

CULTURAL AND LINGUISTIC COMPETENCE

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Chapter Overview

In the United States, there is a growing cultural diversity shift in ethnicity, language, and age. In many minority groups who are low income or uninsured, there are lower eye care utilization rates that may be related to attitudes and actions on the part of optometrists and ophthalmologists, including the lack of understanding and sensitivity of ophthalmologists and optometrists about successful communication strategies and interpersonal approaches that are culturally and age appropriate.[1] Without health care organizations, health care providers and staff who are courteous and respectful in a culturally competent manner, a trusting relationship with the patient will not be developed and the cycle of inequality will be perpetuated. This chapter will explore the relationship between culture and health, language access, and the role individuals, optometric practices, and the profession play in the never ending journey towards cultural competence.

Objectives

1. To provide an understanding of the relationship between CULTURE and HEALTH.
2. The role of the Cultural Competence of health professionals in providing appropriate and quality health care to culturally heterogeneous population groups.
3. The importance of linguistic appropriateness in the functioning of health care services.

Rationale for cultural and linguistic competence in Health Care

In the past 50 years, there have been significant improvements in the health status of individuals. Many of these improvements have been attributed to advances in technology, biomedical and pharmaceutical research, understanding of diseases, health promotion, and disease prevention. One would expect all these positive changes to reflect all segments of the population, unfortunately not all have benefited equally. This pattern of disparity is seen in the incidence of illness, disease, and death and is evident in health care outcomes and utilization [2] in many groups of people, not just minorities who are low income or uninsured. It transcends socioeconomic status and is equally present among individuals from specific racial groups despite income and access to insurance.

Disparities permeate virtually every area in health care delivery including optometry and ophthalmology. There are lower eye care utilization rates that may be related to attitudes and actions on the part of optometrists and ophthalmologists, including the lack of understanding and sensitivity of eye care professionals about successful communication strategies and interpersonal approaches that are culturally

and age appropriate.[1] Our world is on a trajectory of increasing geographic, economic, religious, racial, ethnic, cultural, and linguistic diversity and that our success as a nation hinges on how we meet the challenges diversity poses, while capitalizing on the strengths it provides.[3]

The make-up of the American population continues to change as a result of immigration patterns and significant increases among racially, ethnically, culturally, and linguistically diverse populations already residing in the U.S. Since 1990, the foreign born population has grown by 64% to 32.5 million people, accounting for 11.5% of the U.S. Population. By 2050, it is estimated that whites will make up 46 percent of the population and blacks will increase slightly to 15 percent. Hispanics/Latinos, who currently make up about 15 percent of the population, will account for 30 percent in 2050. Asians, who make up about 5 percent of the population, are projected to increase to 9 percent by 2050.[4] In 2000, 18 percent of the total population 5 years of age and over, or 47.0 million people, reported speaking a language other than English at home. These figures were up from 14 percent (31.8 million) in 1990 and 11 percent (23.1 million) in 1980. The number of people speaking a language other than English at home grew by 38 percent in the 1980s and by 47 percent in the 1990s. A total of 311 languages are spoken in the United States, of which 162 are indigenous, and 149 are immigrant.[5][6][7] The National Virtual Translation Center defines indigenous languages as those that are native to a region and spoken by people indigenous to that region. And this trend is expected to continue. In addition, the population is aging and by 2030, the entire baby boomer generation will be 65 and older which translates to one in five U.S. residents.[8] With a multi-cultural and multigenerational society, there will be a growing need to develop strategies and methods to understand and value cultural (beyond race and ethnicity) and language (including sign language, technology, etc.) diversity in order to deliver care that is of the highest standard.

What is Culture and What Role Does it Play in the Delivery of Health Care?

Culture is defined in many different ways and there are numerous definitions. For the purposes of this chapter, we will provide two definitions to add clarity and insight.

