

BLUEPRINT FOR TEACHING CULTURAL COMPETENCE IN PHYSICAL THERAPY EDUCATION

Background

Improving the health of the citizens of the United States is important for the individual, the community, and the society at large. Because the United States is a nation of diverse citizenry, it is important that healthcare practitioners have the education and skills essential for effective interactions with diverse populations. It is projected that by the year 2030 children from racial/ethnic minorities will account for more than one half of the Nation's population under the age of eighteen. ¹ Referencing data from the *U.S. Census Bureau, American Fact Finder, American Community Survey 2008*, HealthyPeople.gov website cites the following statistics about the U.S population: In 2008, (a) approximately 33 percent, or more than 100 million persons, identified themselves as belonging to a racial or ethnic minority population; (b) 51 percent, or 154 million, were women; (c) approximately 12 percent, or 36 million people not living in nursing homes or other residential care facilities, had a disability; (d) an estimated 70.5 million persons lived in rural areas (23 percent of the population), while roughly 233.5 million lived in urban areas (77 percent); (e) an estimated 4 percent of the U.S. population aged 18 to 44 years identified themselves as lesbian, gay, bisexual, or transgender.²

Improving the health of Americans is an ongoing initiative through the U.S. Department of Health and Human Services (USDHHS), the Office of Minority Health (OMH), and Agency for Healthcare Research and Quality (AHRQ). Since 1979 with the release of the U.S. Surgeon General's report, *Healthy People: Surgeon General's Report on Health Promotion and Disease Prevention* ³ every 10 years, specific objectives targeted at improving health have been developed and monitored. When the issue of health disparities was formally identified in 1999, the U.S. congress requested the Institute of Medicine (IOM) to study the extent of health disparities affecting racial and ethnic minorities. The IOM in March 2002 issued the report, *"Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care"* and proposed strategies for addressing the growing concern of unequal treatment. ⁴ The link between cultural competence and health disparities was addressed in the report.

The USDHHS has targeted reducing health disparities in *Healthy People 2000*; eliminating health disparities in *Healthy People 2010*; and promoting health equity in *Healthy People 2020*. To reduce, eliminate, and achieve health equity in populations with racial and ethnic and/or social economic diversity has been an overarching goal of the *Healthy People* agenda.⁵

Healthy People 2020 states health equity is the “attainment of the highest level of health for all people. Achieving health equity requires valuing everyone equally with focused and ongoing societal efforts to address avoidable inequalities, historical and contemporary injustices, and the elimination of health and health care disparities.”⁶ Cultural competence is a critical component for achieving health equity. In evaluating the determinants of health⁷ and planning for improved health status for all Americans the practice of cultural competence is a facilitator for achieving optimal outcomes. Healthcare practitioners and healthcare agencies need to provide culturally appropriate interactions. Documents such as the *National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health Care*⁸ and *Setting the Agenda for Research on Cultural Competence in Health Care*⁹ are provided to facilitate health care practitioners’ ability to meet the standards for cultural competence.

Cultural competence is currently embedded in all major APTA documents. The APTA House of Delegates 2013 approved a new vision statement for the profession: “Transforming society by optimizing movement to improve the human experience.” The vision statement is supported by the APTA Guiding Principles to Achieve the Vision document. Professional commitment to cultural competence is addressed in the following statements:¹⁰

- **Consumer-centricity.** Patient/client/consumer values and goals will be central to all efforts in which the physical therapy profession will engage. The physical therapy profession embraces cultural competence as a necessary skill to ensure best practice in providing physical therapist services by responding to individual and cultural considerations, needs, and values.
- **Access/Equity.** The physical therapy profession will recognize health inequities and disparities and work to ameliorate them through innovative models of service delivery, advocacy, attention to the influence of the social determinants of health on the consumer, collaboration with community entities to expand the benefit provided by physical therapy, serving as a point of entry to the health care system, and direct outreach to consumers to educate and increase awareness.

- **Advocacy.** The physical therapy profession will advocate for patients/clients/consumers both as individuals and as a population, in practice, education, and research settings to manage and promote change, adopt best practice standards and approaches, and ensure that systems are built to be consumer-centered.

