regs. § 10.21.08.03	Mentally ill, hearing impaired patients who are LEP shall be

		tested for hearing sensitivity in their own language.
Massachusetts	Mass. Gen. Laws Ch. 111, § 25J(b) (emergency services), Ch. 123, § 23A(b) (acute psychiatric services); Mass. Regs. Code tit. 105, § 130.1101 <i>et seq.</i>	Every acute care hospital shall provide competent interpreter services in connection with all emergency room services provided to every non-English speaker who is a patient or who seeks appropriate emergency care or treatment.
	114.3 Code of Massachusetts Regulations §§ 3.02 and 3.06	Home health agencies may apply to rate setting commission for adjustment in rates for provision of interpreters to non-English speaking patients.
	102 Code of Massachusetts Regulations §§ 3.03(6)(a)(1)(a.) and 6.05(6)(a)(1)(a)	Group care facilities for children must maintain records of the primary language of children in their care.
	104 Code of Massachusetts Regulations § 16.02	Requiring Department of Mental Health to make available, to maximum extent possible, clinicians, and case managers who speak the individuals' language.
	105 Code of Massachusetts Regulations § 127.021	As a condition of licensing, mammography facilities must provide specified information to patients. The official commentary to this regulation states that facilities that serve linguistically diverse patients should use reasonable means to communicate the required information to patients who are not proficient in reading English.
	105 Code of Massachusetts Regulations §§ 150.001 and 150.004(H)	Skilled nursing facilities for AIDS patients must provide access to sufficient bilingual services to meet the cultural and language needs of non-English speaking residents.
	105 Code of Massachusetts Regulations §§ 160.303(B)(1)	Substance abuse treatment facilities must keep data listing primary language spoken by patients if other than English.
	105 Code of Massachusetts Regulations § 130.615(C) and (E)	Maternal-newborn service must make available health education materials and activities in languages spoken by any non-English speaking groups that comprise at least 10% of the population served and must have translation services available to ensure that families who speak these languages receive ongoing information about the condition and progress of the mother and infant.
	110 Code of Massachusetts Regulations § 1.06	Requiring Department of Social Services to ensure its social workers conduct activities in language understood by the client.
	115 Code of Massachusetts Regulations § 4.03(1)(c)	Requiring Department of Mental Retardation to write individual records in English, with second language translation (or availability of interpreter services) where necessary for the individual.
	117 Code of Massachusetts Regulations §§ 8.08(d)	Community health centers must post notice of the availability of free care in any language spoken by 10% or more of the residents in the centers' service area.
	130 Code of Massachusetts Regulations § 405.414	Division of Medical Assistance rule requiring Community Health Centers to employ at least one practitioner or translator conversant in the primary language of each substantial population (10% or more of the non-English speaking members that regularly use the CHC).
	130 Code of Massachusetts Regulations § 440.414	Division of Medical Assistance rule requiring early intervention program to be responsive to the needs of non-English populations within its service area.
	130 Code of Massachusetts Regulations § 501.009	Division shall inform MassHealth applicants and members of the availability of interpreter services and provision telephonic or other services unless the applicant chooses to provide his/her own interpretation.
Michigan	Michigan Stat. Ann. § 14.15(b) and (c)	Consequences of abortion must be explained in language understood by patient and consent forms must be printed in English, Aramaic, and Spanish.

	Mich. Stat. Ann. § 33.5133	Patient receiving HIV tests must be given pamphlet describing the test in clear, non-technical English and Spanish.
	Mich. Stat. Ann. § 333.9161	The Department of Licensing and Regulation shall distribute a pamphlet with information about prenatal care and parenting in English, Spanish, and other needed languages.
	Mich. Stat. Ann. § 333.170115	Women's Right to Know (abortion risks and options) pamphlet must be printed in non-technical English, Arabic, and Spanish.
Minnesota	Minn. Stat. Ann. §§ 144.65,. 146A.11	Patients' bill of rights includes reasonable accommodations for those who speak a language other than English.
	Minn. Stat. Ann. § 148B71(1)	Mental health facilities must make reasonable accommodations to inform non-English speaking patients of their legal rights.
	Minn. Stat. Ann. § 256.01 (13)	Mandating pilot projects for language assistance for individuals applying for or receiving aid through county social service agencies.
	Minn. Stat. Ann. § 256B.0625	Covered Medicaid services include oral interpreters when provided by an enrolled health care provider during the course of a person-to-person covered services to an enrolled, LEP recipient.
	Minn. Stat. Ann. § 621.72	Disclosure statement by insurance companies describing payment methods must be printed in English, Spanish, Vietnamese, and Hmong, with reasonable efforts made to provide the information contained in the statement to other LEP persons.
Missouri	Missouri Stat. § 631.135	Respondent accepted to drug or alcohol abuse treatment has the right to have interpreter assistance at the facility or during the hearing, or both, if he is impaired hearing or does not speak English.
	Missouri Stat. § 632.325	If Respondent is accepted for evaluation and/or treatment by psychiatric services through civil detention, he has the right to have an interpreter assist him at the facility or during the hearing or both, if he is hearing impaired or does not speak English.
Montana	Mont. Code Ann. § 33-36-201; Mont. Admin. Reg. §§ 37.108.207, 37.108.236	An access plan for each managed care plan offered in the state must describe the carrier's efforts to address the needs of LEP persons.
	Mont. Admin. Reg. § 37.86.3402	A pregnancy is considered high-risk for an LEP person so as to make that person eligible for case management services.
Nebraska	Neb. Rev. Stat. § 44-7105	A health carrier shall maintain an access plan for each managed care plan that describes the carrier's efforts to address the needs of LEP persons.
	Neb. Admin. R. & Regs. tit. 175, Ch. 8, § 003	Efforts must be made to have residents' rights and responsibilities translated into the appropriate language for LEP residents of ICFs.
	Neb. Admin. R. & Regs. tit. 202, Ch. 6, § 004	Efforts must be made to have residents' rights and responsibilities translated into the appropriate language for LEP residents of facilities for the mentally retarded.
Nevada	40 Nevada Revised Statutes § 442.253 (1) and (3)	Consequences of abortion must be explained in language understood by patient and consent forms must be written in language understood by her.
New Jersey	8 New Jersey Admin. Code §§ 31B-4.37(a)(1), 31B-4.41C	Hospitals must post notices regarding availability of charity care in Spanish, English and any other language spoken by more than 10% of the population of the hospital's service area.
	8 New Jersey Admin. Code §§ 33-	For approval of certificate of need, hospital must show how

	4.10(a)(8), 33A-1.29(b)(3)(ii)-4.10(a)(8)	the project will promote access for racial and ethnic minorities and must document effective communication between the staff of the proposed project and non-English speaking people.
	N.J. Rev. Stat. § 26:2-168	Department of Health must disseminate informational brochure on breast cancer in English and Spanish.
	N.J. Rev. Stat. § 26:2H-12.8.h.	Patients have the right to expect that within their capacity, hospitals will make reasonable response to requests for services, including the services of an interpreter if 10% or more of the population of the hospital's service area speaks that language.
	8 New Jersey Admin. Code §33E-1.5a	For approval of certificate of need for intensive cardiac care units, hospitals should have bilingual clinical personnel available who can overcome language barriers and know and understand cultural differences among patients to the extent possible.
	N.J. Rev. Stat. § 30:4-27.11	Patients admitted to psychiatric facilities have the right to have examinations and services provided through interpreters in their primary means of communication at the earliest possible time.
	8 New Jersey Admin. Code §§ 42A-6.10, 42B-6.6(e)	Drug and alcohol treatment facilities must provide interpreter services if their patient population is non-English speaking.
	8 New Jersey Admin. Code §§ 43H-6.1(a)(14)	Rehabilitation hospitals must provide interpreter services if their patient population is non-English speaking.
	8 New Jersey Admin. Code §§ 43F-6.6	Adult day care centers must provide interpreter services if their patient population is non-English speaking.
	N.J. Rev. Stat. § 30:1-1.1	Requiring the Department of Human Services to establish a comprehensive social services information hotline operating in Spanish and English.
	10 New Jersey Admin. Code § 74-1.3	To meet requirements for bilingual services, Medicaid managed care plans must be able to provide services in Spanish and English and in any other language spoken by more than ten percent of its Medicaid enrollee.
New Mexico	N.M. Admin. Code § 7.11.2 (26)	LEP patients have the right to obtain assistance in interpretation. All patients rights shall be posted in English and Spanish.
	N.M. Admin. Code § 7.20.11	Certification requirements for Child and Adolescent Health Services include provision of culturally competent services, bilingual/bicultural profession, and paraprofessional personnel; needed translators; provision of information to the public about LEP services.
	N.M. Admin. Code § 8.305.8	The Medicaid managed care provider shall provide a toll-free hotline for grievances, which is equipped for communication with LEP members.
New York	10 New York Comp. Codes R. & Reg. § 405.7 (a)(7)	Hospitals must provide skilled interpreters and translations of all significant forms to ensure effective communication with all persons receiving treatment regardless of language. Interpreters and translations shall be regularly available for non-English speaking groups comprising more than 1% of a hospital's service area. Interpreters must be available in inpatient and outpatient settings within 20 minutes and in emergency rooms within 10 minutes of a request by the patient, the patient's family or representative, or a health care provider.
	New York Consolidated Laws Service, Mental Hygiene § 41.47(f)(3)	Office of Mental Health and local mental health agencies to consider the availability of services for non-English speaking persons as part of contracting with community support services programs.