"Culture is the learned and shared knowledge that specific groups use to generate their behavior and interpret their experience of the world." [9] It comprises beliefs about reality, how people should interact with each other, what they "know" about the world, and how they should respond to the social and material environments in which they find themselves. It is reflected in their religions, morals, customs, technologies, and survival strategies. It affects how they work, parent, love, marry, and understand health, mental health, wellness, illness, disability, and death…

"Culture is an integrated pattern of human behavior which includes but is not limited to—thought, communication, languages, beliefs, values, practices, customs, courtesies, rituals, manners of interacting, roles, relationships, and expected behaviors of an ethnic group or social groups whose members are uniquely identifiable by that pattern of human behavior."[9]

Culture extends beyond race and ethnicity and includes, but is not limited to, age, gender, , language, religion, family structure, sexual orientation and gender identity, disability status, social economic status, neighborhood, profession, etc. Culture

structures perceptions, shapes behaviors, tells group members how to behave and provides their identity. Culture influences all aspects of our society and is frequently described as the lens by which people in a specific group view the world.[9]

The way we conduct ourselves, how we receive and process information, what we value, and how we relate to people is influenced by culture. Health care professionals may not realize the significant influence of the "culture of medicine" on their values, belief systems, and behaviors. In a recent article for the *New England Journal of Medicine*, Fox (2005)[10], critiques the lack of awareness of the culture of biomedicine, "far from a neutral background against which other cultures may be measured" (p. 1316). At times clinicians may forget that there are at least two individuals in each encounter, and that these two people bring their individual learned patterns of language and culture to the health care experience. Simply put, there are culturally defined belief systems of what constitutes illness, disease, health, and wellness that may or may not be consistent between patient and clinician during any given encounter. Home remedies, folk medicine, and traditional cultural practices to treat general illnesses and common eye conditions may be prevalent in different segments of the population. Understanding who we are and the cultures of our patients and the communities we serve will aid us in providing care that is respectful, compassionate, effective, and of high quality.

The Link Between Culture and Quality

How then does one define quality of care? In 2001, the Institute of Medicine (IOM) published a report titled, "Crossing the Quality Chasm". This report highlights the divide between the quality of health care people receive and the quality of care they need.[11] Quality of care is more than simply delivering the recommended standard of care based on scientific evidence. The IOM states that health care should be easy to navigate, safe, accessible, and responsive to the needs of the individual patient. This means that health care must be able to respond to culture of individual patients, their families, and the communities in which they live. The IOM further defines quality of care in five dimensions: safety, effectiveness, patient-centeredness, timeliness and efficiency, and equity. (IOM Quality chasm, see table 1). The cultures of the patient, clinician, and the health care system converge and must be adjusted for in order to address the inherent cultural differences on the five dimensions of quality. In 2002, the IOM released a land mark report, "Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care", which cited conclusive evidence that minorities often receive lower quality of care than their white counter parts even when health insurance, social economic status (SES), comorbidities, and stage of presentation have been adjusted for.[12] The IOM's report forced the health care system to confront the startling reality that race, ethnicity, and culture play a pivotal role in quality of care, and that these disparities are unacceptable and must be addressed with a sense of urgency.

The Role of Cultural and Linguistic Competence in Quality of Care

Numerous reasons justify the need for cultural competence at the patient-provider level. The following reasons, adapted from Goode & Dunne specifically for optometry or optometrists, include but are not limited to:

1. the perception of illness and disease and their causes vary by culture;
2. diverse belief systems exist and related to physical and mental health (including vision health), healing, and well-being;
3. culture influences help-seeking behaviors and attitudes toward health care providers;
4. individual preferences affect traditional and other approaches to eye care;
5. patients must overcome personal experiences of biases within the health care systems; and
6. primary care providers, including optometrists, from culturally and linguistically diverse groups are under-represented in current service delivery systems.[13]

To be culturally competent, both optometrists and their practices need to be conscious and deliberate in ways to make this a reality in their daily work. Cultural competency is a journey of discovery and reflection that evolves over an extended period of time. It is not a flavor of the month. This journey requires cultural awareness, the acquisition of knowledge, and the development of skill sets. In order to provide culturally competent care both individuals (providers and support staff) and the health care delivery system must be committed to journey.