Cultural competence is a critical core component of professional practice in physical therapy and should be considered as a part of best practice in providing physical therapy care. Achieving cultural competence as a physical therapist or a physical therapist assistant is a process that is cultivated within the individual through acquisition of knowledge, attitudes and behaviors specific to culture, language and communication. In 2008 the APTA formed a task force to develop a cultural competence curriculum that worked with the APTA Committee on Cultural Competence. *The Blueprint for Teaching Cultural Competence in Physical Therapy Education* is the result of the Task Force and was first published in April 2008. In June 2014 an update to the *Blueprint* was completed.

Blueprint for Teaching Cultural Competence in Physical Therapy Education

Part I. Conceptual Framework

In developing the core curriculum on cultural competence, the APTA Task Force and the Committee on Cultural Competence applied a conceptual framework based on the theoretical constructs of Cross, et al. *Towards a Culturally Competent System of Care*¹¹; and Campinha-Bacote *The Process of Cultural Competence in the Delivery of Healthcare Services*¹². Key aspects of the two models as well as other important concepts provide the framework for the proposed cultural competence curriculum.

1. Defining Cultural Competence

Cross Model: “Cultural 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.”¹¹

Campinha-Bacote Model: Cultural competence is “the process in which the healthcare professional continually strives to achieve the ability and availability to effectively work within the cultural context of the client—family, individual, or community.” This model of cultural competence views cultural awareness, cultural knowledge, cultural skill, cultural encounters, and cultural desire as the five constructs of cultural competence. ¹²

2. Cultural Competence as a Developmental Process

Cross and Campinha-Bacote each state that cultural competence is a developmental process ¹¹, ¹². Campinha-Bacote believes, “Cultural competence is the process of becoming, not a state of being.” ¹³ APTA supports the concept that cultural competence is a developmental process and that education to promote cultural competency in Doctors of Physical Therapy and Physical Therapy Assistants should progress along a continuum that enhances knowledge, attitudes, and skills throughout the educational program, across varied teaching and learning experiences.

3. Factors that Contribute to Developing Cultural Competence

Cross states there are five essential elements ¹¹ that contribute to a system’s ability to become more culturally competent. The system should:

- I. Value diversity
- II. Have the capacity for cultural self-assessment
- III. Be conscious of the dynamics inherent when the cultures interact
- IV. Institutionalize cultural knowledge, and
- V. Develop adaptations to service delivery reflecting an understanding of diversity between and within cultures.

4. Continuum of Cultural Competence

Cross states there are six possibilities in the continuum of cultural competence¹¹:

Cultural Destructiveness: The most negative end of the continuum is represented by attitudes, policies and practices which are destructive to cultures and consequently to the individuals within the culture. The most extreme example of this orientation are programs which actively participate in cultural genocide--the purposeful destruction of a culture.

Cultural Incapacity: The next position on the continuum is one at which the system or agencies do not intentionally seek to be culturally destructive but rather lack the capacity to help minority clients or communities. The system remains extremely biased, believes in the racial superiority of the subdominant group and assumes a paternal posture towards "lesser" races. These agencies may disproportionately apply resources, discriminate against people of color on the basis of whether they "know their place" and believe in the supremacy of dominant culture helpers. Such agencies may support segregation as a desirable policy. They may act as agents of oppression by enforcing racist policies and maintaining stereotypes. Such agencies are often characterized by ignorance and an unrealistic fear of people of color. The characteristics of cultural incapacity include: discriminatory hiring practices, subtle messages to people of color that they are not valued or welcome, and generally lower expectations of minority clients.

Cultural Blindness: At the midpoint on the continuum the system and its agencies provide services with the express philosophy of being unbiased. They function with the belief that color or culture make no difference and that we are all the same. Culturally blind agencies are characterized by the belief that helping approaches traditionally used by the dominant culture are universally applicable; if the system worked as it should, all people--regardless of race or culture--would be serviced with equal effectiveness. This view reflects a well intended liberal philosophy; however, the consequences of such a belief are to make services so ethnocentric as to render them virtually useless to all but the most assimilated people of color.

Such services ignore cultural strengths, encourage assimilation and blame the victims for their problems. Members of minority communities are viewed from the cultural deprivation model which asserts that problems are the result of inadequate cultural resources. Outcome is usually measured by how closely the client approximates a middle class non-minority existence. Institutional racism restricts minority access to professional training, staff positions and services.