	New York Consolidated Law Service, Mental Hygiene §§ 7.09(h)(i) and 13.09(e) (1995)	Office of Mental Health and Office of Mental Retardation and Developmental Disabilities to promulgate rules that address the communications needs of non-English speaking persons and to require facilities to use reasonable means to accommodate language needs.
	New York Consolidated Laws Service, Mental Hygiene § 81.07(b)	Orders to show cause in proceedings for appointment of a guardian must be translated into languages other than English when necessary to inform persons of proceedings.
	14 New York Consolidated Law Service, Mental Hygiene § 21.7	Non-English speaking mental patients must be provided with qualified translation services to facilitate written communication.
	New York Consolidated Law Service, Social Services § 473-a.4.(c)(vii) (1995)	Petition for involuntary commitment must state that if a patient is non-English speaking, reasonable efforts have been made to communicate with her.
North Carolina	10 N.C. Admin. Code § 22G.0412	Notice of public hearing on AAA nutrition plans must be posted in languages other than English when appropriate.
	10 N.C. Admin. Code § 3C.3302(n)	"A patient who does not speak English shall have access, when possible, to an interpreter."
	10 N.C. Admin. Code § 50B.0203(c)(5)	Requiring the county department of social services to verify eligibility information when an applicant is unable to speak English.
Ohio	Ohio Stat. § 2317.56	Woman's Right to Know (abortion options) materials must be printed in English and Spanish.
	Ohio Admin. Code § 5101:1-2-28	Medicaid EPSDT program must have procedures for informing eligible persons who do not speak English.
	Ohio Admin. Code § 5101:1-38-01	During reapplication process for Medicaid, an interpreter must be provided at no cost to LEP individuals.
	Ohio Admin. Code § 5101:1-38-012	During face-to-face initial interview for Medicaid eligibility, an interpreter must be provided at no cost to LEP persons; the individual shall not be required to provide their own interpreter, unless they desire to do so.
	Ohio Admin. Code § 5101:3-2-0717	Hospitals must post notices of the rights of low-income persons to receive services at the hospital in both English and other languages common to the service area.
	Ohio Admin. Code § 5122-14-10	"Each inpatient psychiatric service provider shall ensure that patients, families of patients, and significant others who are non-English-speaking shall have access to interpreters at no additional charge."
	Ohio Administrative Code § 5124:2-01(D)(4)	Hospitals and mental health clinic facilities must ensure that all non-English speaking patients meet with a client advocate who can explain their rights regarding involuntary commitment within 24 hours of admission.
	Ohio Administrative Code § 3793-2-1-12(G)	Referral and information services for drug and alcohol addiction must provide access to patients who speak a language other than English.
Oklahoma	59 Okla. Stat. Ann. § 353.13A	No prescription shall be written in any characters, Figures or ciphers other than in English or Latin language, generally in use among medical and pharmaceutical practitioners.
	Okla. Admin. Code § 310:667-3-3	Establishes a patient's right to make informed decision about medical treatment; requires that information be presented in their own language if they do not speak English.
Oregon	Ore. Rev. Stat. § 409.619	Creates the Oregon Council on Health Care Interpreters to educate and train health care interpreters.
	Ore. Rev. Stat. § 435.205	Provides that any materials related to family planning and contraception produced by the health department shall be made available in language other than English when they are spoken by a significant percentage of the population.

	Ore. Admin. Rules § 410-141-0220	Oregon prepaid health plans (PHPs) must develop written policies to communicate with and provide care to Medicaid recipients where no adult communicates in English and provide or ensure the provision of qualified interpreter services for medical, mental health, or dental visits, including home health.
	Ore. Admin. Rules § 410-141-0280	PHPs must also make culturally sensitive materials available to potential recipients in the primary language of substantial populations.
Pennsylvania	55 Penn. Admin. Code § 1140.41(12)	Providers that contract with state's Healthy Beginnings Plus program must ensure use of qualified interpreters for each non-English speaking patient.
	35 Penn. Stat. § 449.36	Health care practitioners that treat non-English speaking Medicare beneficiaries must post translated signs of patients' rights supplied by Pennsylvania's Bureau of Professional and Occupational Affairs.
	28 Penn. Admin. Code §§ 201.29(k) and 201.30(h)	Nursing homes must make arrangements to communicate patient rights to non-English speaking patients.
	28 Penn. Admin. Code § 553.12	Ambulatory surgery patients who do not speak English shall have access to an interpreter where possible.
	28 Penn. Admin. Code § 201.29(x)	Hospitals must translate notices of patient rights for non-English speaking patients.
	35 Penn. Stat. § 449.36(c)	Hospitals must post translated notices of patient rights for non-English speaking Medicare beneficiaries.
Rhode Island	R.I. Gen. Laws § 23-17-54; R.I. Code R. 14 090 007 § 20.3	Hospitals, as a condition of licensure, must provide a qualified interpreter, if an appropriate bilingual clinician is not available, for all services provided to every non-English speaker who seeks treatment and is not accompanied by a qualified interpreter; persons under age sixteen are not qualified interpreters.
	23 R.I. Laws § 17.5-18(3)	Nursing homes serving non-English speaking patients must attempt to find interpreters to allow patients to exercise their rights.
Texas	Tex. Gov't Code § 531.0213	Health and Human Services Commission will operate a statewide toll-free assistance number that includes assistance for persons who speak Spanish.
	25 Tex. Admin. Code § 29.609(c)(3)	Disproportionate share hospitals must post notices of right to charity care in English and Spanish.
	25 Tex. Admin. Code § 405.88	Facilities for the mentally retarded must make necessary provisions to assess non-English speaking individuals.
	40 Tex. Admin. Code 25 §§ 147.35(10), 153.36(13)	Alcohol and drug abuse education programs and drug offender education programs must make provisions for persons who are unable to read or speak English.
	Tex. Health & Safety Code § 62.103	Applications for Child Health Plan shall, to extent possible, be made available in languages other than English.
	Tex. Health & Safety Code §§ 161.132(e), 161.134(j), 161.135(h), 321.002(h), 25 Tex. Administrative Code §§ 133.52(b)(2); 133.54(a), 40 Tex. Administrative Code § 148.141(b)	Facilities and hospitals offering mental health, rehabilitation and alcohol and chemical dependency services must post notice of patient rights, patient abuse reporting responsibilities, and right to be free from retaliation for reporting violations of law, in English and a second language representative of the demographic makeup of the community served by the facility.
	Tex. Health & Safety Code § 161.136(a)	State health care regulatory agencies are empowered to require mental health services providers to furnish patients with brochures in English and Spanish summarizing laws prohibiting sexual exploitation of patients.
	Tex. Health & Safety Code § 245.023	Abortion facility shall provide written information to women in English and Spanish.
	Tex. Insurance Code § 21.21-7	A health insurer may not use an underwriting guideline that

		is based on the ability of the insured or applicant to speak English fluently or to be literate in the English language.
	25 Tex. Admin. Code § 355.805(c)(3) 25 Tex. Admin. Code § 33.14	Hospitals must advise all patients of the availability of no-cost medical care and the application procedures, in English and Spanish.
	25 Tex. Admin. Code § §404.161(f), 404.162(d)	Families must be informed of EPSDT services using procedures suitable for persons who are illiterate, blind, deaf, or cannot understand English.
	25 Tex. Admin. Code § 405.626	Mental health facilities must provide patient rights brochures to teens and children in English and Spanish. Department of Mental Health and Mental Retardation must print patient rights handbook for mentally retarded in Spanish and English.
Utah	Utah Admin. Code § R501-2-9(J)	Human service programs that contract with the state must employ staff as necessary to communicate with consumers whose primary language is not English.
Vermont	18 Vt. Stat. Ann. § 1852	Patient bill of rights says hospital patients who do not understand English have a right to an interpreter "if the language barrier presents a continuing problem to patient understanding of the care and treatment being provided."
	33 Vt. Stat. Ann. § 7301	Nursing homes must make reasonable accommodations to communicate patients' rights to non-English speaking residents.
Virginia	Va. Stat. § 18.2-76	Department of Health shall publish in English and in each language which is the primary language of 2% of more of the population of the state and display at every local health department information about adoption alternatives, description of the 2-week fetus, and risks of abortion.
	12 Va. Admin. Code § 30-10-50	With respect to any population of vaccine-eligible children a substantial portion of whose parents are LEP, the state will identify program-registered providers who are able to communicate with vaccine-eligible population in the appropriate language and cultural context.
Washington	Wash. Admin. Code §§ 440-22-160 and 440-22-310(b)	Chemical dependency service providers must make available certified interpreters or other acceptable alternatives for persons with Limited English Proficiency and must accommodate limited English proficiency and cultural differences.
	Wash. Rev. Code § 74.04.025(1)	The Department of Social and Health Services and the Office of Administrative Hearings shall ensure that bilingual services are provided to non-English speaking recipients and applicants. DSHS shall employ bilingual staff if the number of applicants and recipients sharing the same language equals or exceeds 50% of the average caseload of a full-time caseworker. DSHS shall ensure bilingual services to supplement staff. Initial client contact materials must inform clients in their primary language of the availability of interpreting services. Notices to clients must contain written communications in their primary language informing them of the significance of the communication and how to obtain assistance in responding to it. DSHS must ensure that sufficient resources are available to allow patients to respond to notices in a timely fashion. Basic informational pamphlets must be translated into Spanish, Vietnamese, Cambodian, Laotian, Chinese, and other languages determined to be primary languages by DSHS.
	Wash. Admin. Code § 246-452-010	Written explanations about charity care must be provided in any language spoken by more than 10% of the population in the hospital's service area and must be interpreted for other non-English speaking patients.