Cultural and linguistic competence: Definitions and frameworks

Cultural Competence Defined

There are many definitions of cultural competence. It is important for us as health care professionals to conceptualize, understand, and accept this term within the context of our journey in becoming culturally competent optometrists. Cross, Bazron, Dennis, and Issacs define cultural competence as “a set of congruent behaviors, attitudes, and policies that come together in system, agency, or amongst professionals that enables that system, agency, or those professionals to work effectively in cross-cultural situations.”[14]

Cultural competence requires that organizations:

- Have a congruent, defined set of values and principles, and demonstrate behaviors, attitudes, policies, and structures that enable them to work effectively cross-culturally;
- Have the capacity to (1) value diversity, (2) conduct self-assessment, (3) manage the dynamics of difference, (4) acquire and institutionalize cultural knowledge, and (5) adapt to the diversity and cultural contexts of communities they serve; and

- Incorporate the above into all aspects of policymaking, administration, practice, and service delivery and systematically involve consumers, key stakeholders and communities.

Cultural competence is a developmental process that evolves over an extended period of time. Individuals, organizations, and systems are at various levels of awareness, knowledge and skills along the cultural competence continuum.

Another definition is by Mutha, Allen, and Welch who define cultural competence as "a set of skills, knowledge, and attitudes which enhances a clinician's understanding of and respect for patients' values, beliefs and expectations; awareness of one's assumptions and value system in addition to those of the US medical system; and ability to adapt care to be congruent with the patient's expectations and preference."[15] Finally the Office of Minority Health defines cultural competence as "the ability of health organizations and practitioners to recognize the cultural beliefs, attitudes, and health practices of diverse populations and to apply that knowledge in every intervention – at the *systems* level or at the *individual* level – to produce a positive health outcome."[16] The common threads to all these definitions are respecting patients, valuing their culture, acquiring knowledge and skills, and institutional commitment and capacity. .

In addition to looking inward, there should be time spent on examining our environment. As a profession that seeks to prevent vision loss, heal vision threatening diseases and conditions, improve visual function, and provide rehabilitation for those who have vision loss, do our practices demonstrate an understanding of vision loss? Is our staff trained to understand blindness and the cultural implications of this disability? Are our materials offered in large print? Does our physical environment account for the importance of lighting and contrast? Do we offer interpretation services (in languages other than English and in sign language)? Do we screen our educational materials for cultural biases? Does our office décor reflect the communities we serve? Are we welcoming to all cultures? These subtle messages communicate our values and our commitment to the communities we serve.

Cultural competence is not an easy journey and requires the time and commitment of individuals and organizations to be aware and honest with themselves to address internal biases along with an openness and respect to appreciate and adapt to cultural differences. Cultural competence is beyond simply increasing the diversity of optometric providers because diversity alone does not guarantee that the optometric workforce is able to respond appropriately to the health care needs and preferences of a multicultural society. A diverse *and* culturally competent optometric workforce is a prerequisite to respond to the current and emergent U.S. demographic trends, to address racial and ethnic health care disparities, and to provide care that is of high quality and equitable. A diverse and culturally competent workforce fosters a work environment that is inclusive of all groups, maximizes the potential of all employees, and values the variety of perspectives all employees bring to the workplace at all levels of the organization.[17]

There is no one method for getting started on the journey towards cultural and linguistic competence at either the individual or organizational level. Organizations may embark on this journey at different points of departure with different estimated times of arrival for achieving specific goals and outcomes. Health care organizations,

including those that provide optometric care, are at various stages along the cultural competence continuum. Similarly their personnel have different levels of awareness, knowledge, and skills related to cultural and linguistic competence. Few health care organizations have evolved to a degree of proficiency in which cultural and linguistic competence is infused at the levels of policy, administration, practice and service delivery, and patient/family and community engagement.[18]

