

JULY 2011
The Need for Culturally Competent Health Care Providers

In 2000, almost 15 percent (more than 1.3 million) of the people in the State of Ohio were ethnically diverse. The United States Census Bureau estimates that by the year 2015, Ohio's minority population will grow to more than 2.1 million people, nearly 20 percent of the state's population.¹

With the face of Ohio continuing to diversify, the role of culture and its effect on the needs of patients/consumers in the health care world becomes increasingly important. In our quest to provide our communities with the highest quality services, we must have a heightened understanding of how beliefs and traditions related to culture or ethnic identity can affect a patient's/consumer's attitude toward health care. These cultural beliefs and traditions can affect attitudes about food, gender roles, folk healing methods, appropriate methods of disciplining children and the definition of family.²

Cultural competence is the ability to adapt service delivery to meet the diverse needs of the communities that we serve. The first step in successfully adapting service is recognizing that our own values may conflict or be inconsistent with those of other cultural or ethnic groups. Knowing the cultural makeup of family planning agencies' communities is undoubtedly important, but simply not enough. Appropriate cultural competence training and policies give staff, at all levels, the knowledge and the ability to treat the diverse populations.

Cultural competence is a set of behaviors, attitudes and policies aimed at bridging linguistic and cultural gaps between patients/consumers and caregivers. When attempts are made to successfully bridge these gaps, improved health care outcomes are expected. Increased understanding on the part of the provider will allow for more specific and complete information to be obtained from the patient/consumer that will in turn lead to improved diagnoses and treatment plans. Patients/consumers who are able to successfully communicate with their caregiver will be more likely to comply with those treatment plans and experience fewer delays in seeking care.³

Enclosed you will find the following:

- Tips for improving the caregiver/patient relationship across cultures.
- A self-assessment based on the National Standards for Culturally and Linguistically Appropriate Services in Health Care compiled by the U.S. Department of Health and Human Services Office of Minority Health.

The purpose of this assessment is to aid you in determining your agency's strengths and weaknesses in providing culturally and linguistically appropriate health services. This instrument may also aid you in identifying ways that the Ohio Department of Health can assist your agency in its efforts to bridge gaps between patients/consumers and caregivers.

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

In 1997, the U.S. Department of Health and Human Services Office of Minority Health initiated a project to develop recommended national CLAS standards that would support a more consistent and comprehensive approach to cultural/linguistic competence in health care. The CLAS standards reflect input from a broad range of stakeholders including hospitals, community-based clinics, managed care organizations, physicians, nurses and other providers, state and federal agencies, accreditation and credentialing agencies, educators, patient advocates, advocacy groups and consumers.

The following self-assessment is based on the 14 national CLAS standards published in the OMH CLAS final report in March 2001.

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Self-Assessment of Culturally and Linguistically Appropriate Services

Standard #1: Understandable and Respectful Care

Respectful care is taking into consideration the values, preferences and expressed needs of the patient/consumer (e.g., folk and religious beliefs influence a family's reaction and approach to health care; influence disciplining children; expectations for children acquiring self-help skills; attitudes toward food; definition of "family and gender roles;" sexual orientation; age/life cycle factors). Attitudes about health care are often transmitted from generation to generation.

Cultural competence is being able to recognize and respond to health-related beliefs and cultural values, disease incidence and prevalence and treatment efficacy. It is important to be aware of alternative healing methods such as folk healers, folk methods and alternative therapies (acupuncture, acupressure, massage, nerve stimulation, vibration, therapeutic touch).

Does your agency provide understandable and respectful care?

1. How has your agency integrated understandable and respectful care into patient encounters?

We provide clients with privacy and do initial interviews and assessments 1:1 with the nurse.

2. What training does your agency's staff receive in identifying and responding to health care beliefs?

Staff attend some type of cultural awareness conference annually. We also have speakers at our staff meetings who are not professionals, just community or staff members who have a different cultural background.

The health department Strategic Plan and Cultural Diversity Statement are on the web site, public comment is asked for on the home page.

Annually the staff participates in a CLAS Assessment review

The staff is required to complete a cultural diversity training annually and provide a certificate.