	Washington Revised Code §§ 2.43.010 and 2.43.020, Washington Administrative Code § 10-08-150	Interpreters must be provided to non-English speaking persons in legal proceedings, including administrative proceedings.
Wisconsin	Wisconsin Administrative Code, Chapter HSS, § 102.01(b)(4)	In administering state Medicaid program, agencies that serve substantial non-English speaking or limited-English speaking populations must take whatever steps are necessary to communicate with them.
	Wisconsin Department of Health and Social Services Administrative Directive AD-52 (May 24, 1985)	DHSS divisions must translate program information into languages spoken by at least 5% or 1,000 individuals in the agencies service area. All individuals accessing DHSS services are entitled to the assistance of qualified interpreters at the time they apply for and receive services and in the processing of complaints and appeals. DHSS divisions are required to maintain and distribute lists of bilingual employees and to pay for qualified interpreters when qualified staff or interpreters are not available.
	Wis. Stat. Ann. § 253.10(3)(d)	Written information about abortion alternatives must be provided to patients in English, Spanish, and languages spoken by a significant number of state residents.

APPENDIX E. PROFESSIONAL NURSING ASSOCIATIONS' WEB SITES

Nursing Association	Web Address	Date Accessed	Mission
Academy of Medical-Surgical Nurses (AMSN)	http://www.medsurnurse.org/	1/12/2004	The mission of AMSN is to enhance the clinical expertise, professionalism, and leadership of nurses caring for adults in hospitals, the community, and long-term care.
American Academy of Ambulatory Care Nursing (AAACN)	http://aaacn.inurse.com/	1/12/2004	The AAACN is the association of professional nurses who identify ambulatory care practice as essential to the continuum of high quality, cost-effective health care. The mission of the AAACN is to advance and influence the art and science of ambulatory care nursing.
American Assembly for Men in Nursing (AAMN)	http://people.delphiforums.com/brucewilson/	1/12/2004	The purpose of the AAMN is to provide a framework for nurses, as a group, to meet and to discuss and influence factors that affect men as nurses.
American Association of Critical-Care Nurses (AACN)	http://www.aacn.org/	1/12/2004	The AACN is committed to providing the highest quality resources to maximize nurses' contributions to caring and improving the healthcare of critically ill patients and their families.
American Association of Nurse Anesthetists (AANA)	http://www.aana.com/	1/12/2004	The mission of the AANA is to advance excellence in anesthesia services through meeting its members' professional needs and increasing public awareness that Certified Registered Nurse Anesthetists provide patients with high-quality anesthesia services in all practice settings.
American Association of Occupational Health Nurses (AAOHN)	http://www.aaohn.org/	1/12/2004	As the primary association for the largest group of healthcare professionals serving the workplace, AAOHN is driven by a mission to ensure that OHNs are the authority on health, safety, productivity, and disability management for worker populations.
American Board of Nursing Specialties (ABNS)	http://www.nursingcertification.org/	1/12/2004	The purposes of the ABNS are to provide a forum for nursing certification collaboration; promote the value of nursing certification to various publics, and provide a mechanism for accreditation and recognition of quality nursing specialty certification accreditation.
American College of Nurse Practitioners (ACNP)	http://www.nurse.org/acnp/	1/12/2004	The mission of the ACNP is to unite and represent, politically and professionally, nurse practitioners across the United States and its territories. These efforts are to ensure an appropriate, prevention-based healthcare system to better meet the healthcare needs of individuals, families, and communities.
American Nurses Association (ANA)	http://www.ana.org/	1/12/2004	The ANA is a full-service professional organization representing the Nation's 2.6 million registered nurses through its 54

			constituent State associations and 13 organizational affiliate members. The ANA advances the nursing profession by fostering high standards of nursing practice, promoting the economic and general welfare of nurses in the workplace, projecting a positive and realistic view of nursing, and by lobbying the Congress and regulatory agencies on healthcare issues affecting nurses and the public.
American Psychiatric Nurses Association (APNA)	http://www.apna.org/	1/12/2004	The APNA provides leadership to promote psychiatric-mental health nursing, to improve mental health care for culturally diverse individuals, families, groups, and communities and to shape health policy for the delivery of mental health services.
Emergency Nurses Association (ENA)	http://www.ena.org/	1/12/2004	The ENA's mission is to provide visionary leadership for emergency nursing and emergency care.
Hospice and Palliative Nurses Association (HPNA)	http://www.hpna.org/	3/29/2004	The HPNA's purpose is to exchange information, experiences, and ideas; to promote understanding of the specialties of hospice and palliative nursing; and to study and promote hospice and palliative nursing research.
National Alaska Native American Indian Nurses Association (NANAINA)	http://www.nanaina.com	1/12/2004	The NANAINA supports Alaska Native and American Indian students, nurses, and allied health professionals through the development of leadership skills and continuing education; advocates for the improvement of health care provided to American Indian and Alaska Native consumers; and works to increase culturally competent health care provided to Alaska Native and American Indian consumers.
National Association of Hispanic Nurses (NAHN)	http://www.thehispanicnurses.org/	3/29/2004	The NAHN strives to serve the nursing and healthcare delivery needs of the Hispanic community and the professional needs of Hispanic nurses.
National Association of Pediatric Nurse Practitioners (NAPNAP)	http://www.napnap.org/	1/12/2004	The NAPNAP is the professional organization that advocates for children (infants through young adults) and provides leadership for Pediatric Nurse Practitioners who deliver primary health care in a variety of settings.
National Association of School Nurses (NASN)	http://www.nasn.org/	1/12/2004	The NASN's core purpose is to advance the delivery of professional school health services to promote optimal learning in students.
National Black Nurses Association (NBNA)	http://www.nbna.org/	1/12/2004	The NBNA's mission is to provide a forum for collective action by Black nurses to investigate, define, and advocate for the healthcare needs of African Americans and to implement strategies that ensure access to health care, equal to or above healthcare standards of the larger society.
National Coalition of Ethnic Minority Nurse Associations (NCEMNA)	http://www.ncemna.org	5/12/2004	The NCEMNA, a nonprofit professional organization, advocates for equity and justice in nursing and health care for ethnic minority populations. The

			NCEMNA is made up of AAPINA, NANAINA, NAHN, NBNA, and PNA.
National Council on State Boards of Nursing (NCSBN)	http://www.ncsbn.org/	1/12/2004	The purpose of the NCSBN is to provide an organization through which boards of nursing act and counsel together on matters of common interest and concern affecting the public health, safety, and welfare, including the development of licensing examinations in nursing. The council's major functions include developing the NCLEX–RN® and NCLEX–PN® examinations, performing policy analysis, and promoting uniformity in relationship to the regulation of nursing practice, disseminating data related to the licensure of nurses, conducting research pertinent to the NCSBN's purpose, and serving as a forum for information exchange for members.
National Conference of Gerontological Nurse Practitioners (NCGNP)	http://www.ncgnp.org/	1/12/2004	The goals of the NCGNP are to: <ul style="list-style-type: none"> • Advocate quality care for older adults • Promote the professional development of advanced practice nursing • Provide continuing gerontological education for advanced practice nurses • Promote communication and professional collaboration among healthcare providers • Support research related to the care of older adults
National League for Nursing (NLN)	http://www.nln.org/	1/12/2004	The mission of the NLN is to advance quality nursing education that prepares the nursing workforce to meet the needs of diverse populations in an ever-changing healthcare environment.
National Student Nurses Association (NSNA)	http://www.nсна.org/	1/12/2004	The NSNA mission is to organize, represent, and mentor students preparing for initial licensure as registered nurses, as well as those enrolled in baccalaureate completion programs; convey the standards and ethics of the nursing profession; promote development of the skills that students will need as responsible and accountable members of the nursing profession; advocate for high quality health care; and advocate for and contribute to advances in nursing education.
National Organization for Associate Degree Nursing (N–OADN)	http://www.noadn.org	1/12/2004	The N–OADN is the leading advocate for associate degree nursing education and practice and promotes collaboration in charting the future of healthcare education and delivery.
Nurses Organization of Veterans Affairs (NOVA)	http://www.vanurse.org	1/12/2004	The objectives of the NOVA are to: <ul style="list-style-type: none"> • Provide for quality nursing care to the veteran patient • Facilitate open communication among all VA nurses and those persons or organizations impacting on the VA healthcare system • Influence the recruitment and retention of professional nurses • Provide learning opportunities for NOVA