Cultural Competence Continuum [14]

Cultural destructiveness is characterized by attitudes, policies, structures, and practices within a system or organization that are destructive to a cultural group.
Cultural incapacity is the lack of capacity of systems and organizations to respond effectively to the needs, interests and preferences of culturally and linguistically diverse groups.
Cultural blindness is an expressed philosophy of viewing and treating all people as the same.
Cultural pre-competence is a level of awareness within systems or organizations of their strengths and areas for growth to respond effectively to culturally and linguistically diverse populations.
Cultural Competence is a level where systems and organizations demonstrate an acceptance and respect for cultural differences and create mission statements, policies, procedures, structures, and systems to meet the needs of the communities in which they serve.
Cultural Proficient is a level where agencies seek to add to the knowledge of culturally competent practice through research, new therapeutic approaches to care and to publish and disseminate the results of demonstration projects.

Linguistic Competence Defined

In 2001, the Department of Health and Human Services' Office of Minority Health (OMH) published the National Standards on Culturally and Linguistically Appropriate Services, commonly referred to as the CLAS standards.[16] These 14 standards are primarily directed at health care organizations to provide structure to what constitutes culturally competent and linguistically appropriate care. The 14 standards (see Table 2) are organized by themes: Culturally Competent Care, Language Access Services, and Organizational Supports for Cultural Competence. Within this framework, there are three types of standards of varying stringency. CLAS guidelines are current Federal requirements for all recipients of Federal funds. CLAS guidelines are activities recommended by OMH for adoption by Federal, State, and national accrediting agencies. CLAS recommendations are suggested by OMH for voluntary adoption by health care organizations.

This chapter proffers a definition of linguistic competence that extends beyond language access services and addresses a broader constellation of communication issues, needs, and preferences within health care organizations and systems. Linguistic Competence is defined as 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 persons of limited English proficiency (LEP), those who have low literacy skills or are not literate, and individuals with disabilities. Linguistic competency requires organizational and provider capacity to respond effectively to the health literacy needs of populations served. The organization must have policy, structures, practices, procedures and dedicated resources to support this capacity.[19]

Interpretation services should be provided by someone who is trained in order to ensure quality of care. Often times, immigrant families use family or children to address the barriers of language and often more miscommunication and poor quality of care is the outcome. Language access services, health literacy, and the provision of alternative communication for individuals with disabilities improves care. Improved communication has a potential to improve the capacity of health care providers to make accurate diagnosis, prevent patients form exposure to unnecessary risks from diagnostic procedures, enable providers to truly obtain informed consent and allow patients to participate in clinical decision making.

Case 1.

B.L. is a 55 year old Native American man, who speaks English fluently and lives in New Mexico, is diagnosed with glaucoma and medical treatment is initiated with Xalatan ophthalmic solution, 1 drop each eye before bedtime. At the appointment, he acknowledged his understanding of this chronic disease and understood the treatment plan. At his 1 month follow-up, the optometrist discovered B.L. has not taken his glaucoma medication and he had sought a second opinion with the medicine man. The medicine man told B.L. that he does not have glaucoma and does not need to be treated. The optometrist is flabbergasted and cannot believe how this man who appears to be acculturated in American culture would believe in such “hocus pocus”.

What can be done to bridge the divide between the optometrist and his patient so that B.L. will receive the care he needs? The optometrist consults with B.L.’s primary care doctor and learns about the concept cultural brokering and refers the optometrist to a cultural broker. A cultural broker is a person who understands western medicine and in this case the ways of the medicine man. B.L. and the optometrist, along with the cultural broker, were able to address B.L.’s fears and create an atmosphere to manage and treat his glaucoma.

Case 2.