All staff is scheduled to attend "Bridges Out of Poverty" training October 2011

3. What resources would help your agency to achieve this standard (funds, training, etc.)?

Funds

Standard #2: Diverse Staff and Leadership

A diverse staff is one that is representative of the diverse demographic population of the service area and includes the leadership of the organization as well as its governing boards, clinicians and administrative personnel.

Building staff that adequately mirrors the diversity of the patient/consumer population should be based on continual assessment of staff demographics as well as demographic data from the community. Staff refers not only to personnel employed by the health care organization but also its subcontracted and affiliated personnel. Examples of the types of staff members whose backgrounds should reflect the community's diversity include clinical staff, support staff, clergy and lay volunteers and high-level decision makers.

Organizations should encourage the retention of diverse staff by fostering a culture of responsiveness toward the ideas and challenges that a culturally diverse staff offers.

Does your agency have a diverse staff (administrative and clinical)?

1. What percentage of your staff (clinical, support, administrative, volunteers) is multicultural and/or multilingual?

Multicultural 20%

Multilingual 0%

Both 0%

2. Does staff diversity reflect the diversity of the service area?

The majority (90%) of the county population is Caucasian. 10% of the population which includes African Americans, Hispanics, and Asians. We also have a population of Amish that we serve but is not reflected with our staff.

Our Family Service Education Coordinator(Supervises 8 home visiting staff with HMG and MIECHV programs is African American and she is intimately aware of the needs of the Warren community.

3. What resources would help your agency to achieve this standard (funds, training, etc.)?

Funds and possibly training on minority recruitment.

Standard #3: Ongoing Education and Training

Health care organizations should ensure that staff at all levels and across all disciplines receive ongoing education and training in culturally and linguistically appropriate service delivery. Budgetary expenditures should be allocated each year to the development of cultural competence as well as the development of job descriptions of staff working with culturally diverse patients. Training objectives should be tailored for relevance to the particular functions of the trainees and the needs of the specific populations served.

Do staff members participate in ongoing cultural competence education and training?

1. What percentage of the following staff has participated in cultural competency training?

Administrative Staff 100%

Clinical Staff 100%

2. What percentage of staff (both administrative and clinical) is required to attend ongoing cultural competency training? **100%**

3. How do you address cultural competency in your training and orientation for new staff members? *Please attach copies of any orientation materials related to cultural competence.*

**It is a part of the agency mission statement and The Strategic Plan. The mission statement is a part of the orientation packet. (see attached)
The mission statement and CLAS Assessment is reviewed /completed annually at a staff meeting**

4. What resources would help your agency to achieve this standard (funds, training, etc.)?

This could be expanded into the orientation materials without needing any additional resources.

Standard #4: Language Assistance Services

Language assistance services are the availability of bilingual staff who can communicate directly with patients/consumers in their preferred language (first preference); face-to-face interpretation provided by trained staff or volunteer interpreters (next preference); telephone interpreter services should be used as supplemental system when an interpreter is needed instantly or when services are needed in an unusual or infrequently encountered language. Limitations in English Proficiency (LEP) are not an indicator of the patient's/consumer's intelligence. The patient/consumer may/may not be literate in their language of origin or English.

Sample follow-up questions that indicate whether a patient understands specific information/instructions:

- How would you explain this information to your husband (wife, cousin)?
- Tell me what you know about...
- How would you know if (your blood sugar was low)?
- Show me how you would...
- What would you do if (you felt dizzy or shaky)?
- What have I forgotten to explain?
- What could I/this brochure/video/etc. have explained better?

Does your agency provide appropriate language assistance services?

1. What languages are spoken by your community?

English is the primary language. There is a small amount of Spanish and Chinese also spoken. German is spoken in the Amish community. The Amish also speak English

2. What percentage of staff members are proficient in the languages of the community? **100% English 0% Spanish or Chinese**

3. How many trained translators and interpreters are available?

We have no trained translators or interpreters. We utilize OPTIMAL PHONE INTERPRETERS, a telephone interpreter services. We have also utilized a worker from a local Chinese restaurant.

4. What training certification(s) do the translators hold? *Please attach any materials related to translation certification.* **All translators with OPTIMAL are credentialed, See attached**

5. What is your agency's policy regarding interpreter services?

Our policy is to provide interpreter services and only utilize the client's friends and/or family when the client makes the request. Often, this is the client's wish.