Eligibility for services is often ethnocentric. For example, foster care licensing standards in many states restrict licensure of extended family systems occupying one home. These agencies may participate in special projects with minority populations when monies are specifically available or with the intent of "rescuing" people of color. Unfortunately, such minority projects are often conducted without community guidance and are the first casualties when funds run short. Culturally blind agencies suffer from a deficit of information and often lack the avenues through which they can obtain needed information. While these agencies often view themselves as unbiased and responsive to minority needs, their ethnocentrism is reflected in attitude, policy and practice.

Cultural Pre-Competence: Culturally competent agencies are characterized by acceptance and respect for difference, continuing self-assessment regarding culture, careful attention to the dynamics of difference, continuous expansion of cultural

knowledge and resources, and a variety of adaptations to service models in order to better meet the needs of minority populations. The culturally competent agency works to hire unbiased employees, seeks advice and consultation from the minority community and actively decides what it is and is not capable of providing to minority clients.

Advanced Cultural Competence: The most positive end of the scale is advanced cultural competence or proficiency. This point on the continuum is characterized by holding culture in high esteem. The culturally proficient agency seeks to add to the knowledge base of culturally competent practice by conducting research, developing new therapeutic approaches based on culture and publishing and disseminating the results of demonstration projects. The culturally proficient agency hires staff who are specialists in culturally competent practice. Such an agency advocates for cultural competence throughout the system and improved relations between cultures throughout society.

During the process of identifying a theoretical framework that supports the education of Doctors of Physical Therapy and Physical Therapist Assistants for developing the qualities of culturally competent practitioners, the APTA Task Force and the Committee on Cultural Competence adopted the Cross definition of cultural competence and the Cross continuum of cultural competence as well as the Campinha-Bacote model of cultural awareness, knowledge, skill, encounter, and desire. When educating Doctors of Physical Therapy and Physical Therapists Assistants towards developing cultural competency and cultural proficiency, the APTA Task Force and the Committee on Cultural Competence proposed a holistic model that challenges the physical therapy practitioner to: (a) desire being culturally competent; (b) master the process of self awareness, knowledge building, skill development that results in cultural competency; and (c) engage in health encounters that are positive and affirming to patients, families, friends, and colleagues, and enhance the diverse society in which work and personal life occur.

A holistic model of cultural competence education in physical therapy requires the student to:

- I. Examine self through reflective practice;
- II. Learn about the diversity dimensions that influence health outcomes, and affect the human experience both positively and negatively;

- III. Recognize the need for a patient-centered approach for delivery of culturally competent physical therapy services;
- IV. Value effective communication between the patient and the therapist as a fundamental for delivery of culturally competent care;
- V. Incorporate the National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Healthcare
- VI. Address the determinants of health that influence health outcomes;
- VII. Apply core knowledge about culture, belief systems, and traditions to enhance the patient-therapist interaction.

A holistic model for cultural competence education in physical therapy assumes that educators are culturally competent and that institutions of higher education and programs in physical therapist and physical therapist assistant education exist within organizations that seek to be culturally competent as defined by their mission, core values, policies and procedures, and operational practices.

Part II Definitions and Models Used to Support the Theoretical Constructs

Culture: The Agency for Health Care Research and Quality (AHRQ) states there is no one definition for culture that is uniformly referenced. Culture is often defined as the integrated patterns of human behavior that include thoughts, communications, actions, beliefs, customs, as well as institutions of racial, ethnic, religious, or social groups.

Competence: The capacity to function within the context of culturally integrated patterns of human behavior defined by a group.¹²

Explanatory Model¹³: Arthur Kleinman a physician and anthropologist, developed the Explanatory Model (EM) process to describe and compare how the professional caregiver/health care provider (HCP) and the lay patient/family perceive and interpret any single episode of illness (patient psychosocial perspective) and disease (HCP biomedical perspective). The (EM) process is designed to enhance the health care provider's skill in

eliciting sensitive personal health belief and health behavior information from a patient's or family's point of view that is critical to the development of effective, culturally competent patient centered plan of care. The explanatory model process explores 5 major health areas during a disease/illness episode from both the HCP and the patient/family's points of view. The 5 major health areas as defined by Kleinman are:

- Etiology
- Time & mode of onset of symptoms
- Pathophysiology
- Course of sickness (degree of severity – acute, chronic, etc.)
- Treatment

It is expected that the HCP will examine his/her EM first and then proceed to elicit that of the patient/family. Questions used to explore these five areas from the patient's/family's point of view: What, why, how, and who question examples include:

- What do you call the problem?
- What do you think the illness does?
- What do you think the natural course of the illness is?
- What do you fear?
- Why do you think this illness or problem has occurred?
- How do you think the sickness should be treated?
- How do you want to be helped?
- Who should be involved in the decision-making?