			<p>members</p> <ul style="list-style-type: none"> • Foster a high level of professional nursing practice • Foster research and academic excellence in VA nursing service
Philippine Nurses Association of American (PNAA)	http://www.pnaa03.org/	3/29/2004	The purpose of the PNAA is to provide an organization that will uphold the professional image and foster the welfare of Filipino nurses in the United States.
Society of Pediatric Nurses (SPN)	http://www.pedsnurses.org/	1/12/2004	The mission of the SPN is to promote excellence in nursing care of children and their families through support of its members' clinical practice, education, research, and advocacy.
Transcultural Nursing Society (TCNS)	http://www.tcns.org/	4/12/2004	The mission of the global TCNS is to ensure that professionals prepared in transcultural nursing will meet the culture care needs of the people in the world.

APPENDIX F. CULTURAL COMPETENCE IN NURSING: MODELS, THEORIES, FRAMEWORKS, AND TOOLS

Transcultural Concepts in Nursing Care (Andrews and Boyle, 2003)

Andrews and Boyle provide a synthesis of transcultural theories, models, and research in a textbook titled *Transcultural Concepts in Nursing Care*. Rather than focusing on a specific cultural group, the authors assert that a comprehensive cultural assessment is the foundation of culturally competent nursing care. Andrews and Boyle developed a Transcultural Nursing Assessment Guide to gather relevant data. Selected questions are shown in Figure 30; the entire tool can be found in an Appendix of the textbook. The authors provide a framework to discuss transcultural concepts across the life span—with childbearing women and families, adolescents, middle-aged adults, and the elderly. The application of cultural concepts in nursing practice is illustrated in selected clinical topics and issues. The book includes case studies based on actual clinical experiences as well as evidence-based practice research as they apply to the topic.

Figure 30. Selected Questions from the Transcultural Nursing Assessment Guide

Section	Question
Biocultural Variations and Cultural Aspects of the Incidence of Disease	<ul style="list-style-type: none"> • Does the client have distinctive features characteristic of a particular ethnic or cultural group? • How do anatomic, racial, and ethnic variations affect the physical examination?
Communication	<ul style="list-style-type: none"> • What language does the client speak at home? • What is the fluency level of the client in English? • Does the client need an interpreter? • What are the styles of nonverbal communication?
Cultural Affiliations	<ul style="list-style-type: none"> • With what cultural group(s) does the client report affiliation? • Where was the client born? • Where has the client lived?
Cultural Sanctions and Restrictions	<ul style="list-style-type: none"> • How is modesty expressed by men and women? • Does the client have any restrictions on sexuality, exposure of various body parts, certain types of surgery?
Developmental Considerations	<ul style="list-style-type: none"> • Are there any distinct growth and developmental characteristics that vary with the client's cultural background? • What are the beliefs and practices associated with developmental life events such as pregnancy, birth, and death?
Educational Background	<ul style="list-style-type: none"> • What is the client's highest educational level attained? • Can the client read and write English?
Health-Related Beliefs and Practices	<ul style="list-style-type: none"> • How does the client describe his or her health condition? • Does the client rely on cultural healers?
Kinship and Social Networks	<ul style="list-style-type: none"> • Who comprises the client's social network? • How does the client's family participate in the promotion of health?
Nutrition	<ul style="list-style-type: none"> • How are foods prepared at home? • Who shops for and chooses food? • Do religious beliefs and practices influence the client's diet?
Religious Affiliation	<ul style="list-style-type: none"> • What is the role of religious beliefs and practices during health and illness? • Are there healing rituals or practices that the client believes can promote health or hasten recovery from illness?
Values Orientation	<ul style="list-style-type: none"> • What are the client's attitudes, values, and beliefs about his/her health or illness status? • How does the client view work, leisure, education?

Source: Andrews MA, Boyle JS. *Transcultural Concepts in Nursing Care*. 4th ed. Philadelphia, PA: Lippincott Williams & Wilkins; 2003.

Attributes of Cultural Competence (Burchum, 2002)

Using Rodgers' method of conceptual analysis, Burchum identified the attributes of cultural competence shown in Figure 31. Burchum's model depicts cultural competence as a nonlinear and continuous dynamic process. Cultural competence builds on increases in knowledge and skill development related to the attributes of cultural awareness, knowledge, understanding, sensitivity, interaction, and skill.

Figure 31. Attributes and Dimensions of Cultural Competence

Attributes	Dimensions
Cultural awareness	<ul style="list-style-type: none"> • Explore one’s own culture • Become aware of one’s ethnocentric views, biases, and prejudices • Recognize the existence of similarities and differences between and among cultures
Cultural knowledge	<ul style="list-style-type: none"> • Acquire knowledge of cultures other than one’s own • Acquire recognition of differences in communication styles and etiquette between and among cultures • Acquire familiarity with conceptual and theoretical frameworks
Cultural understanding	<ul style="list-style-type: none"> • Understand that “Western medicine” does not have all the answers • Understand that culture shapes one’s beliefs, values, and behavior • Understand that there are racial, ethnic, and cultural variations, thus avoiding stereotyping • Understand the concerns and issues that occur when one’s values, beliefs, and practices differ from those of the dominant culture • Understand how marginalization influences patterns of seeking care
Cultural sensitivity	<ul style="list-style-type: none"> • Appreciate and respect individual client’s beliefs and values • Appreciate and value diversity • Appreciate and genuinely care about those of other cultures • Appreciate how one’s own cultural background may influence professional practice
Cultural interaction	<ul style="list-style-type: none"> • Interact with those of other cultures • Engage in practice with those of other cultures
Cultural skill	<ul style="list-style-type: none"> • Perform cultural assessments that consider beliefs and values, family roles, health practices, and the meanings of health and illness • Perform physical assessments that incorporate knowledge of racial variations • Communicate, either personally or through the appropriate use of interpreters and other resources, in a manner that is understood and that effectively responds to those who speak other languages • Employ nonverbal communication techniques that take into consideration the client’s use of eye contact, facial expressions, body language, touch, and space • Provide care that incorporates development of a respectful and therapeutic alliance with the client • Provide care that overcomes biases and is modified to respect and accommodate the values, beliefs, and practices of the client without compromising one’s own values • Provide care that is beneficial, safe, and satisfying to the client • Provide care that elicits a feeling by the client of being welcome, understood, important, and comfortable • Provide care that addresses disadvantages arising from the client’s position in relation to networks • Provide care that includes self-empowerment strategies

Cultural proficiency	<ul style="list-style-type: none"> • Add new knowledge through conducting research by developing new culturally sensitive therapeutic approaches, and by delivering this information to others • Evidence a commitment to change
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Source: Burchum JL. Cultural competence: an evolutionary perspective. *Nurs Forum* 2002;37:5–15.

Model for Cultural Competence (Campinha-Bacote, 1999)

This model views cultural awareness, cultural knowledge, cultural skills, cultural encounters, and cultural desire as constructs of cultural competence. These five constructs have an interdependent relationship with each other; all five constructs must be addressed or experienced. The intersection of these constructs illustrates the true process of cultural competence. The constructs are defined in Figure 32.

Figure 32. Constructs of Campinha-Bacote’s A Culturally Competent Model of Care

Component	Description
Cultural awareness	Deliberate, cognitive process in which healthcare providers become appreciative and sensitive to the values, beliefs, lifeways, practices, and problem-solving strategies of clients’ cultures
Cultural knowledge	Process of seeking and obtaining a sound educational foundation about culturally diverse groups, including the area of worldviews and the field of biocultural ecology
Cultural skill	Ability to collect relevant cultural data regarding the clients’ health histories and presenting problems as well as accurately performing a culturally specific physical assessment
Cultural encounters	Process that encourages healthcare providers to engage directly in cross-cultural interactions with clients from culturally diverse backgrounds
Cultural desire	Motivation of healthcare providers to “want to” engage in the process of cultural competence

Source: Adapted from Campinha-Bacote J. A model and instrument for addressing cultural competence in health care. *J Nurs Educ* 1999;38:203–7.

The mnemonic “ASKED” represents questions for the individual. In providing culturally appropriate services, nurses may consider the following question, “In caring for this cultural group, have I ASKED myself the right questions?” (Campinha-Bacote, 2003b):

- **Awareness:** Am I aware of my personal biases and prejudices towards cultural groups different from mine?
- **Skill:** Do I have the skill to conduct a cultural assessment and perform a culturally-based physical assessment in a sensitive manner?
- **Knowledge:** Do I have knowledge of the patient’s worldview and the field of biocultural ecology?
- **Encounters:** How many face-to-face encounters have I had with patients from diverse cultural backgrounds?
- **Desire:** What is my genuine desire to “want to be” culturally competent?