6. What resources would help your agency to achieve this standard (funds, training, etc.)? **Funds to develop a directory/registry of interpreters/translators.**

Standard #5: Right to Receive Language Assistance Services

Health care organizations must provide to patients/consumers in their preferred language both verbal and written notices informing them of their right to receive language assistance services. At all points of contact, health care organizations should also distribute written notices with this information and post translated signage.

Some successful methods for informing patients/consumers about language assistance services include: using language identification or "I speak..." cards; posting and maintaining signs in regularly encountered languages at all points of entry; creating uniform procedures for timely and effective telephone communication between staff and LEP persons; including statements about the services available and the right to free language assistance services in appropriate non-English languages in brochures; booklets; outreach materials; and other materials that are routinely distributed to the public.

Does your agency make patients/consumers aware of their right to receive language assistance services?

1. What methods does your agency employ to make patients/consumers aware of their right to receive language assistance services?

- Language identification cards

Signs in regularly encountered languages at all point of entry

Uniform procedures for timely and effective telephone communication between

staff and LEP persons

Statements in appropriate non-English languages in brochures, booklets,

outreach materials

Other, please explain:

- Client intake records will include primary language
- Brochures in multiple languages are accessible thru CDC for Pandemic Prep, Influenza campaigns, Immunization information, are obtained by the health department as needed.

2. What resources would help your agency to achieve this standard (funds, training, etc.)? **training and funds**

Standard #6: Competence of Language Assistance

Linguistic competence is the capacity of an organization and its personnel to communicate effectively and convey information in a manner that is easily understood by diverse audiences including LEP persons, those who have low literacy skills or are not literate and individuals with disabilities (e.g., impaired vision or hearing).

The organization must have policy, structures, practices, procedures and dedicated resources to support this capacity (National Center for Cultural Competence).

This is based on the percentage of consumers from diverse ethnic/racial groups served in their preferred language.

Health care organizations must assure the competence of language assistance provided to LEP 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).

Is your agency linguistically competent?

1. How does your agency meet the needs of people of limited English proficiency?

Low literacy skills/ not literate:

We try to assure that all material that we develop is appropriate for those with low literacy skills. Our staff also will assist clients 1:1 to go over written information.

If unable to read, the forms will be read to them.

Primary language other than English:

Use of interpreter provided by our agency or use of a family or friend if client wishes.

Persons with disabilities (impaired vision or hearing):

Hearing impaired/deaf- use of TTD devise.

Use of family or friend brought in by client.

Vision impaired./blind-

Information will be read to the client

2. When staff identifies LEP persons, what is the policy/procedure for responding?

Low-literacy skills/not literate: See #1

Primary language other than English: See #1

Persons with disabilities (impaired vision or hearing): See #1

3. What resources would help your agency to achieve this standard (funds, training, etc.)? **Funds**

Standard #7: Patient-Related Materials

Health care organizations must make available easily understood patient-related materials and post signage in the languages of the commonly encountered group and/or groups represented in the service area. Examples of relevant patient-related materials include: applications, consent forms and medical treatment instructions (consult the Office for Civil Rights guidance on Title VI on what is considered "vital" documents). Meaningful access is not limited to written translations. Written materials should never be used as a substitute for oral interpreters. Media resources should be screened for cultural and racial stereotypes.

Does your agency make available easily understood patient-related materials that reflect the languages and cultures of the service area?

1. Do your agency's patient-related materials reflect the languages and cultures represented in the service area? *Please attach your best example of patient-related material that reflects the languages and cultures of your agency's service area.*

See attached.

2. What resources would help your agency to achieve this standard (funds, training, etc.)? **funds**

Standard #8: Written Strategic Plan

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 culturally and linguistically appropriate services. The strategic plan should be developed with the participation of consumers, community and staff who can convey the needs and concerns of all communities and all parts of the organization affected by the strategy.

Does your agency have a written strategic plan for providing culturally and linguistically appropriate services?

1. Does your agency have a strategic plan related to cultural competency and defined steps for its integration at every level of organizational planning? *Please attach a copy of your agency's strategic plan related to cultural competency.*

Strategic Plan (posted on TCHD website), does prioritize meeting the needs of the communities diversity, is reviewed annually and updated as appropriate.