Language issues are also important with patients who speak English. In a community health center clinic, an optometrist experiences the complex problems of language, even with 2nd generation immigrant American adolescents who are bilingual. The optometrist, a monolingual English speaker, related the example of a 14 year old Asian

girl who presented to the eye clinic because of a failed vision screening. During the case history when the social history was addressed, the optometrist was shaking because of the response to the question of drug use was asked. The optometrist asked about cocaine and the teenager said no and then stated, “My mother does the cocaine.” First, the optometrist said, “Oh my god!!” And proceeded to ask her to explain the cocaine use in more detail. The Asian girl replied, "Yes, my mommy does the cooking, she cook rice, she cook noodles, she cook all the food in the house."

The optometrist was relieved and learned a valuable lesson -- the importance of language perception and what we take for granted when we are talking to people. This can happen to anyone, not only from a person who is bilingual and affects both the provider and the patient.

Conclusion

Cultural and linguistic competency are widely recognized as fundamental aspects of quality in health care and mental health care – particularly for diverse patient populations, and as essential strategies for reducing disparities by improving access, utilization, and quality of care.[9] Cultural competency has been recognized as a viable way to improve the quality of care and to eliminate racial health disparities in the U.S. Many national organizations have followed the lead of the Office of Minority Health. In 2006, the National Center for Quality Assurance (NCQA) developed the “Recognizing Innovation in Multicultural Health Care” awards program [20] as a forum for shared learning to explore strategies to tie cultural competence into existing quality improvement efforts. In addition, the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) and the Center for Medicare and Medicaid Services (CMS) have introduced policy level approaches to cultural competency and are involved with the national Quality Forum to develop a comprehensive framework and preferred practices for measuring and reporting cultural competency.

Optometry is a vital part of health care and as a primary health care profession; we have an opportunity to help improve the delivery of health care by providing care in a culturally and linguistically appropriate manner. This can only be accomplish when individuals and optometric practices are committed to change through self assessment, policies, learning processes and structures by which organizations and individuals develop and support attitudes, behaviors, practices and systems that are needed for effective cross-cultural interactions. When these changes occur, our patients benefit, quality of care improves, and health disparities will be eliminated.

STUDY QUESTIONS

1. Define culture and cultural competence in your own words.
2. List all the cultures you identify with? Do your patients belong to more than one culture? How does this impact the way you deliver care?
3. Why is language perception and access important in the delivery of care?
4. What are some next steps for you to begin your journey to cultural and linguistic competence?

Table 1: IOM's definition of quality of care [11]

IOM – quality of care

1. Safety: it is not simply protecting the patient from medical errors or infections from procedures. It includes avoiding misdiagnosis, preventing patients from exposure to unnecessary risks, and ensuring informed consent.
2. Effectiveness: to use evidence based guidelines but to integrate best research evidence with clinical expertise and patient values. Systems need to be in place to detect health disparities by stratifying measures by race/ethnicity and age, etc. Providers to have ability to ascertain patient preferences and values is a clear component of effectiveness.
3. Patient-centeredness: compassion, empathy, and responsiveness to the needs, values, and expressed preferences of the individual patient.
4. timeliness and efficiency: timely system to prevent patients from experiencing harmful delays in receipt of necessary services and a efficient system avoids quality and administrative waste. Language barriers may contribute to longer hospital stays, longer waits in Emergency department.
5. Equity: system that provides high quality of care that does not vary because of personal characteristics such as gender, ethnicity, geographic location, and SES. System should monitor by stratifying data.

Table 2: CLAS Standards [16]

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

Standard 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.

Standard 3
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.

Standard 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 limited English proficiency at all points of contact, in a timely manner during all hours of operation.

Standard 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.

Standard 6
Health care organizations must assure 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).

Standard 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.

Standard 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 culturally and linguistically appropriate services.

Standard 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.

Standard 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.

Standard 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.

Standard 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.

Standard 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.

