



Cultural Competence and HRSA

Cultural Competence Umbrella

Barriers

HRSA Facilitating Cultural Competence

## CULTURALLY COMPETENT CARE

*To be culturally competent doesn't mean you are an authority in the values and beliefs of every culture. What it means is that you hold a deep respect for cultural differences and are eager to learn, and are willing to accept, that there are many ways of viewing the world.*

—C. Galbraith<sup>1</sup>

Janice Brown,\* a 42-year old African-American woman, has called Upper Northwest Washington, D.C., home her entire life. Until 2 years ago, she worked as an administrative assistant at a large corporation. After 20 years of service, she was laid off, losing her pension, her health insurance, and her home. She is extremely close to her family and lives with one of her adult sons and his family in the same building where her mother lives. Despite her economic troubles, Janice describes her life following the layoff as relatively normal—until she caught a cold that would not go away. She soon became worried; a family friend had told her a few months ago that an old boyfriend had died suddenly of “cancer”—which she knew was sometimes code for AIDS. Janice put off getting care until she started having trouble breathing. A family friend rushed Janice to the local emergency room, where a doctor noticed she had thrush and encouraged Janice to have an HIV test. A few

\*Janice's story is a vignette based on multiple interviews with women living with HIV disease.

## DID YOU KNOW?

- The Ryan White HIV/AIDS Program addressed the need to create a culturally competent system of care for people living with HIV/AIDS that did not previously exist.
- You can read about the Health Resources and Services Administration's approach to, and history of, culturally competent care here: [www.hab.hrsa.gov/livinghistory/issues/competency\\_1.htm](http://www.hab.hrsa.gov/livinghistory/issues/competency_1.htm).
- True cultural competence includes linguistic competency and health literacy.



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Since the early days of the HIV epidemic one fact has remained fundamental to the Ryan White HIV/AIDS Program's approach to helping people living with HIV/AIDS (PLWHA): The best care must be rooted in a culturally competent approach. Indeed, it was the lack of culturally competent care available for disenfranchised PLWHA within the health care system at large that gave rise to the Ryan White HIV/AIDS Program to fill this need.

For patients and providers to understand one another, they must be culturally and linguistically in sync. This may simply mean providing translation services to bridge a language barrier or it may be as involved as creating an atmosphere of acceptance and safety for someone who has never felt at home or taken care of. At its core, cultural competence means understanding the uniqueness of each population—and each individual—affected by HIV/AIDS and the challenges that are specific to them.

Although there are, of course, trends among particular populations, each person is a kaleidoscope of all of his or her experiences leading up to engagement in care and everything that occurs thereafter.

This *HRSA CAREAction* newsletter focuses on the ways in which HRSA is staying true to our early guiding mission. We are providing translation services and programs to improve and foster health literacy, and we are training outreach workers to speak the language of the communities in which they work. And, more recently, our Special Projects of National Significance program has launched *IHIP*, Integrating HIV Innovative Practices, complete with training manuals, curricula, webinars, and an online community to foster learning, creativity, and best practices. Together, all of these steps create a stronger safety net, healthier communities, and more informed providers.

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Prepared for HRSA/HAB by Impact Marketing + Communications

#### **Photographs**

Cover: AIDS Service Center representatives. New York, NY

Copies are available to be downloaded at [www.hab.hrsa.gov](http://www.hab.hrsa.gov).

This publication lists non-Federal resources to provide additional information to consumers. The views and content in those resources have not been formally approved by the U.S. Department of Health and Human Services (HHS). Listing of the resources is not an endorsement by HHS or its components.

days later, she was dually diagnosed with HIV and AIDS. Janice says, "A nurse referred me to a local clinic for HIV-positive women. I didn't want to go. I was afraid someone might see me and tell my family. But I had to take a chance. I was feeling terrible and fearful of dying and leaving my family alone."

To her surprise, the women's clinic, located in an unmarked building on a side street, soon became a respite for Janice, who has yet to tell anyone about her diagnosis. "The clinic understands that not everyone wants to advertise their business," she says. "Anyone who might see will just think I'm going to the nearby supermarket. Once I'm inside, I feel like I'm home. I don't have to hide."

Janice goes in early for her appointments so she can sit in the waiting room with its overstuffed couches, magazines, and modest coffee station. Colorful artwork, much of it made by patients, lines the walls. Staff members greet clients as if they are family.