2. Who (staff, patients, community) is involved in the development of a strategic plan related to cultural competency?

Clinic staff meeting 7/29/2011, discussed/reviewed CLAS objective, CLAS Self Assessment and the Trumbull County Health Department's Mission statement and Strategic Plan.

The CLAS Self Assessment and Cultural Diversity statement was e-mailed to all(clinic and environmental staff) 8/2011 and asked for a comment replay be e-mail.

The mission statement related to cultural diversity and the Strategic Plan are posted on our website and public comment is elicited by an e-mail address on the home page.

3. What methods does your agency use to evaluate cultural competency?

We do survey our clients twice a year and one of this questions asks if services met the client needs.

Survey will be updated 2012 to reflect the addition of addressing cultural sensitivity.

4. What resources would help your agency to achieve this standard (funds, training, etc.)?

The CLAS document (training)

Standard #9: Organizational Self-Assessments

Linking CLAS-related measures with routine quality and outcome efforts may help build the evidence base regarding the impact of CLAS interventions on access, patient satisfaction, quality and clinical outcomes. Patient/consumer and community surveys and other methods of obtaining input are important components of organizational quality improvement activities.

Does your agency employ organizational self-assessments that include a measure of cultural and linguistic competence?

1. Is your agency currently conducting patient/consumer and/or community surveys as a means to evaluate cultural and linguistic competence? *Please attach a sample survey.*

**Survey is not specific to cultural needs. A copy is attached.
The survey will again be developed and distributed in 2012.**

2. What information/data does your agency use to evaluate progress related to cultural competency?

None at this time , will re-evaluate client satisfaction surveys 2012 in order to address cultural sensitivity issues

3. What resources would help your agency to achieve this standard (funds, training, etc.)?

Training

Standard #10: Patient/Consumer Data

Data on the individual patient's/consumer's race, ethnicity and spoken and written language should be collected in health records, integrated into the organization's management information systems and periodically updated. For health encounters that involve or require the presence of a legal parent or guardian who does not speak English, the management information system record and chart should document the language not only of the patient/consumer but also of the accompanying adult(s). No patient/consumer should be required to provide race, ethnicity or language information, nor be denied care or services if he or she chooses not to provide such information.

Does your agency routinely collect and update patient/consumer data related to culture and language?

1. Does your agency's information systems include patients' primary spoken language and identified ethnicity?

Yes

2. What methods are employed by your agency to collect and maintain information regarding patients' demographic data, including primary spoken language and identified ethnicity?

Intake of client immunization records, will include the addition of primary language and ethnicity. Reports can be pulled from this data system

3. How often is this information updated?

With each client contact

4. What information is currently collected regarding patient's primary spoken language and identified ethnicity?(please check all that apply).

Race

Ethnicity

Primary spoken language, to start 8/8/2011

Primary written language

Primary language of accompanying adult(s) (in the case of a minor)

Other, please explain:

Changes in data collection system-funding

5. What resources would help your agency to achieve this standard (funds, training, etc.)?

Change in Match forms. Funds.

Standard #11: Community Profile

Health care organizations should involve the community in the design and implementation of the community profile (demographic, cultural and epidemiological) and needs assessment. A community needs assessment should include: percentage of cultures, age and gender, religions, refugees and immigrants, income distribution, unemployed, languages spoken and read, non-English speaking, fourth grade reading levels and types of alternative/complementary services.

Does your agency utilize community members in creating a community profile and needs assessment?

1. Does your agency use a variety of methods to collect demographic, clinical and cultural data for groups in our service area? If so, please explain which methods are used.

Surveys, Focus groups, Client contact at immunization clinics

2. Who (community members, staff, local organizations) is involved in creating the community profile and needs assessment?

We have formed a partnership with FCFC to create a community assessment committee made up of members of a variety of agency representatives the survey is completed every other year

3. What is your agency's involvement in developing a complete, updated community needs assessment?

We have partnered with FCFC to develop and fund a community assessment committee that would be active year round doing assessment and planning.

4. What resources would help your agency to achieve this standard (funds, training, etc.)?

Funds

Standard #12: Community Partnerships

Health care organizations should develop participatory, collaborative partnerships with their communities and utilize a variety of formal and informal mechanisms to facilitate community and patient/consumer involvement in designing and implementing CLAS-related activities. Specific methods for obtaining community input include surveys, public meetings, focus groups, advisory committees, coalition building (e.g., parent-to-parent network).