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

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Appendix – Web Resources

ASSESSMENT (INDIVIDUAL)

1. **Cultural Competence Health Practitioner Assessment (CCHPA)** http://www11.georgetown.edu/research/gucchd/nccc/features/CCHPA.html

ASSESSMENT (ORGANIZATION)

1. US Department of Health and Human Resources. Health Resources and Services Administration (HRSA). (2001) **Health Resources and Services Administration Study On Measuring Cultural Competence in Health Care Delivery Settings.** http://www.hrsa.gov/culturalcompetence/measures/default.htm

2. Association of American Medical Colleges. **Tool for Assessing Cultural Competence Training.** http://www.aamc.org/meded/tacct/start.htm

COMMUNICATION

1. **Defining cultural competence: a practical framework for addressing racial/ethnic disparities in health and health care. Betancourt JR, Green AR, Carrillo JE, Ananeh-Firempong O 2nd. Public Health Rep. 2003 Jul-Aug;118(4):293-302.** http://www.pubmedcentral.nih.gov/articlerender.fcgi?tool=pubmed&pubmedid=12815076

CULTURE BROKERING

1. **Bridging the Cultural Divide in Health Care Settings: the Essential Role of Cultural Brokers.** http://www11.georgetown.edu/research/gucchd/nccc/documents/Cultural_Broker_Guide_English.pdf
   NCCC developed 29 page tool "to encourage the use of cultural brokering as a key approach to increasing access to, and enhancing the delivery of, culturally competent care." Definitions, history, skills needed, implementing and sustaining programs; overall website http://www.culturalbroker.info/

CULTURAL COMPENTENCY OVERVIEW

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2. **Office of Minority Health; National Standards on Culturally and Linguistically Appropriate Services** (CLAS) (3) http://www.omhrc.gov/templates/browse.aspx?lvl=2&lvlID=15

3. **Office of Minority Health: Cultural Competency Tab** http://www.omhrc.gov/templates/browse.aspx?lvl=1&lvlID=3
   Includes pages on "What Is Cultural Competency?" "Guides and Resources", "National Standards", "Organizations and Programs", "Policies, Initiatives and Laws", "Training Tools for Physicians and Others"

4. US Department of Health and Human Resources. Office of Minority Health. **Physicians Practical Guide to Culturally Competent Care** https://cccm.thinkculturalhealth.org/

5. American Medical Student Association. **Cultural Competency in Medicine.** http://www.amsa.org/programs/gpit/cultural.cfm
   Topics included are from a student's point of view: What does it mean to be culturally competent? How do physicians-in-training perform a cultural assessment? Isn't being a good physician enough to treat everyone? The patient doesn't speak English, now what?

6. Management Science for Health Sciences. **Providers Guide to Quality and Culture: Culturally Competent Organizations.** http://erc.msh.org/mainpage.cfm?file=9.1.htm&module=provider&language=English
   Tutorial on organizational competency.

7. National Center for Cultural Competency. NCCC **Curricula Enhancement Module Series** -- http://www.nccccurricula.info/overview/A2.html

8. California Endowment. **A Manager's Guide to Cultural Competence Education for Health Care Professionals.** http://www.calendow.org/uploadedfiles/managers_guide_cultural_competence%281%29.pdf
   Includes topics such as "what is cultural competency", "why do health care professionals need to be trained in cultural competency?" and more.