Janice says her provider understands that delivering HIV/AIDS care involves more than medicine and lab reports. "My case manager and doctor care about me as a person. They listen to me and don't judge me for asking what I think are stupid questions about my medications and appointments," she says. "They understand from personal experience what it means to be an African-American woman and why it is hard for me to tell my family about my illness. I know my family will wonder what I did wrong—because I used to think that way about people with AIDS."

### **CULTURAL COMPETENCE AND HRSA**

The Health Resources and Services Administration's (HRSA's) vision of "Healthy Communities, Healthy People" ([www.hrsa.gov/about/strategic\\_plan.html](http://www.hrsa.gov/about/strategic_plan.html)) offers a framework that supports the provision of high-quality comprehensive health care that is characterized by sensitivity and effective communication. HRSA recognizes that no single approach or solution exists to achieving the goal of eliminating disparities in health outcomes and providing truly culturally competent and linguistically appropriate care. According to HRSA's *Guiding Principles for Cultural Competency*,

Cultural differences between providers and clients affect the provider-client

relationship. How clients feel about the quality of that relationship is directly linked to client satisfaction, adherence, and subsequent health outcomes. If the cultural differences between clients and providers are not recognized, explored, and reflected in the medical encounter, client health outcomes may suffer.<sup>2</sup>

Because most jurisdictions in the United States are dynamic and becoming ever more diverse, HRSA grantees will continue to need health care communication learning opportunities.<sup>3</sup>

Health care providers and institutions funded through HRSA grants and cooperative agreements to train health care workers should be aware of cross-cultural and language-appropriate communications, as well as general health literacy issues. HRSA continues to support and promote a unified health communication perspective.<sup>3</sup>

### THE CULTURAL COMPETENCE UMBRELLA

“Culture refers to integrated patterns of human behavior that include the language, thoughts, communications, actions, customs, beliefs, values, and institutions of racial, ethnic, religious, or social groups.”<sup>4</sup> *Cultural competence*, as it applies to the clinical setting, broadly refers to the ability to work effectively in cross-cultural situations.<sup>5</sup> Whereas culture “is a way of life that is shared between groups of people ... it also includes components that are unique to the individual.”<sup>6</sup>

Within the health care arena, cultural competence is viewed as a continuum rather than as a one-time goal, and involves a provider creating a clinical setting that puts clients at ease and encourages them to remain engaged in care. HRSA’s AIDS Education Training Centers (AETCs) National Resource Center’s *Guiding Principles for Cultural Competency* further defines cultural competence as a dynamic “two-way street” in which clinicians and patients “establish effective interpersonal and working relationships that supersede cultural differences.”<sup>7</sup>

Providers engaged in culturally competent care tailor their services to the individual, social, cultural, and linguistic needs of their patients. Cultural competence requires more than knowing a patients’ language or food preferences. Culturally competent HIV/AIDS care reflects an understanding of patients’ unique worldview, particularly as it relates to their perception of health, which may be reflective of their cultural background and norms, their health literacy, and their ability to access services.

For people living with HIV/AIDS (PLWHA) such as Janice—who learned she had HIV *and* AIDS while unemployed and without health insurance—culturally competent care from a Ryan White HIV/AIDS Program–funded clinic offers a much-needed door to life-saving HIV treatment and services. She feels she is treated “like a person,” which encourages her to remain engaged in care.<sup>8,9</sup> Indeed, patients like Janice describe their clinic as a second home—a safe space staffed by clinicians and support personnel who understand their patients’ social norms and the unique situations of the patients they serve.

Although linguistic competency often refers to meeting the needs of patients with limited English proficiency, it can also be understood as the need for clear patient-provider communication. For example, is the clinician able to speak in a manner easily understood by a patient? Can the clinician describe how to take a medication without using difficult scientific jargon?<sup>10</sup>

Creating environments where learning can occur is crucial to improving the health of both communities and individuals. *Health literacy* refers to the patient’s ability to use text, numbers, and general information to navigate the everyday world and manage his or her health.<sup>11</sup> This involves not only understanding how to follow the directions on a bottle of medication but also reading signs, maps, and transportation schedules to find the clinic.<sup>12,13</sup> The Institute of Medicine’s 2004 study, *A Prescription to End Confusion*, describes health literacy as “the degree to which individuals have the capacity to obtain, process, and understand basic health information and services needed to make appropriate health decisions.”<sup>14</sup>