When applying the Explanatory Model, the interviewer should begin with a statement of respect such as, "I know different people have very different ways of understanding illness, please help me understand how you see things..." These questions are not expected to be separate from the interview process, but are intended to be integrated into the traditional interview format of questioning.

Comparison of the HCP's EM with that of the patient/family will reveal gaps in knowledge, understanding, health beliefs and behaviors. These differences/gaps are expected to be considered as the HCP(s) and patient/family develop a collaborative plan of care that adapts to the patient's/family's specific needs and provides a clear 'road map' for patient education (as identified through the EM process).

Diversity Dimensions: There are both primary and secondary diversity dimensions that have traditionally resulted in discrimination in the United States. Specific health disparities can be related to each diversity dimension.

Primary diversity dimensions include:

- Age
- Race
- Gender
- Sexual Orientation
- Ethnicity/Nationality
- Mental/Physical Ability
- Socioeconomic status
- Religion

Secondary diversity dimensions include:

- Work background
- Income
- Marital Status
- Geographic Location
- Family Background
- Education

L.E.A.R.N. Model: A model for culturally effective communication: ¹⁵

Listen

- Listening is a most important part of effective communication:
 - Identify and greet family or friends of the patient;
 - Ask patient with English as a second language if they would like an interpreter;
 - Start interview with an open-ended question;
 - Do not interrupt the patient as s/he speaks

Elicit

- The patient's health beliefs are elicited as they pertain to:
 - the health condition
 - the reason for the visit
 - the patient's expectations

- **Assess**

- Investigate potential attributes and problems in the person's life that may have an impact on health and health behaviors.

- **Recommend**

- A plan of action is recommended with an explanation why the specific recommendations are being made, for example, treatment dates, times, duration, interventions...

- **Negotiate**

- When the recommended plan is not readily agreed upon, negotiate a plan of action that is agreed upon by the patient and the provider.

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The R.E.S.P.E.C.T Model of Cross-Cultural Communication ¹⁶

- **Rapport**

- Connect on a social level
- Seek the patient's point of view
- Consciously attempt to suspend judgment
- Recognize and avoid making assumptions

- **Empathy**

- Remember that the patient has come to you for help
- Seek out and understand the patient's rationale for his or her behaviors or illness
- Verbally acknowledge and legitimize the patient's feelings

- **Support**

- Ask about and try to understand barriers to care and compliance
- Help the patient overcome barriers
- Involve family members if appropriate
- Reassure the patient you are and will be available to help

- **Partnership**

- Be flexible with regard to issues of control
- Negotiate roles when necessary
- Stress that you will be working together to address medical problems

- **Explanations**

- Check often for understanding
- Use verbal clarification techniques

- **Cultural Competence**

- Respect the patient and his or her culture and beliefs
- Understand that the patient's view of you may be identified by ethnic or cultural stereotypes

- Be aware of your own biases and preconceptions
- Know your limitations in addressing medical issues across cultures
- Understand your personal style and recognize when it may not be working with a given patient
- **Trust**
 - Self-disclosure may be an issue for some patients who are not accustomed to Western medical approaches
 - Take the necessary time and consciously work to establish trust

Part III Goals and Objectives for Cultural Competence Education in Physical Therapy

Using a traditional framework for developing core competencies in physical therapist and physical therapist assistant education, the APTA Task Force and Committee on Cultural Competence identified knowledge, attitudes, and skills necessary to develop as a culturally competent physical therapy practitioner.

Overarching Goals

1. Cultural competence education should increase self-awareness about the diversity dimensions and how the presence of barriers to gaining knowledge, attitudes, and skills for enhancing service delivery to diverse patient populations can adversely affect patients, families, friends, oneself, colleagues, and society on the whole.
2. Cultural competence education should provide knowledge, attitudes, and skills that enable the physical therapy practitioner to demonstrate best practice through clinical excellence and social responsibility.
3. Cultural competence education should provide knowledge, attitudes, and skills that can promote improved health care delivery and promote health equity through eliminating health disparities.
4. Cultural competence education applies the National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Healthcare.