EDUCATION

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FURTHER BACKGROUND READING

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2. **IOM Report Crossing the Quality Chasm.** http://www.iom.edu/Object.File/Master/27/184/Chasm-8pager.pdf

3. **IOM Report Unequal treatment: What healthcare providers need to know about racial and ethnic disparities in health-care.** http://www.iom.edu/Object.File/Master/4/175/Disparitieshcproviders8pgFINAL.pdf

LANGUAGE ACCESS

1. Website of the **Federal Interagency Working Group on Limited English Proficiency** http://www.lep.gov/index.htm.

2. US Dept of Justice. Civil Rights Department. Executive Order 13166: **Improving Access to Services for Persons with Limited English Proficiency** http://www.usdoj.gov/crt/cor/13166.php

3. **Office of Minority Health; National Standards on Culturally and Linguistically Appropriate Services** (CLAS) http://www.omhrc.gov/templates/browse.aspx?lvl=2&lvlID=15

4. International Medical Interpreters Association. **Standards of Practice.** http://www.imiaweb.org/standards/standards.asp

5. **Hablamos Juntos. Language policy and practice in health care.** http://www.hablamosjuntos.org/
   *Includes many documents on "**Signs that Work**", "**Interpreter Services**" "**More than Words**". All documents deal with how to improve services primarily for Spanish speakers but applicable to many. One sample is "**Five Steps to Improving Communications with LEP Populations"** http://www.hablamosjuntos.org/mtw/html_toolkit/pdf/toolkit2_finlo-zamoedits_r4_PROOF.pdf. There are many more of these.*

6. **Language Barriers in Health Care Settings: An Annotated Bibliography of the Research Literature ,** 2003.
   http://www.hablamosjuntos.org/pdf_files/cal.endow.bibliography.pdf

7. **Linguistic Competence in Primary Health Care Delivery Systems: Implications for Policy Makers**
   http://www11.georgetown.edu/research/gucchd/nccc/documents/Policy_Brief_2_2003.pdf

8. **A Patient-Centered Guide to Implementing Language Access Services in Healthcare Organizations --**
   http://www.omhrc.gov/templates/content.aspx?ID=4375&lvl=2&lvlID=107

9. US Department of Health and Human Resources. Office of Minority Health. **Health Care Language Services Implementation Guide**
   https://hclsig.thinkculturalhealth.org/user/home.rails

10. **The Access Project** http://www.accessproject.org/new/pages/publications2008.php
    *The Access Project has produced a number of informational guides on topics of interest to community health organizations. These publications address issues of local health policy and organizational strategies. One topic of publications is **Language Access.** Most are linked PDFs.*

11. **Addressing Language Access Issues in Your Practice: A Toolkit for Physicians and Their Staff Members** --
    http://www.calendow.org/uploadedFiles/language_access_issues.pdf

LAWS, LEGISLATION

1. **Civil Rights Act of 1964 --** http://www.usdoj.gov/crt/cor/coord/titlevi.php

2. **Office of Minority Health: Cultural Competency Tab** --
   http://www.omhrc.gov/templates/browse.aspx?lvl=2&lvlID=14

RESOURCE LINKS

1. **National Center for Cultural Competence.** http://www11.georgetown.edu/research/gucchd/nccc/

2. US Department of Health and Human Resources. Health Resources and Services Administration (HRSA). **Cultural Competence Resources for Health Care Providers** http://www.hrsa.gov/culturalcompetence/

3. **Cultural Competence Resources - Health Sciences Library, University Libraries, University at Buffalo.** http://libweb.lib.buffalo.edu/dokuwiki/hslwiki/doku.php?id=cultural_competence_resources

4. **Multi-Cultural Resources for Health Information.** http://sis.nlm.nih.gov/outreach/multicultural.html

TUTORIALS

1. National Center for Cultural Competency. NCCC **Curricula Enhancement Module Series** -- http://www.nccccurricula.info/overview/A2.html

2. US Department of Health and Human Resources. Office of Minority Health. **Physicians Practical Guide to Culturally Competent Care** https://cccm.thinkculturalhealth.org/

3. US Department of Health and Human Resources. Office of Minority Health. **Health Care Language Services Implementation Guide** https://hclsig.thinkculturalhealth.org/user/home.rails

4. Management Science for Health Sciences. **Providers Guide to Quality and Culture: Culturally Competent Organizations.** http://erc.msh.org/mainpage.cfm?file=9.1.htm&module=provider&language=English