Cultural Negotiation—A Constructivist-Based Model (Engebretson and Littleton, 2001)

This model identifies the nursing process as an interaction between the nurse and the client’s family, which

occurs within the culture of the healthcare system. The major constructs of the model are defined in Figure 33.

Figure 33. Constructs of the Engebretson and Littleton Model

Construct	Definition
Nursing process	Fundamental systematic and logical problemsolving approach that directs nursing care; involves the nurse and client/family
Nurse	Professional engaged in nursing process with the goal of facilitating the client/family through the health/illness process; the nurse is product of his or her cultural heritage, personal and professional experience, formal and informal knowledge, and personal knowing
Client/family	Recipient of nursing care (person or family) who interacts with the nurse through the nursing process; the client/family is a product of his or her cultural heritage, personal and professional experience, formal and informal knowledge, and personal knowing
Healthcare system	Professional delivery of healthcare services in which the nurse, client/family, and other healthcare professionals interact
Ecological context	Physical and social worlds, including time and place, in which the healthcare system exists

Source: Engebretson J, Littleton LY. Cultural negotiation: a constructivist-based model for nursing practice. *Nurs Outlook* 2001;49:223–30.

CONFHER Framework (Fong, 1985)

Fong (1985) provides the mnemonic CONFHER as a framework for assessing a client’s cultural background.

- **C**ommunication style: client’s language and nonverbal social customs
- **O**rientation: client’s cultural identity
- **N**utrition: food preferences, specifically when sick
- **F**amily relationships: how client defines family and how family makes decisions
- **H**ealth beliefs: traditional care, descriptions of illness, feelings about care
- **E**ducation: client’s learning preference
- **R**eligion: client’s religious or spiritual preferences

Giger and Davidhizar Transcultural Assessment Model and Theory (Giger and Davidhizar, 2003)

The Giger and Davidhizar Transcultural Assessment Model provides a structure and theoretical basis for culturally competent care. Nurses must vary their approach to each client, taking into account each individual’s unique cultural identity. A nursing assessment evaluates six cultural phenomena or dimensions. Figure 34 shows the six dimensions: communication, space, social organization, time, environmental control, and biological variation.

Figure 34. Six Phenomena of the Giger and Davidhizar Transcultural Assessment Model

Phenomena	Description
Communication	<ul style="list-style-type: none"> • Language spoken • Voice quality • Pronunciation • Use of silence • Use of nonverbal
Space	<ul style="list-style-type: none"> • Degree of comfort observed (conversation) • Proximity to others • Body movement • Perception of space
Social Organization	<ul style="list-style-type: none"> • Culture • Race • Ethnicity • Family role function • Work • Leisure • Church • Friends
Time	<ul style="list-style-type: none"> • Use of • Measure • Definition • Social Time • Work Time • Time orientation (future, present, or past)
Environmental Control	<ul style="list-style-type: none"> • Cultural health practices • Values • Definition of health and illness
Biological Variation	<ul style="list-style-type: none"> • Body structure • Skin color • Hair color • Other physical dimensions • Enzymatic and genetic factors • Susceptibility to illness and disease • Psychological characteristics, coping, and social support

Source: Giger JN. Davidhizar R. *Transcultural Nursing: Assessment & Intervention*. 4th ed. St. Louis, MO. Mosby, Inc; 2003.

Leininger’s Theory of Culture Care Diversity and Universality (Leininger, 1997)

The central purpose of the theory was to discover, document, interpret, and explain the predicted and multiple factors influencing and explaining care from a cultural holistic perspective. The goal of the theory was to provide culturally congruent care that would contribute to the health or well-being of people. The Sunrise Model was developed as a conceptual guide related to the theoretical tenets of the Theory of Culture Care. Selected definitions of the theory are shown in Figure 35.

Figure 35. Selected Definitions of Leininger’s Theory of Culture Care Diversity and Universality

Construct	Definition
Culturally congruent care	Refers to those actions and decisions related to CCP/M, CCA/N, and CCR/R which are specifically tailored to meet client needs to improve or maintain health or to face death and disabilities
Cultural care preservation/ maintenance (CCP/M)	Refers to actions and decisions that help people of a particular culture retain and/or preserve relevant care values so that they can maintain their well-being, recover from illness, or face handicaps and/or death
Cultural care accommodation/ negotiation (CCA/N)	Refers to actions and decisions that help people of a designated culture adapt to or negotiate with others for a beneficial or satisfying health outcome with professional care providers
Cultural care repatterning/ restructuring (CCR/R)	Refers to actions and decisions that help a client reorder, change, or greatly modify his or her lifeways for new, different, and beneficial healthcare patterns while respecting the client’s cultural values and beliefs and still providing beneficial or healthier lifeways than before the changes were coestablished with the client
Cultural and social structure dimensions	Refers to the dynamic, holistic, and interrelated patterns or features of culture related to religion or spirituality, kinship (social), political (and legal), economic, education, technology, cultural values, language, and ethnohistorical factors of different cultures
Environmental context	The totality of an event, situation, or related life experiences that gives meaning and order to guide human expressions and decisions within a particular environmental setting, situation, or geographical area
Care	The abstract and manifest phenomena or expressions related to assistive, supportive, enabling, and facilitating ways to help others with evident or anticipated needs to improve health, a human condition, a lifeway, or to face death

Source: Leininger M. Overview of the theory of culture care with the ethnonursing research method. *J Transcult Nurs* 1997;8:32–52.

ACCESS Model (Narayanasamy, 2002)

The ACCESS Model was developed to offer a framework for nurses to deliver transcultural nursing care. ACCESS is an acronym of the components of the model: assessment, communication, cultural negotiation and compromise, establishing respect and rapport, sensitivity, and safety. Figure 36 describes the components of the model.

Figure 36. Components of the ACCESS Model

Component	Description
Assessment	Focus on cultural aspects of clients' lifestyle, health beliefs, and health practices
Communication	Be aware of variations in verbal and nonverbal responses
Cultural negotiation and compromise	Become more aware of aspects of other people's culture as well as understanding clients' views and explaining their problems
Establishing respect and rapport	Nursing relation portrays genuine respect for clients' cultural beliefs and values
Sensitivity	Deliver diverse culturally sensitive care to culturally diverse groups
Safety	Enable clients to derive a sense of cultural safety

Source: Narayanasamy A. The ACCESS model: a transcultural nursing practice framework. *Br J Nurs* 2002;11:643–50.

Purnell Model for Cultural Competence (Purnell, 2002)

Nurses, physicians, and physical and occupational therapists in a variety of countries and languages have used the Purnell Model for Cultural Competence, developed in 1998. The schematic model is a circle with an outlying rim representing global society, a second rim representing community, a third rim representing family, and an inner circle representing the person. The 12 domains move from more general phenomena to more specific phenomena. Figure 37 provides a brief description of the 12 domains.

Figure 37. Domains from the Purnell Model for Cultural Competence

Domain	Description
Overview/heritage	Concepts related to the country of origin, current residence, the effects of topography of the country of origin and the current residence, reasons for emigration, educational status, and occupations
Communication	Concepts related to the dominant language and dialects; contextual use of the language; paralanguage variations such as voice volume, tone, and intonation; and the willingness to share thoughts and feelings Concepts related to nonverbal communications such as eye contact and body language; temporality in terms of past, present, and future orientation; clock versus social time; and the use of names
Family roles and organization	Concepts related to the head of household and gender roles, family roles and developmental tasks of children and adolescents, child-rearing practices, and roles of the age and extended family members
Workforce issues	Concepts related to autonomy, acculturation, assimilation, gender roles, ethnic communication styles, individualism, and healthcare practices from the country of origin
Biocultural ecology	Variations in ethnic and racial origins such as skin coloration and physical differences in body

	stature; genetic, hereditary, endemic, and topographical diseases; and differences in how the body metabolizes drugs
High-risk behaviors	Use of tobacco, alcohol, and recreational drugs; lack of physical activity; nonuse of safety measures such as seatbelts and helmets; and high-risk sexual practices
Nutrition	Having adequate food; the meaning of food; food choices, rituals, and taboos; and how food and food substances are used during illness and for health promotion and wellness
Pregnancy and childbirth practices	Fertility practices; methods for birth control; views toward pregnancy; and prescriptive, restrictive, and taboo practices related to pregnancy, birthing, and postpartum treatment
Death rituals	How the individual and the culture view death, rituals and behaviors to prepare for death, burial practices, and bereavement behaviors
Spirituality	Religious practices and the use of prayer, behaviors that give meaning to life, and individual sources of strength
Healthcare practice	Focus of health care such as acute or preventive; traditional, magicoreligious, and biomedical beliefs; individual responsibility for health; self-medicating practices; and views toward mental illness chronicity and organ donation and transplantation
Healthcare practitioner	Status, use, and perceptions of traditional, magicoreligious, and allopathic biomedical healthcare providers

Source: Adapted from Purnell, L. The Purnell Model for Cultural Competence. *J Transcult Nurs* 2002;13:193–6.