Teaching and Learning Objectives for Knowledge, Affective, and Psychomotor Domains

Developing Doctors of Physical Therapy and Physical Therapy Assistants as culturally competent practitioners requires the students be able to:

Knowledge Domain

1. Describe the changing demographics in US society and the effects on health care.
2. Identify factors that contribute to health disparities and health inequality.
3. Discuss strategies to reduce and eliminate health disparities and promote health equity.
4. Explain the major conceptual frameworks for developing cultural competence.
5. Describe the role of the physical therapist/physical therapist assistant in cross-cultural relationships.
6. Evaluate cultural beliefs and practices that influence health care practice.
7. Identify barriers to providing culturally competent health care.
8. Discuss the dimensions of culture and diversity.
9. Describe the benefits of organizational practices that support cultural competence including: (a) interpreter services, (b) health literacy initiatives, and (c) complementary health programs.
10. Assess physical therapist patient/client management: Screening, examination, evaluation, diagnosis, prognosis, interventions, and outcomes using culturally appropriate tests and measures and techniques.
- 10b. Assess physical therapist assistant scope of practice in the delivery of interventions and expected outcomes using culturally appropriate data collection and techniques.
11. Evaluate clinical practice guidelines to assess how culturally competent and culturally proficient care aligns with the recommendations.
12. Analyze the effect culturally competent and culturally proficient health care has in improving health care delivery in varied settings, with persons of different ages, across the lifespan.

Attitudes Domain

13. Value that cultural competence is a developmental process that is critical to systems, organizations, groups, professions, individuals, and self.

14. Recognize the importance of understanding self and issues of personal biases and influences that affect self.
15. Demonstrate awareness of multifaceted components of culture and belief systems relative to self and others.
16. Appreciate the differences that exist within and across cultural groups and the need to avoid overgeneralization and negative stereotyping.
17. Demonstrate the desire to respond in a culturally competent manner during clinical encounters.
18. Accept the responsibility for being a culturally competent health care practitioner.
19. Value that cultural competence is a dynamic goal that requires a life-long commitment.
20. Advocate for culturally competent health care in all settings across the lifespan.
21. Appreciate the importance of effective cross cultural communication in order to affect the best outcomes of care
22. Strive to promote a society that embraces cultural competence and aspires for cultural proficiency in all health care encounters.

Skills Domain

23. Demonstrate effective active listening, verbal and non-verbal communication necessary for developing and maintaining a therapeutic alliance.
24. Apply Kleinman's Explanatory Model in patient interactions to develop a thorough understanding of the patient's beliefs and unique point of view on each health care episode.
25. Apply the L.E.A.R.N. model to enhance effective cross cultural communication with patient/client interactions, families, and caregivers.
26. Demonstrate verbal and non-verbal rapport in culturally competent practice that includes sensitivity to dimensions of diversity such as: age, disability, gender, sexual orientation, socioeconomic status, race, ethnicity/nationality, and religion.
27. Utilize reflective practice during critical thinking and problem solving during each patient/client interaction.
28. Demonstrate appropriate use of interpreter services.

29. Evaluate level of health literacy in patient education materials to match each patient's unique needs.
30. Demonstrate the ability to negotiate physical therapy interventions with patients/clients and caregivers and to adapt plans of care to meet patient's/families' unique health care needs.
31. Apply the principles of cultural competency to individuals across the life span in a variety of physical therapy settings.
32. Collaborate with health care providers to support best practices in health care including health promotion, disease prevention, and wellness.
33. Develop and disseminate scholarly writings, consumer brochures, policies and procedures to support effective culturally competent care.

IV Teaching Methodology

Effective teaching and learning in the area of cultural competence education should be provided using a variety of teaching methods and resource materials that immerse students in cultural encounters representative of local, national and global communities. The educational experiences may include lecture, discussion, role play, simulations, interactive games and active training techniques that lead to self-awareness and self reflection around culture and diversity.

Application of the theories, principles, and practices for advancing education in cultural competence may be achieved through the use of case studies, problem-based learning, community service and engagement activities, clinical case reporting, and clinical education experiences strategically placed throughout the curriculum. In each teaching and learning encounter the student is an active learner and the facilitator works within the context of the course or clinical experience to provide the student with experiences that can engender true interest in traversing the cultural competency continuum of knowledge, attitudes, and skills critical for developing cultural competency and cultural proficiency.