A clinic that strives to implement cultural competence can strengthen its capacity not only to serve current patients but also to recruit new ones.<sup>15</sup> Cultural competence can be elusive, however, because, like HIV treatment itself, the expression and content of the culture, language, and literacy of PLWHA populations are constantly evolving. At the same time, the demographics of the AIDS epidemic continue to change. Thus, a clinic that in the 1990s served a predominantly immigrant population with limited English proficiency may now find itself serving the adult children of its original patients—a new generation most likely born in the United States and fluent in English. Providers must therefore continually revisit and refresh their skills in delivering culturally competent care to the PLWHA populations they serve. Lucy Bradley-Springer, primary investigator of the Mountain Plains AETC, says,

Knowing general cultural norms can help inform how you initially approach a patient . . . from their individual experience, not as a stereotype. You may become competent in one or a dozen areas over time; but you'll never become completely culturally competent. It is an ideal you're always striving for.

### **Increasing U.S. Diversity**

The United States is a linguistically and culturally diverse country that is becoming even more diverse with time. According to an April 2010 report by the U.S. Census Bureau, over the last 3 decades the U.S. population increased by 34 percent whereas the speaking of languages other than English at home rose by 140 percent. The Spanish language accounted for 23.4 million people.<sup>16</sup> People born in Asia, however, recently surpassed Hispanics/Latinos as the largest group of new immigrants, and only 53 percent of foreign-born Asian Americans say they speak English very well.<sup>17</sup>

Limited English literacy coupled with a lack of familiarity with the U.S. health care system can create challenges for patients trying to navigate an unfamiliar system, decrease utilization, and worsen health outcomes.

### **Diversity in the HIV/AIDS Community**

The cultural and ethnic diversity of the HIV/AIDS epidemic in the United States is well known. The vast majority of PLWHA today are members of historically underserved and marginalized populations, most notably racial and ethnic minorities. These groups account for nearly 70 percent of the approximately 50,000 new HIV cases diagnosed every year in the United States, and for well over half of all PLWHA.<sup>18,19</sup>

African-Americans are most affected by HIV/AIDS, followed by Hispanics/Latinos, Asians, Native Hawaiian/Pacific Islanders, and American Indian/Alaska Natives.<sup>20</sup> HIV has also had a particularly devastating impact on subpopulations that cut across these groups, including men who have sex with men (MSM), substance users—most particularly injection drug users (IDUs)—currently and formerly incarcerated persons, and transgender women.<sup>21,22,23</sup>

Geographic differences create different cultural norms and access-to-care issues. For example, the deep South has been hard hit by HIV/AIDS in recent years, whereas living in small communities may limit anonymity and increase the sense of stigma among PLWHA.

Individual characteristics of PLWHA as well as where and how they access care may vary.

Within groups of the same race or ethnicity, country of origin creates diversity in both norms and behavioral risk factors. Hispanic men born in Puerto Rico, for example, are more likely than other Hispanic men to contract HIV through IDU or high-risk heterosexual contact. By contrast, sexual contact with other men is the primary cause of HIV infection among Hispanic men born in Central or South America, Cuba, Mexico, and the United States.<sup>24</sup>

### **BARRIERS TO CULTURALLY COMPETENT CARE**

Research suggests that PLWHA have many socio-cultural environments<sup>25</sup> and multiple markers of potential marginalization. For example, HIV-positive

#### **CULTURE, LANGUAGE, AND LITERACY**

Sociolinguistics is the examination of language as it is used in society. Linguistic competency must take into consideration not only the population a person living with HIV/AIDS is from but also that person's unique individual needs. To be most effective, providers must speak the "language" of their patients and recognize that "language" may mean many things to many people.

For example, outreach workers may need to understand the culture and slang of the drug-using community to best reach and communicate with their target audience. Youth-serving providers may need to understand social media terminology. Linguistic competency may mean translating materials into another language; however, translation alone may be insufficient: Are patients literate in their spoken language? Are the materials written at their health literacy level?

True cultural competence encompasses all of these components, as well as an awareness that each patient is a unique individual with his or her own subset of health care knowledge and life experiences, requiring a tailored approach.