Cultural Diversity in Health and Illness (Spector, 2003)

Spector’s book *Cultural Diversity in Health and Illness* seeks to increase the reader’s awareness of the dimensions and complexities involved in delivering nursing and health care to people from diverse cultural backgrounds. Spector argues that the provider of health care has been socialized into a distinct “provider culture” that may conflict with patients who have differing cultural beliefs. The book incorporates three main theories: Estes and Zitzow’s Heritage Consistency Theory, the HEALTH Traditions Model, and Giger and Davidhizar’s cultural phenomena affecting health (described above). Heritage consistency originally described the extent to which a person’s lifestyle reflected his or her tribal culture, but has been expanded to study a person’s traditional culture, such as European, Asian, African, or Hispanic. The values indicating heritage consistency exist on a continuum. The HEALTH Traditions Model uses the concept of holistic health and explores what people do to maintain, protect, or restore health. Figure 38 shows nine interrelated phenomena of physical, mental, and spiritual health with personal methods of maintaining, protecting, and restoring health. Spector also provides a Heritage Assessment Tool consisting of 29 questions.

Figure 38. The Interrelationship of Physical, Mental, and Spiritual Health and Methods To Maintain, Protect, or Restore Health

Health Status	Physical	Mental	Spiritual
Maintain Health	Traditional clothing, diet, and activities	Social and family supports; hobbies	Religious practices; prayer or meditation
Protect Health	Special diets and food taboos; symbolic clothing	Family and community activities	Superstitions; amulets and talisman
Restore Health	Homeopathic remedies	Relaxation; exorcism	Religious rituals; changing names

Source: Spector RE. *Cultural Diversity in Health and Illness*. 6th ed. Upper Saddle River, NJ: Prentice Hall Health; 2003.

Interlocking Paradigm of Cultural Competence (Warren, 1999)

The Interlocking Paradigm of Cultural Competence (IPCC) is a model of how psychiatric nurses can theoretically and philosophically understand, develop, and proficiently use culturally competent strategies and assessment techniques. The five factors in the paradigm are the nurse-patient interaction, theory, philosophy, process, and assessment. All factors in the IPCC are drawn using an interrelated, overlapping style, which means that the paradigm reflects the interdependence and continually evolving nature of the culturally competent process. Figure 39 describes the five factors of the IPCC.

Figure 39. Factors in the Interlocking Paradigm of Cultural Competence

Factor	Basis	Description
Nurse-patient interaction	Peplau (1952, 1988)	<ul style="list-style-type: none"> • Center of paradigm • Interaction may involve an individual, group, or community • Nurse understands and interprets both the nurse's and patient's behaviors
Theory	Leininger's Theory of Culture Care Diversity and Universality (1995)	<ul style="list-style-type: none"> • Grounding for how professional nurses should conduct themselves in their education, practice, and research settings • Nurses use empathetic care and caring to provide psychological and physical assistance to patients • Nurses use techniques of cultural preservation, negotiation, and repatterning to maintain, restore, or improve the patient's health
Philosophy	Nichols' World View Model (1987)	<ul style="list-style-type: none"> • Provides psychiatric nurses with an understanding of how persons from different cultures have developed their knowledge, values, and belief systems (i.e., worldview) • Four components that comprise a worldview are cultural axiology, epistemology, logic, and process • Four areas of predominant worldviews are (1) European American, (2) African, African-American, Hispanic, and Arabic, (3) Asian, Asian American, and Polynesian, and (4) Native American
Process	Campinha-Bacote's Culturally Competent Model (1994)	<ul style="list-style-type: none"> • Provides specific guidelines for developing basic cultural competence • Four components of cultural competence: (1) cultural awareness, (2) cultural knowledge, (3) cultural skill, and (4) cultural encounter
Assessment	Purnell's 12-Domain Model for Cultural Competence (1998)	<ul style="list-style-type: none"> • Provides a systematic psychological, physiological, and cultural guideline for the assessment of patients • Expands upon Leininger's, Nichols', and Campinha-Bacote's models • Elicits cultural information based on the following domains:

		(1) overview and heritage, (2) communication, (3) family roles and organization, (4) workforce issues, (5) biocultural ecology, (6) high-risk behaviors, (7) nutrition, (8) pregnancy and child-bearing practices, (9) death rituals, (10) spirituality, (11) healthcare practices, and (12) healthcare practitioners
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Source: Adapted from Warren BJ. Cultural competence in psychiatric nursing: an interlocking paradigm approach. In: Keltner NL, Schwecke LH, Bostrom CE eds. *Psychiatric Nursing*. St. Louis, MO: Mosby, Inc.; 1999. pp. 199–218.

Multidisciplinary Models of Cultural Competence

LEARN Model (Berlin and Fowkes, 1982)

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

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

Developmental Continuum (Cross et al., 1989)

Cross and colleagues' Developmental Continuum ranges from "cultural destructiveness" to "cultural proficiency." The six possible points on the continuum are described in Figure 40.

Figure 40. Six Points on the Developmental Continuum

Point	Description
Cultural destructiveness	"A system which adheres to this extreme assumes that one race is superior and should eradicate 'lesser' cultures because of their perceived subhuman position"
Cultural incapacity	Lack of capacity to help diverse clients or communities; practices may include discriminatory hiring practices or lower expectations of minority clients
Cultural blindness	Provision of services with the express philosophy of being unbiased, functioning with the belief that all people are equal and the same
Cultural precompetence	Recognition of weakness in serving diverse cultural groups and attempts to improve services to a specific population

Cultural competence	“Characterized by the acceptance and respect for differences, continuing self-assessment regarding culture, careful attention to the dynamics of difference, continuous expansion of cultural knowledge and resources, and a variety of adaptations to service models in order to better meet the needs of minority populations”
Cultural proficiency	The most advanced point on the continuum is characterized by holding culture in high esteem, always seeking to increase knowledge of culturally competent practice

Source: 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 Technical Assistance Center for Children’s Mental Health, Georgetown University Child Development Center; 1989.

ETHNIC Framework (Levine et al., 2000)

Levine and colleagues (2000) suggest the mnemonic tool ETHNIC for assessing a client’s cultural beliefs:

- **E**xplanation: client’s explanation of the problem
- **T**reatment: treatments clients have used already for the problem
- **H**ealers: from whom client has sought advise, including family, friends, or folk healers
- **N**egotiate: finding an option agreeable to both provider and client
- **I**ntervention: determined by healthcare provider; may include alternative treatments
- **C**ollaboration: collaborate with client, family members, other healthcare team members, healers, and community resources

Five Stages of Cultural Competency (Salimbene, 1999)

Salimbene describes cultural competency in nursing care as a matter of evolving one’s thoughts, attitudes, and actions through five stages:

1. Ethnocentricity
2. Awareness and sensitivity to cultural and language difference
3. Ability to refrain from forming stereotypes and judgments that are based on one’s own cultural framework
4. Acquisition of knowledge about the cultures of the patients whom nurses serve
5. Acquisition of skills and strategies to identify cultural difference and to know how to deal with them in a way that both meets the patient’s needs and expectations and satisfies the nurse’s standards of quality care

BATHE Framework (Stuart and Lieberman, 1993)

Stuart and Lieberman (1993) provide the mnemonic BATHE for eliciting the psychosocial context of the client’s presenting problem:

- **B**ackground: A simple question. “What is going on in your life?” elicits the context of the patient’s visit.
- **A**ffect (the feeling state): Asking “How do you feel about what is going on?” or “What is your mood?” allows the patient to report and label the current feeling state.
- **T**rouble: “What about the situation troubles you the most?” helps the physician and patient focus,

and may bring out the symbolic significance of the illness or event.

- **Handling:** “How are you handling that?” gives an assessment of functioning and provides direction for an intervention.
- **Empathy:** “That must be very difficult for you” legitimizes the patient’s feelings and provides psychological support.