V Assessment

Assessment is an integral part of the education process. The curriculum for developing cultural competency in physical therapist and physical therapist assistant education is subject to

assessment through programmatic review of the teaching and learning objectives and the student outcomes of learning. Students are asked to evaluate the curriculum content across the varied teaching and learning experiences. Evaluation of student outcomes within the three domains of learning can occur through a variety of assessment measures in didactic and clinical coursework across the curriculum:

1. Assessment of Knowledge Domain:

Knowledge can be assessed using a variety of assessment measures including pre and post written examinations of theories and principles, application of knowledge in reflection papers or during class/seminar discussions, and critical thinking for clinical decision-making during case presentations.

2. Assessment of Attitudes Domain:

Attitudes can be assessed using a variety of assessment measures including standard survey instruments, self assessment questionnaires/profiles, structured interviews, values clarification exercises, seminar discussion, videotaped clinical encounters, simulations, role playing activities, journal and other reflective writing activities, threaded discussion boards, and presentation of clinical cases.

3. Assessment of Skills Domain:

Skills can be assessed with direct observation of patient interview skills, clinical encounters, written and/or oral clinical case presentations, interactions with interpreters and health care providers as well as review of plans of care including written home exercise programs and other health literacy materials.

Summary

The APTA *Blueprint for Teaching Cultural Competence in Physical Therapy Education* is intended as a guide to assure that core knowledge, attitudes, and skills specific to developing cultural

competence are being addressed in the education programs. The primary goal of the curriculum blueprint is to enable faculty to prepare future physical therapy practitioners to meet the health care needs of diverse consumers in a culturally competent manner. It is a belief that culturally competent health care practitioners can, in fact, reduce or eliminate health disparities and promote health equity for all across the lifespan in rural and urban settings.

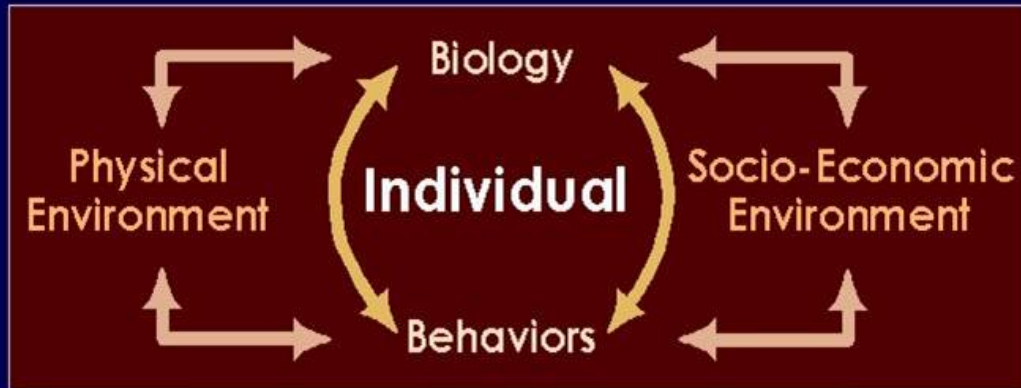
Resources for Teaching Cultural Competence

1. National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health and Health Care www.ThinkCulturalHealth.hhs.gov
2. National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care: A Blueprint for Advancing and Sustaining CLAS Policy and Practice <https://www.thinkculturalhealth.hhs.gov/pdfs/EnhancedCLASStandardsBlueprint.pdf>
3. Transforming the Face of Health Professions Through Cultural and Linguistic Competence Education: The Role of the HRSA Centers of Excellence www.hrsa.gov/culturalcompetence/cultcompedu.pdf
4. The Providers Guide to Health and Quality
<http://erc.msh.org/mainpage.cfm?file=1.0.htm&module=provider&language=English&group=&mgroup=>
5. AHRQ “Setting the Agenda for Research on Cultural Competency”
<http://www.ahrq.gov/research/findings/factsheets/literacy/cultural/index.html>
6. Health Literacy Universal Precautions Toolkit
<http://www.ahrq.gov/professionals/quality-patient-safety/quality-resources/tools/literacy-toolkit/healthliteracytoolkit.pdf>
7. Determinants of Health
<http://www.healthypeople.gov/2020/about/DOHAbout.aspx>