Does your agency develop community partnerships?

1. How does your agency obtain community input concerning the needs of the cultural groups in our service area? If so, please explain methods used.

We periodically survey clients who utilize our services. In the past we also held an informal focus group with a group of Amish clients. We used the assistance of one of our Amish clients to assist us to invite clients and we held the meeting in their neighborhood at one of their homes. We have also had contact with one of the Bishops in the Amish community.

2. What are your agency's strengths in obtaining community input?

For the most part, clients trust us and give honest answers. We have been willing to "go to the source" eg. Amish. We were able to recognize that we were only doing a superficial job and approached FCFC to partner with us to do a more thorough job, which led to the community survey started in 2008. In 2011 we added an email address to the home page asking for public comment

3. What are your agency's weaknesses in obtaining community input?

Not enough staff, time, or experience to do a thorough job.

4. What resources would help your agency to achieve this standard (funds, training, etc.)?

Funds, training

Standard #13: Conflict/Grievance Resolution Processes

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. Ideally, this responsiveness may be achieved by integrating cultural sensitivity and staff diversity into existing complaint and grievance procedures as well as into policies, programs, offices or committees charged with responsibility for patient relations and legal or ethical issues.

Does your agency use conflict/grievance resolution processes that are culturally/ linguistically competent?

1. Please explain your agency's current patient complaint and grievance procedures?

See attached, the policy and procedure is posted in English and Spanish in the health department client common area.

2. Has your agency integrated cultural sensitivity and staff diversity into existing complaint and grievance procedures? If so, please explain current policy.

As #1

3. What resources would help your agency to achieve this standard (funds, training, etc.)?

This can (and will) be done with the need for additional resources.

Standard #14: Implementation

Agencies should regularly make available to the public information about their progress and successful innovations in implementing the CLAS standards and provide public notice about the availability of this information. Examples include organizations describing specific organizational changes or new programs in response to CLAS standards; CLAS-related interventions or initiatives undertaken; and/or accomplishments made in meeting the needs of diverse populations.

Communication methods can include stand-alone documents, member publications, newsletters targeting the communities served, presentations at conferences,

newspaper articles, television, radio (broadcast media) and postings on Web sites. Agencies should evaluate progress using rates of service utilization; reason-specific no-show rates; and reason-specific drop-out rates.

Does your agency make available to the public information regarding the implementation of initiatives related to cultural/linguistic competence?

1. What methods does your agency employ to make the public aware of initiatives related to cultural/linguistic competence (please check all that apply)?

Stand alone documents, posted CLAS Assessment in client common area.

Member publications

Community-targeted newsletters

Presentations at conferences

Newspaper articles

Broadcast media

Web Site postings

Other, please explain: Annual staff meeting, recent 7/21/2011

All on site and off site immunization clinics

2. What resources would help your agency to achieve this standard (funds, training, etc.)? **Funds**

Tips for Improving the Caregiver/Patient Relationship Across Cultures

1. Culture determines the roles for polite, caring behavior and will formulate the patient's concept of a satisfactory relationship. Do not treat the patient in the same manner you would want to be treated.
2. In most countries, a greater distance between caregiver and patient is maintained through the relationship. Begin by being more formal with patients who were born in another culture. Except when treating children or very young adults, it is best to use the patient's honorific (Mr., Ms., Mrs., Sr.) name when addressing him or her.
3. In many cultures, it is disrespectful to look directly at another person (especially one in authority) or to make someone "lose face" by asking him or her questions. Do not be insulted if the patient fails to look you in the eye or ask questions about treatment.
4. Adopt a line of questioning that will help determine some of the patient's central beliefs about health/illness and illness prevention. Do not make any assumptions

about the patient's ideas about the ways to maintain health, the cause of illness or the means to prevent or cure it.