APPENDIX G. RESOURCES ON SPECIFIC CULTURAL GROUPS

Citation	Purpose	Methods	Main Points
(Beachy et al., 1997)	To provide a basic understanding of Amish culture and traditions to help nurses provide culturally sensitive care	Literature review	<ul style="list-style-type: none"> • Amish culture assessed with nursing implications of the application of the Giger and Davidhizar Transcultural Assessment Model • Communication: Build trust by treating people as individuals • Space: Generally maintain 2 to 3 feet of distance • Social organization: Must develop trust to be effective health educators; be aware of education level • Time: Hard work is expected and learned at an early age so Amish patients may not feel comfortable resting • Environmental control: Amish want to know options to make informed healthcare decisions • Biological variations: Assess psychiatric status, especially depression
(Covington, 2001)	To increase knowledge about effects of culture on nurse-patient and nurse-family relationships and on health outcomes; to discuss assessment of culturally diverse patients; to identify research related to cultural diversity and incorporate that research into practice	Literature review and opinion	<ul style="list-style-type: none"> • Change from client-nurse model to client-nurse-family model • Although case studies that have turned "bad" provide evidence for the need for culturally competent care, continued research is needed to support the impact of cultural competency on patient outcomes • Assessing diverse patients: communication, beliefs, space, social and family structure, time • Provides major findings from articles on diverse populations • Provides strategies for practice
(Geissler, 1998)	To provide basic information about peoples of the countries of the world	English language literature review	<ul style="list-style-type: none"> • Provides information about the main ethnic groups from 200 countries • Information includes: location's major languages, ethnic groups, and religions; predominant sick care practices; endemic diseases; health team relationships;

			dominance patterns; birth and death rites; food practices; infant feeding practices; childrearing practices; and national childhood immunizations
(Leininger, 1994b)	To document the dominant cultural lifeways, patterns, values, and norms for nurses in the United States	Observation and interview	<ul style="list-style-type: none"> • Why learn about the culture of nursing? • Assist newcomers • Historical guide to reflect on past and current changes • Essential to understand own culture to provide sensitive and understanding care • Appreciate the differences and similarities of nursing culture regionally, nationally, and worldwide • Tribes of nursing: Friendly (South); Novel (West—CA); Historic (New England); and Blue Collar (Midwest or urban centers)
(Purnell, 1999a)	To describe the Appalachian population to help nurses provide culturally competent care	Literature review and opinion	<ul style="list-style-type: none"> • Appalachian Whites are three times more likely to be in a lower socioeconomic status than non-Appalachian Whites • Traditional Appalachians practice the ethic of neutrality, which has four themes: avoid aggressions and assertiveness, do not interfere in others' lives, avoid dominance over others, and avoid arguments and disagreements • 82 percent of Appalachian men do not believe women should work outside the home • Health education should begin with the family, especially the grandmothers • Predominant occupations place Appalachians at risk for respiratory diseases • Clients often delay seeking treatment • Strong belief in folk medicine Information generalized to the group may not be true for the individual
(Purnell, 1999b)	To describe Panamanian practices for health promotion and wellness, disease and illness prevention, and the meaning of respect afforded by	Survey of 70 Panamanians	<ul style="list-style-type: none"> • Roles are divided according to gender • A high rate of Catholicism exists • No real balance of hot/cold,

	healthcare providers		<ul style="list-style-type: none"> wet/dry for maintaining health Few poor health behaviors reported Proper respect is needed from healthcare providers
(Purnell, 2001)	To describe Guatemalan practices for health promotion and wellness, disease and illness prevention, and the meaning of respect afforded by healthcare providers	Survey of 25 Guatemalans	<ul style="list-style-type: none"> Roles amongst Hispanics are typically divided by gender Guatemalans believe in a balance of hot/cold and wet/dry, which is something healthcare providers need to understand Few participants used folk practitioners Communication about procedures, asking permission before touching a patient, and engaging the client in conversation are ways to show respect as a provider in Guatemalan culture
(Spinks et al., 2000)	To provide an overview of providing healthcare for lesbian clients	Literature review and opinion	<ul style="list-style-type: none"> Barriers to health care are faced at both the macro and micro levels Health providers should gather histories in a nonheterosexual centered way STIs and other health promotion issues should still be considered in the lesbian population Rapport and trust between provider and patient need to be developed The Feminist Women's Health Center serves as a model for providing culturally competent care for lesbians
(Stebnicki and Coeling, 1999)	To describe the deaf culture	Literature review and opinion	<ul style="list-style-type: none"> Ways for nurses to have cultural competence for deaf communities: facilitating deaf communities, valuing deaf pride and using American Sign Language, spending time with patients, and helping to obtain technical devices
(Warren, 2001)	To educate case managers about providing services to African Americans	Literature review and opinion	<ul style="list-style-type: none"> African Americans may need less medication than their White counterparts African Americans are at greater risk for cardiovascular disease Asking clients how they identify themselves is the best way to interact African Americans also have

			<p>issues with trusting medical care providers</p> <ul style="list-style-type: none"> • Respect is another important quality to this group • Relational worldview is also important • Patients find spirituality to be important to their case management
(Yeo et al., 2000)	To examine expatriate Japanese couples' perceptions and experiences of prenatal care and childbirth	Indepth interviews with 11 Japanese couples	<ul style="list-style-type: none"> • Language barriers affected all aspects of care • Japanese physicians and couples believe that fetal ultrasound permits surveillance for normal fetal development • Participants reported that taking a prenatal vitamin made them feel uncomfortable as vitamins are seen as a shortcut to "real food" • Epidural anesthesia is not routinely offered in the practice of obstetrics in Japan • Japanese couples felt that American doctors and nurses were highly professional and more democratic, open, and jovial than their Japanese counterparts
(Zoucha and Zamarripa, 1997)	To describe a nursing theory that supports the significance of culture as an essential concept of nursing practice	Literature review and case study of Mexican American client with an ostomy	<ul style="list-style-type: none"> • Describes Leininger's Sunrise Model • Describes concepts Leinginger and others have identified for Mexican Americans: individual attention (small talk), family support, respect (deference to elders), and filial love (love and confidence) • Case study presented
(Zoucha, 1998)	To explore the care experiences, views, patterns, and meanings of Mexican Americans who have received professional nursing care	Ethnonursing research method; interviewed 15 Mexican American key informants and 25 family/friends, nurses, and other healthcare professional informants	<ul style="list-style-type: none"> • Mexican Americans expected and valued care expressions and practices from registered nurses who were professional, friendly, and respectful; took time with them; and communicated in Spanish • Mexican Americans viewed nurses as noncaring if they did not combine Mexican American generic care values with professional nursing practice and did not communicate in Spanish • Confidence was expressed by informants as desirable in the care of Mexican Americans

			(care provided with love and confidence); nurses must earn confidence of client
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APPENDIX H. WHITE PRIVILEGE

Peggy McIntosh describes the daily effects of White privilege in her life. She chose those conditions that attach more to skin color than to class, religion, ethnic status, or geographical location, but asserts that these factors are intertwined.

1. I can if I wish arrange to be in the company of people of my race most of the time.
2. If I should need to move, I can be pretty sure of renting or purchasing housing in an area that I can afford and in which I would want to live.
3. I can be pretty sure that my neighbors in such a location will be neutral or pleasant to me.
4. I can go shopping alone most of the time, pretty well assured that I will not be followed or harassed.
5. I can turn on the television or open the front page of the paper and see people of my race widely represented.
6. When I am told about our national heritage or about "civilization," I am shown that people of my color made it what it is.
7. I can be sure that my children will be given curricular materials that testify to the existence of their race.
8. If I want to, I can be pretty sure of finding a publisher for this piece on White privilege.
9. I can go into a music shop and count on finding the music of my race represented, into a supermarket and find the staple foods that fit with my cultural traditions, into a hairdresser's shop and find someone who can cut my hair.
10. Whether I use checks, credit cards, or cash, I can count on my skin color not to work against the appearance of financial reliability.
11. I can arrange to protect my children most of the time from people who might not like them.
12. I can swear, or dress in secondhand clothes, or not answer letters, without having people attribute these choices to the bad morals, the poverty, or the illiteracy of my race.
13. I can speak in public to a powerful male group without putting my race on trial.
14. I can do well in a challenging situation without being called a credit to my race.
15. I am never asked to speak for all the people of my racial group.
16. I can remain oblivious of the language and customs of persons of color who constitute the world's majority without feeling in my culture any penalty for such oblivion.
17. I can criticize our Government and talk about how much I fear its policies and behavior without being seen as a cultural outsider.
18. I can be pretty sure that if I ask to talk to "the person in charge," I will be facing a person of my race.
19. If a traffic cop pulls me over or if the IRS audits my tax return, I can be sure I have not been singled out because of my race.
20. I can easily buy posters, postcards, picture books, greeting cards, dolls, toys, and children's magazines featuring people of my race.
21. I can go home from most meetings of organizations I belong to feeling somewhat tied in, rather than isolated, out-of-place, outnumbered, unheard, held at a distance, or feared.
22. I can take a job with an affirmative action employer without having coworkers on the job suspect that I got it because of race.
23. I can choose public accommodation without fearing that people of my race cannot get in or will be mistreated in the places I have chosen.
24. I can be sure that if I need legal or medical help, my race will not work against me.
25. If my day, week, or year is going badly, I need not ask of each negative episode or situation whether it has racial overtones.
26. I can choose blemish cover or bandages in "flesh color" and have them more or less match my skin.

This essay is excerpted from Working Paper 189, "White Privilege and Male Privilege: A Personal Account of Coming To See Correspondences through Work in Women's Studies" (1988), by Peggy McIntosh; available for \$4.00 from the Wellesley College Center for Research on Women, Wellesley MA 02181. The working paper contains a longer list of privileges.