African-American MSM may experience multifaceted and devastating layers of prejudice, including racism, homophobia, and HIV stigma, from a variety of actors, including not only strangers but also their families, friends, communities, and the staff where they access care.<sup>26,27</sup> Clinicians, who often have little time to meet with patients,<sup>28</sup> may reduce them to stereotypes on the basis of preconceived notions about a patient's community.<sup>29,30</sup> These attitudes can result in challenging patient-provider communication. Internalization of such negative health care experiences may prompt PLWHA to drop out of care.<sup>31,32,33,34</sup>

Eliminating disparities in health outcomes in which culture and language play a crucial role remains a challenge; because the problem has no single cause, no single solution exists.<sup>7</sup> Additionally, although African-Americans and Hispanics are overrepresented among PLWHA, they are underrepresented in the physician and nursing workforce. The demand for multilingual and culturally competent providers will only increase as the Nation becomes more diverse. This challenge is not specific to HIV, however, but is true across disciplines, resulting in fierce competition for a limited number of talented minority providers.

### **RYAN WHITE HIV/AIDS PROGRAM PROVIDERS: CREATIVITY IN MEETING THE CHALLENGES OF CULTURAL COMPETENCE**

Programs that are truly culturally competent involve clients *and* community members in identifying community needs, assets, and barriers, and create appropriate program responses. Clients and community members all play an active role in needs assessment, program development, implementation, and evaluation. Some programs institutionalize this relationship by making people from the community voting members of their governing boards. Others use community advisory boards, client panels, task forces, or town meetings to ensure that they receive input and recommendations from clients and the community.

Programs should identify specific hiring qualifications and mandated training requirements relating to language, medical interpretation (i.e., translation), and cultural competence. Allocating budget and staff time for cultural competence training, review, and testing is useful. Many AETC sites have sought to establish a certain number of training sessions each year that focus on cultural competence or address it as one topic within a broader curriculum.

Ryan White HIV/AIDS Program providers have a deep history of training and hiring people who reflect the communities that their clinics serve. From the person at the front desk who checks clients in, to the health care navigator who helps them track appointments, to the doctor who assesses their health,<sup>35</sup> these staff members can be particularly helpful in securing patient buy-in and trust and in ensuring that patients see a familiar and friendly face when they come to the clinic. Clinics with limited resources for staff or that face recruitment challenges due to ongoing health care workforce shortages often have to find ways to fill personnel gaps. This may mean, for example, hiring a telephone interpretation service that specializes in clarifying health care information for PLWHA with limited English proficiency. Such a service can be facilitated by an empathetic administrative employee who, though not a member of the patient population, is able to build trust with clients. Strategies for building trust may include learning key phrases in the patients' language(s) and understanding and practicing social norm practices related to polite conversation, eye contact, or touch.

Strategies for institutionalizing cultural competence throughout the health care delivery system include

- ▶ Integrating cultural competence into strategic planning,
- ▶ Making staffing and activities for cultural competence an integral piece of a sustainable funding stream, and
- ▶ Designing cultural competence activities that are replicable (for both other cultural groups and other health care programs).

Staff within a provider facility can incorporate culturally appropriate practices into the structure of the facility itself. This may involve using subdued or nonexistent outside signage that maximizes patient confidentiality. Nonclinical seating areas may be created to provide comfortable, private spaces in which adult clients wait for services, and safe play areas for their children. Providers have also made efforts in recent years to shift to a "medical home" model, in which the entire spectrum of client services is provided under one roof or in close proximity, enabling clients to easily and conveniently access the particular services they need. Culturally competent approaches have been particularly helpful in retaining HIV patients in care. (See box, **10 Guiding Principles in Establishing Patient Centeredness and Equity in Health Care.**)

## HRSA'S ROLE IN FACILITATING THE DEVELOPMENT OF CULTURALLY COMPETENT HIV/AIDS CARE

HRSA has conducted extensive research related to cultural competence and developed a wealth of capacity-building resources and training sessions geared to helping Ryan White HIV/AIDS Program providers efficiently and effectively identify and implement culturally competent practices in their HIV/AIDS service delivery (see **Online Resources**); most of these resources can be found at HRSA's TARGET Center ([www.careacttarget.org/](http://www.careacttarget.org/)) and at the AIDS Education and Training Centers (AETCs) National Resource Center ([www.aidsetc.org/](http://www.aidsetc.org/)).