5. Often, patients are afraid to tell Western caregivers that they are visiting a folk healer or are taking an alternative medicine concurrently with Western treatment because in the past they have experienced ridicule. Allow the patient to be open and honest. Do not discount beliefs that are not held by Western biomedicine.
6. Belief in the supernatural may result in his or her failure to either follow medical advice or comply with the treatment plan. Do not discount the possible effects of beliefs in the supernatural's effects on the patient's health. If the patient believes that the illness has been caused by bewitchment, the evil eye or punishment, the patient is not likely to take any responsibility for his or her cure. Inquire indirectly about the patient's belief in the supernatural or use of nontraditional cures.
7. In many cultures, medical decisions are made by the immediate family or the extended family. If the family can be involved in the decision-making process and the treatment plan, there is a greater likelihood of gaining the patient's compliance with the course of treatment. Try to ascertain the value of involving the entire family in the treatment.
8. "The need to know" is a unique American trait. In many cultures, placing oneself in the doctor's hands represents an act of trust and a desire to transfer the responsibility for treatment to the physician. Watch for and respect signs that the patient has learned as much as he or she is able to deal with. Be restrained in relating bad news or explaining in detail complications that may result from a particular course of treatment (this does not suggest that the caregiver should withhold health-related information from the patient).
9. Whenever possible, incorporate into the treatment plan the patient's folk medication and folk beliefs that are not specifically contradicted. This will encourage the patient to develop trust in the treatment and will help assure that the treatment plan is followed.

Additional Resources

1. Agency for Healthcare Research and Quality (AHRQ)
<http://www.ahrq.gov/research/minorix.htm>
The AHRQ Web site contains a list of sites related to disparities in health care as well as cultural competence. The site also provides information on "The Role of Community-Based Participatory Research: Creating Partnerships, Improving Health."
2. Commonwealth Fund
<http://www.cmf.org>
The Commonwealth Fund is a private fund that is dedicated to helping people become more informed about their health care and improving care for vulnerable populations such as children, elderly people, low-income families and minority Americans. This site contains a wealth of information on minority health and the quality of care for underserved populations.
3. National Center for Cultural Competence (NCCC)
<http://www.georgetown.edu/research/gucdc/nccc>
The NCCC web site offers a broad overview of Cultural/Linguistic Competence as well as references to recent publication on a wide variety of related topics (available in PDF format).
4. National Institutes of Health (NIH)
<http://www.cc.nih.gov/ccc/plan/disparities.html>
This site provides a copy of the NIH Strategic Plan on Reducing Health Disparities. This strategic plan addresses issues related to improving cultural and linguistic competence.
5. American Medical Association (AMA)-*Folk Remedies Among Ethnic Subgroups*
<http://www.ama-assn.org/ama/pub/article/2036-2524.html>
This site provides specific information on folk medicine in addition to general information on cultural ideas of health and illness.
6. U.S. Department of Health and Human Services Office of Minority Health (OMH)-*Potential Measures/Indicators for Cultural Competence*
<http://www.hrsa.gov/OMH/cultural/attachment3.html>
This site provides a detailed list of potential measures and indicators for cultural and linguistic competence broken down into specific topic areas and domains ranging from values and attitudes to policies and procedures.

References

1. United States Census Bureau - *Projected State Populations by Sex, Race, and Hispanic Origin*.
<http://www.census.gov/population/projections/state/stpjrace.txt>
2. Spector RE. *Cultural Diversity in Health and Illness*. 4th ed. Appleton and Lange. Stamford, CT; 1996.
3. HRSA Bureau of Primary Health Care - *Cultural Competence: A Journey*.
<http://www.bphc.hrsa.gov/culturalcompetence/default.htm>
4. University of Michigan Health System - *Approaches for Cross-Cultural Relationships- Tips for Improving the Caregiver/Patient Relationship Across Cultures*. <http://www.med.umich.edu/multicultural/ccp/approaches.htm>
5. U.S. Department of Health and Human Services Office of Minority Health (OMH)-*National Standards for Culturally and Linguistically Appropriate Services in Health Care (CLAS)*.
<http://www.omhrc.gov/omh/programs/2pgprograms/finalreport.pdf>
6. University of Michigan Health System – *Questions to Ask Your Patient*.
<http://www.med.umich.edu/multicultural/ccp/questions.htm>
7. DDHS Office of Minority Health – *Practical Guide for Implementing the Recommended National Standards for Culturally and Linguistically Appropriate Services in Health Care*. <http://www.omhrc.gov/clas/guide2a.asp>