8. World Health Organization, Commission on Social Determinants of Health. Closing the Gap in a Generation: Health equity through action on the social determinants of health.
http://www.who.int/social_determinants/en/
9. Healthy People 2010 Determinants of Health Model
<http://www.healthypeople.gov/2020/about/DOHAbout.aspx>
10. Unnatural causes: Is inequality making us sick? <http://www.unnaturalcauses.org/>
11. Cultural Competence Assessment Measures
 - a. The Intercultural Development Inventory® (IDI®) <http://idiinventory.com/>
 - b. Cultural Competence Self-Assessment Questionnaire (CCSAQ)
http://eric.ed.gov/ERICWebPortal/custom/portlets/recordDetails/detailmini.jsp?_nfpb=true&_ERICExtSearch_SearchValue_0=ED399684&_ERICExtSearch_SearchType_0=no&accno=ED399684
 - c. Cross Cultural Adaptability Inventory (CCAI) http://ccaiassess.com/CCAI_Tools.html
 - d. Multicultural Awareness, Knowledge, and Skills Assessment (MAKSS)
http://cart.rmcdenver.com/instruments/multicultural_awareness.pdf
 - e. Cultural Self-Efficacy Scale (CSES) http://userpage.fu-berlin.de/~health/faq_gse.pdf
 - f. Inventory for Assessing the Process of Cultural Competence Among Healthcare Professionals revise (IAPCC-R©); Inventory for Assessing the Process of Cultural Competence Among Healthcare Professionals-Student Version (IAPCC-SV©); Inventory for Assessing A Biblical Worldview of Cultural Competence Among Healthcare Professionals (IABWCC©)

Determinants of Health

Policies and Interventions



Access to Quality Health Care

Healthy People 2010

National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care (The National CLAS Standards)

The National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care (The National CLAS Standards) aim to improve health care quality and advance health equity by establishing a framework for organizations to serve the nation's increasingly diverse communities.

Principal Standard

1) Provide effective, equitable, understandable and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy and other communication needs.

Governance, Leadership and Workforce

2) Advance and sustain organizational governance and leadership that promotes CLAS and health equity through policy, practices and allocated resources.

3) Recruit, promote and support a culturally and linguistically diverse governance, leadership and workforce that are responsive to the population in the service area.

4) Educate and train governance, leadership and workforce in culturally and linguistically appropriate policies and practices on an ongoing basis.

Communication and Language Assistance

5) Offer language assistance to individuals who have limited English proficiency and/or other communication needs, at no cost to them, to facilitate timely access to all health care and services.

6) Inform all individuals of the availability of language assistance services clearly and in their preferred language, verbally and in writing.

7) Ensure the competence of individuals providing language assistance, recognizing that the use of untrained individuals and/or minors as interpreters should be avoided.

8) Provide easy-to-understand print and multimedia materials and signage in the languages commonly used by the populations in the service area.

Engagement, Continuous Improvement and Accountability

9) Establish culturally and linguistically appropriate goals, policies and management accountability, and infuse them throughout the organizations' planning and operations.

10) Conduct ongoing assessments of the organization’s CLAS-related activities and integrate CLAS-related measures into assessment measurement and continuous quality improvement activities.

11) Collect and maintain accurate and reliable demographic data to monitor and evaluate the impact of CLAS on health equity and outcomes and to inform service delivery.

12) Conduct regular assessments of community health assets and needs and use the results to plan and implement services that respond to the cultural and linguistic diversity of populations in the service area.

13) Partner with the community to design, implement and evaluate policies, practices and services to ensure cultural and linguistic appropriateness.

14) Create conflict- and grievance-resolution processes that are culturally and linguistically appropriate to identify, prevent and resolve conflicts or complaints.

15) Communicate the organization’s progress in implementing and sustaining CLAS to all stakeholders, constituents and the general public.

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3. 1979 Surgeon General’s Report <http://healthypeople.gov/2020/about/history.aspx> accessed July 14, 2014.
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6. Health Equity Attainment available at <http://healthypeople.gov/2020/about/disparitiesAbout.aspx> Accessed July 14, 2014.
7. Determinants of Health available at <http://www.healthypeople.gov/2020/about/DOHAbout.aspx> Accessed on July 14, 2014.
8. National Standards on Culturally and Linguistically Appropriate Services (CLAS) in Health and Health Care available at www.omhrc.gov/CLAS Accessed on June 30, 2014.
9. Setting the Agenda for Research on Cultural Competence in Health Care available at <http://www.ahrq.gov/research/cultural.htm> Accessed on June 30, 2014.
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