These materials predominantly draw from the AETCs National Resource Center's "core components" of cultural competence, which were set forth in the 2006 document *Guiding Principles for Cultural Competency*. In addition to outlining the tenets of culture and its variability over time, the document stresses that "culturally appropriate training materials and capacity-building programs for HIV minority and minority-serving providers should include an expanded view of cross-cultural competence and [of] issues that apply within and across cultures."<sup>7</sup>

Of particular note are HRSA's new Integrating HIV Innovations Practices (IHIP) education materials, which include training manuals, curricula, and webinars. These materials provide guidance on adapting and incorporating best practices that have been developed by Ryan White HIV/AIDS Program providers with support from the Special Projects of National Significance (SPNS) program. All of IHIP's capacity-building materials address the importance of cultural competence in adopting SPNS-supported practices within an agency's overall operations.

HRSA's training materials reflect the culturally and linguistically appropriate services (CLAS) standards set forth in 2001 by the Department of Health and Human Services Office of Minority Health (OMH).<sup>36</sup> Enhanced through interagency efforts and a national review in 2011, the CLAS standards (See box, **National Standards for CLAS**) outline the full spectrum of patient needs that health care professionals must consider when delivering care. They offer a particularly powerful framework for Ryan White HIV/AIDS Program providers, who deliver HIV care and services to members of underserved and marginalized populations, including racial and ethnic minorities, non-English speaking populations, and rural communities.<sup>37</sup> (See box, **National Standards for CLAS**.)

With the establishment of its Culture, Language, and Health Literacy Committee in August 2010, HRSA has continued to raise the bar in building the cultural-competence capacity of Ryan White and other HRSA program clinics. This group revisited notions of health literacy and cultural and linguistic competence as elements and indicators of effective provider-patient communication and revised the language in Policy Operations Memorandum (POM) 2007-01. This memorandum outlined HRSA's support for and promotion of unified health communication, which encompasses cultural and linguistic competence and health literacy. The committee also broadened the original POM language, enabling it to be adapted more readily in funding opportunity announcements and to inform evaluation or monitoring adherence to POM guidelines.<sup>3,37</sup>

HRSA has added major enhancements to its highly successful Web training continuing medical education (CME) course, *Effective Communication Tools for Healthcare Professionals* or ECTHP (formerly the *Unified Health Communication Course*). With feedback from the provider community, the course has been enhanced to include more specific ethno-cultural information as well as the most current health literacy, cultural, and linguistic competence references.

Ensuring that cultural competence is reflected across training disciplines continues to be at the forefront of planning efforts, HRSA has created the National Alliance for HIV Educational Workforce Development, which meets monthly, as does the Minority AIDS Initiative National Network Group. These groups work to increase access to, reduce disparities in, and improve the quality of HIV care and service through workforce development, education, and technical assistance.

## THE FUTURE OF THE RYAN WHITE HIV/AIDS PROGRAM AND CULTURAL COMPETENCE

Ryan White HIV/AIDS Program grantees' and providers' incorporation of culturally competent practices not only helps ensure that PLWHA receive the care they need but also advances the full implementation of the National HIV/AIDS Strategy (NHAS).<sup>38</sup> The NHAS outlines a roadmap to ultimately ending the HIV epidemic in the United States by *reducing the number of people who become infected with HIV; increasing access to care and improving health outcomes for PLWHA; and reducing HIV-related health disparities*.<sup>39,40,41</sup> The Ryan White HIV/



## 10 GUIDING PRINCIPLES IN ESTABLISHING PATIENT CENTEREDNESS AND EQUITY IN HEALTH CARE

1. Elicit the patient's views on illness and treatment practices to understand his or her health values, particular concerns, and expectations for care.
2. Assess the cultural norms, values, and customs that influence the patient's health-seeking behaviors, practices, and expectations for the physician-patient relationship.
3. Assess the patient's environmental context to determine what social experiences and resources may be affecting illness behaviors or health-seeking practices.
4. Identify a range of treatment goals for a given medical condition that can be mutually satisfactory and that take into account the patient's cultural health beliefs, practices, norms, customs, and traditions.
5. Identify the social and environmental factors that may interfere with adherence to treatment goals.
6. Work collaboratively with the patient to negotiate treatment plans that incorporate aspects of the biomedical model while integrating cultural concepts for treating illness that are familiar and important to the patient.
7. Develop communication skills that respect the patient's cultural norms, values, and language.
8. Use patient education strategies that take into consideration literacy, cultural appropriateness, and language concordance.
9. Acknowledge that personal, professional, and institutional factors can affect aspects of clinical decision-making that, in turn, may lead to disparities in care.
10. Take proactive steps to adapt institutional and system processes that support clinical practice aimed at delivering clinically appropriate and culturally responsive care.