APPENDIX I. CULTURAL COMPETENCY CURRICULUMS AND TRAINING EXAMPLES

Organization and Citation	Description	Topics Covered	Models	Teaching Methods
University of Washington, Bothell Nursing Program (Abrums and Leppa, 2001)	"Nursing Care and Cultural Variation" course for BSN students focusing on discrimination and oppression in health care	<ul style="list-style-type: none"> • Culture of nursing • American culture (White, middle-class) • Health belief systems and illness/disease distinctions • Social identity and experiences of race, class, gender, sexual orientation, and disability • Nursing care of disenfranchised or forgotten groups (discrimination) 	Theory of "relational positionality"	<ul style="list-style-type: none"> • Discussion • Materials: <i>American Ways</i> (Althen, 1988); "Essay from the Bahamas" (June Jordan, 1998); film "Color of Fear" (Wah, 1994)
University of Wisconsin-Milwaukee College of Nursing (Clinton, 1996)	Three-credit required, beginning-level course for preclinical baccalaureate nursing students	<ul style="list-style-type: none"> • Broad definition of culture and its relevance to health • History and sociology of ethnic groups in the United States: immigration, slavery • Health-promoting functions of U.S. ethnic groups • American social theories of past two centuries • Reflection on personal cultural values and beliefs • Cultural assessment tools • Contrast between folk and modern healthcare systems • Mental health and illness • Effects of prejudice and discrimination on health • Specific ethnic groups: African Americans, Asian Americans and Pacific Islanders, Arab Americans, European Americans, Hispanic Americans, Jewish Americans, and Native Americans 	Tool = Fong's CONFHER	Not discussed; focused mainly on content of course
University of Washington (Chrisman, 2003)	3-hour, 9-week summer course titled "Culture, Diversity, and Nursing Practice"	<ul style="list-style-type: none"> • Basic concepts in cultural competence • Health-seeking process • Health and illness beliefs • Healing and healthcare delivery • Chronic illness 	Drawn from Chrisman's, Leininger's, and Campinha-Bacote's models and theories	<ul style="list-style-type: none"> • Lectures • Guest speakers • Readings • Discussions
University of Washington (Chrisman, 2003)	3-hour, 10-week semester course titled "Clinical Applied Anthropology"	<ul style="list-style-type: none"> • Medical anthropology • Folk and lay healthcare practices • Culture-bound syndromes • Chronic illness • Folk healers, Western practitioners, and dual use • Stress • Public and international health 	Drawn from Chrisman's, Leininger's, and Campinha-Bacote's models and theories	<ul style="list-style-type: none"> • Lecture • Guest speakers • Readings • Discussion
Malmo University, Sweden	Incorporation of Leininger's theory and	<ul style="list-style-type: none"> • Awareness of culture for oneself and patient 	Leininger's Theory of Culture Care Diversity	<ul style="list-style-type: none"> • Nursing care journal • Interaction in community

(Gebru and Willman, 2003)	Sunrise Model into all 3 years of nursing education; specific goals developed for each year	<ul style="list-style-type: none"> Ethnonursing research method Applying transcultural knowledge at group level Transcultural knowledge of specific cultural groups: Thai, geriatric, and home care 	and Universality	and clinical settings
City University of New York (Jeffreys, 2002)	3-credit, 15-week graduate seminar core course focusing on philosophy, ethics, concepts, skills, theory, research, and practices underlying transcultural care; current issues explored in relation to clinical nurse specialist competencies	<ul style="list-style-type: none"> Ethnonursing research method Racism, discrimination, and cultural bias Cross-cultural heritage Assessment tools Biocultural ecology Physical assessment Transcultural perspectives: family and community, pain and discomfort, spirituality and religion, complementary and alternative medicine, mental health Cultural groups: Czech Americans, African Americans, homosexual and bisexual clients, multiple heritage individuals, Chinese, Hispanic, Korean, different age groups Future directions of TCN 	<p>Leininger's Theory of Culture Care Diversity and Universality</p> <p>Purnell Model for Cultural Competence</p>	<ul style="list-style-type: none"> Lecture Films Large-group discussion Small-group discussion Simulated role play Class Web page
University of Texas at Arlington School of Nursing (Kardong-Edgren, 2003)	"Cultural Variation in Health Care: A Comparative Analysis of Two Cultures": a 3- or 6-credit summer session class for undergraduate and graduate students with a 2-week field study in Mexico	<ul style="list-style-type: none"> Overview of Mexican culture Introduction to field methods of studying another culture Two-week language immersion program in Mexico Student presentations of field study project 	Purnell and Paulanka (1998) <i>Transcultural Health Care</i>	<ul style="list-style-type: none"> Immersion Language classes Discussion Cultural journal
Ball State University School of Nursing, Indiana (Ryan et al., 2002)	A group of 20 faculty members from 7 regional schools established an electronic Web page called Community of Communities (COC); article presents examples of uses of COC with graduate nursing classes: Computers in Nursing, Nursing Theory, Nursing Research, and Nursing Concepts 2 and 3	<ul style="list-style-type: none"> Integrate COC into all distance-learning courses in the RN-BSN and graduate nursing programs COC provides a common database of cultures and phenomena Eleven culturally focused modules based on the Giger and Davidhizar Transcultural Assessment Model 	Giger and Davidhizar Transcultural Assessment Model	<ul style="list-style-type: none"> Internet-based Case study and discussion questions
University of Wisconsin-Eau Claire School of Nursing (Wendler and Struthers, 2002)	A Web-based, asynchronous course in cross-cultural health for undergraduate and graduate students;	<ul style="list-style-type: none"> Impact of culture on health, illness, and wellness Health responses and patterns of African-American, Latino, Hmong, 	Module on conceptual models, but specific models not described	<ul style="list-style-type: none"> Cooperative learning (group project—synthesis document) Student discovery journal Guest listener (a minority

	faculty specified that students must enter the course twice per week, but timing was left to the discretion of the student	and Native American people • Online teaching-learning modules (p. 322)		faculty voice) • Participation in cultural enrichment activities
Cape Fear Valley Health Systems, North Carolina (Amerson, 2001)	One-month competency-based orientation curriculum to promote and validate a minimal level of understanding and performance of nursing duties within the institution, with one outcome being cultural assessment	<ul style="list-style-type: none"> • The impact of ethnicity, religion, and culture on health and illness • Six cultural phenomena from the Giger and Davidhizar Transcultural Assessment Model • Handouts of four major ethnic groups listing cultural values and beliefs common to each group; presented with a caveat about individuality • Analysis of one's own cultural beliefs • Leininger's three modes for culturally congruent care 	Giger and Davidhizar Transcultural Assessment Model Leininger's Theory of Culture Care Diversity and Universality	<ul style="list-style-type: none"> • Lecture • Handouts • Case studies
Upper Valley Medical Centers, Ohio (Campinha-Bacote et al., 1996)	Four 1-hour sessions based on constructs of Campinha-Bacote's model; program was voluntary for nurses employed at the center	<ul style="list-style-type: none"> • Cultural awareness: Pederson's (1988) "Outside Expert Awareness Exercise" • Cultural Knowledge: "Cultural Bingo" • Cultural skill: assessment tools by Leininger, Bloch, Fong, and Giger and Davidhizar • Cultural encounter session not described 	Campinha-Bacote's Culturally Competent Model of Care	<ul style="list-style-type: none"> • Discussion • Games • Video • Music
Robert Wood Johnson University Hospital (Kleber, 2003)	Diversity Committee through Human Resources, the Diversity Resource Center through the Nursing Division, and the community health promotion program work to sponsor educational programs throughout the year	<ul style="list-style-type: none"> • New hire orientation: video; Diversity Committee speaks at orientation • Courses: Spanish for medical personnel, medical sign language, and ESL course for employees (planning phase) • Sponsor an annual diversity day • Nursing Diversity Resource Center allows access to information about patients of different backgrounds • Volunteer interpreter list available for staff • Tours of the community offered • Religion workshops to educate staff on needs of their patients and fellow employees (planning phase) 	None reported	<ul style="list-style-type: none"> • Lecture • Video • Discussion
End of Life Nursing Education Consortium (ELNEC) (Matzo et al., 2002)	Three-day ELNEC "Train the Trainers" program consisting of nine modules; one	<ul style="list-style-type: none"> • Definition and components of culture and cultural competence • Cultural assessment 	None reported	<ul style="list-style-type: none"> • Lecture • Video (p. 276) • Case studies (example presented, p. 276)

	module focuses on cultural considerations in end-of-life care	<ul style="list-style-type: none"> • Cultural considerations of communication • Beliefs regarding death and dying, afterlife, and bereavement • Specific groups: Latino, African-American, Chinese American, Native American 		
Jefferson County, Alabama (Smith, 2001)	Evaluation study Intervention group of currently licensed registered nurses received 8.5 hours of "culture school"	<ul style="list-style-type: none"> • Relationship between person, environment, health, and nursing care • Application of the Giger and Davidhizar Transcultural Assessment Model and Theory 	Giger and Davidhizar Transcultural Assessment Model and Theory	Not reported