Reprinted with minor modifications from: U. S. Department of Health and Human Services, Office of Minority Health. *Physician toolkit and curriculum: Resources to implement cross-cultural clinical practice guidelines for Medicaid practitioners*. March 2004. Available at <http://minorityhealth.hhs.gov/assets/pdf/checked/1/toolkit.pdf>.

AIDS Program plays a major role in delivering HIV care to hard-to-reach, underserved, and vulnerable PLWHA and is involved in unprecedented Federal interagency efforts to realize the NHAS goals.<sup>39</sup>

The culturally competent approaches employed by Ryan White HIV/AIDS Program providers promise to become even more effective and diverse as efforts related to the NHAS continue and as HRSA prepares for full implementation of the Patient Protection and Affordable Care Act (ACA; Public Law 111-148) in 2014. The ACA will bring more PLWHA into care, some for the first time. These patients will need care and attention that takes into account their unique worldviews and experiences. The law promises to help expand initiatives to

strengthen cultural competence training for all health care providers, including those supported through the Ryan White HIV/AIDS Program, and help ensure that all populations are treated equitably.

Ultimately, Ryan White HIV/AIDS Program providers "work best when they have a respect for their patients," says Kim Johnson, director of technical assistance, training, and treatment at the National Minority AIDS Council. Understanding the cultural and linguistic needs and health literacy of patients "should not be a sort of add-on or stand-alone, but [should be] inherent to your thinking and how you care for people."<sup>42</sup> This has been—and will continue to be—the hallmark of the Ryan White HIV/AIDS Program.

## NATIONAL STANDARDS FOR CLAS

### **Standard 1**

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

### **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, and 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 patients/consumers with limited English proficiency by interpreters and bilingual staff. Family and friends should not be used to provide interpretation services (except at the request of 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 activities related to culturally and linguistically appropriate services (CLAS) 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 use 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.

Reprinted with minor modifications from: U.S. Department of Health and Human Services, Office of Minority Health. *National standards for culturally and linguistically appropriate services in health care: Final report. 2001*. Available at: <http://minorityhealth.hhs.gov/assets/pdf/checked/finalreport.pdf>.

## ➔ ONLINE RESOURCES

### **Clear Communication: A NIH Health Literacy Initiative**

[www.nih.gov/clearcommunication](http://www.nih.gov/clearcommunication)

### **Cultural Competence and Multicultural Care Workgroup Training Exchange**

[www.aidsetc.org/aidsetc?page=cf-ccte-00](http://www.aidsetc.org/aidsetc?page=cf-ccte-00)

### **Cultural Competency Curriculum Modules**

<http://minorityhealth.hhs.gov/templates/browse.aspx?lvl=1&lvlid=3>

### **Cultural Competence Works: Using Cultural Competence to Improve the Quality of Health Care for Diverse Populations and Add Value to Managed Care Arrangements:**

<http://health-equity.pitt.edu/278/>

### **Culture, Language and Health Literacy**

[www.hrsa.gov/culturalcompetence](http://www.hrsa.gov/culturalcompetence)  
[www.hrsa.gov/culturalcompetence/research.html](http://www.hrsa.gov/culturalcompetence/research.html)

### **Effective Communication Tools for Healthcare Professionals (CME that has helped more than 20,000 health care professionals and students)**

[www.hrsa.gov/publichealth/healthliteracy](http://www.hrsa.gov/publichealth/healthliteracy)

### **Health Literacy for Public Health Professionals**

[www.cdc.gov/healthliteracy/GetTraining.html](http://www.cdc.gov/healthliteracy/GetTraining.html)

### **Health Literacy Online**

[www.health.gov/healthliteracyonline](http://www.health.gov/healthliteracyonline)

### **Mitigating health disparities through cultural competence, HRSA CAREAction Newsletter**

<ftp://ftp.hrsa.gov/hab/august2002.pdf>

### **National Standards for Culturally and Linguistically Appropriate Services in Health Care: Final Report**

<http://minorityhealth.hhs.gov/assets/pdf/checked/finalreport.pdf>

### **Plain Language.gov, Improving Communication from the Federal Government to the Public**

[www.plainlanguage.gov](http://www.plainlanguage.gov)

### **Think Cultural Health: Advancing Health Equity at Every Point of Contact**

[www.thinkculturalhealth.hhs.gov](http://www.thinkculturalhealth.hhs.gov)

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