Meets Learning Need Codes 1000, 1040, 6000, and 6010. To take the Continuing Professional Education quiz for this article, log in to ADA's Online Business Center at www.eatright.org/obc, click the "Journal Article Quiz" button, click "Additional Journal CPE Articles," and select this article's title from a list of available quizzes.

Moving Cultural Competency from Abstract to Act

This article is reprinted from the February 2010 issue of the Journal *(2010; 110:180-187).*

The buzz phrase "cultural competency" has made a splash in the scientific literature of late, with many organizations and authors emphasizing why it is important, analyzing the effectiveness of programs that teach it, and working to establish some uniformity in how it is defined. Variation lies even in whether to label cultural competence as a process, outcome, or skill (1).

Despite the good intentions of cultural competency proponents and educators to lead efforts toward eliminating disparities in health care and acknowledging patients as having multiple personal spheres of influence that affect their health care experience, some resistance—as well as skepticism and resentment—remain. Some individuals believe that cultural competence as a means to improve care is not rooted in scientific evidence (2,3).

Some objections to cultural competency programs are rooted in the assumption that they will teach cultural competency by way of providing certain groups' preferences alongside the disclaimer that these characteristics, in fact, may not be true of everyone within that group. But there is an inherent suggestion in this idea that "culture" pertains to race and ethnicity—an idea that most groups and institutions have rebuffed. Moreover, the suggestion of culture as a technical skill that can be mastered, by virtue of use of the term "competency," is viewed by some as reductionism of culture to merely encompassing ethnicity, nationality, and language—and exclusionary of other "inseparable" factors of culture, such as economic, political, religious, psychological, and biological conditions (4). It is generally accepted that cultural identity encompasses sex, age, nationality, language, religion, and other factors (5); Purnell (6), however, also includes secondary characteristics—educational status, socioeconomic status, occupation, political beliefs, urban vs rural residence, sexual orientation, and immigration status, among other factors—in his model of cultural competence.

Rather than identifying culture in the health care context as the day-to-day practices that inform health and health intervention outcomes among labeled groups, it is more valuable to note that "culture determines how a person defines health, recognizes illness, and seeks treatment," and acknowledge that "values about good health and disease prevention, care and treatment of the sick, whom to consult when ill, and the social roles between the client or patient and health care professionals" varies across cultural strata (7).

Cultural competence, thus, is composed of "specific cognitive, affective, and psychomotor skills that are necessary for the facilitation of cultural congruence between provider and patient" (1). Still, although there may be commonalities among patients born of the same cultural category, individual experience—which could very well be driven by cultural background—is the likely dominant force in how a patient views health care. For that reason, it is antithetical to view cultural competence as an end-result, because "an intention of eventual mastery is not possible" (1).

However, this view has not been adopted by all who promote the importance of cultural competency skills. Some view cultural competency programs simply as a means for charging extra money (8) or as an "industry that, among other activities, has been known to conduct patronizing racial sensitivity training for doctors" (9).

Because health care is rooted in science, a program geared toward an audience of health care practitioners must come with empirical evidence—and that is what much of the current literature is lacking. The emphasis in the literature has been on definition, rather than application (10). Despite the view that cultural competency cannot be "define[d] precisely enough to operationalize it in clinical training and best practices" (4), many cultural competency advocates are now attempting to move the discussion beyond the theoretical and into an action plan that uses theoretical frameworks and models to actually provide guidance on how to not just be aware of cultural competence and appreciate its importance but to *practice* it.

THERE IS STAKEHOLDER BUY-IN: NOW WHAT?

Of course, before cultural competency can be implemented in any successful capacity, buy-in of key stakeholders is essential. Some reports—such as those by Wu and Martinez (10) and Wilson-Stronks and Galvez (11)—are focusing on community engagement as necessary to realization of veritable culturally competent care. In fact, Wu and Martinez identify community

This article was written by ***Karen Stein,*** *MFA, a freelance writer in Querétaro, México. Stein is a former editor of the* Journal *and has also taught English and composition at the academic level. She currently runs a center for teaching English in México.*
doi: 10.1016/j.jada.2010.03.010

participation and feedback as the most critical factor, noting that although it can be a challenge to make it happen, "Meaningful community participation not only provides a health care organization with an understanding of its patients' needs, it also helps to allocate resources effectively and establishes a system to hold the organization accountable for providing quality services" (10). However, organizational integration (preventing chopping-block status of such programs when budget cuts are imminent and avoiding the appearance of "project-of-the-day" status), realistic goals, leadership support, and solid, ongoing training of staff and other participants in these programs are also necessary to realize implementation (10). Several case studies have demonstrated how cultural competency can be effectively integrated at the organizational level. Examples include the following (10):

- Race- and ethnicity-related data capture led to enhanced self-assessment of practice gaps and education in cultural norms improved staff's ability to address diversity in the National Initiative for Children's Healthcare Quality project.
- Organizational leadership at the L.A. Care Health Plan in Los Angeles, CA, was spurred to action by sustainability data presented as staff training worked at dispelling feelings of being burdened by more work.
- Community outreach workers were employed to market the services of Children's Hospitals and Clinics of Minnesota and a boost in the number of patients with limited English proficiency helped to make a business case for retaining cultural competency programs.
- Cultural competency training was integrated into all new-hire training and a newly contracted chief executive officer was hired partly based on a commitment to the standards of culturally and linguistically appropriate services at Woodhull Medical and Mental Health Center, Brooklyn, NY.

As noted in an October 2009 *Journal* article (12), the Joint Commission had begun to lay the groundwork for establishing a standard definition of what makes an organization or institution culturally competent. But standardized culturally competent care at the practitioner level could be a detriment to effective care because culture is a major force in "determin[ing] how a person defines health, recognizes illness, and seeks treatment" (7). Care that is customized to the individual's needs and preferences could yield more positive outcomes, but there is the perception that "the current health care workforce has not been adequately prepared or educated to care for or work with persons of the nonmajority culture in anything other than in a dominating, overseer type role" (1).

Thus, though many studies have generated helpful suggestions on how organizations and institutions might adopt cultural competency programs and policies, the literature mostly hasn't been addressing this crucial question: How is cultural competency put into action at the practitioner level?

In the most effective strategizing for the complex changes necessitated by implementation of cultural competency programming, "system stakeholders . . . develop a clear link between their ideas and the strategies they intend to put into place," as "the result of an idea is never separate from its source" (1).

SEEDS OF CHANGE

The theory of change, a defined set of steps to determine a group's path to reach a desired long-term goal, is a useful cognitive behavioral approach to addressing how best to incorporate cultural competency into organizational structures. The three categories of theory of change—recorded (conceptualization), expressed (operationalization, or converting a vague idea into a measurable concept), and active (implementation)—all speak to the basic requirements of cultural competency programs (1).

Models of health care delivery, as explained by Alexander (1), can be an effective means for designing a transition from theory to practice because they help participants in the change process to work toward the following:

- making sense of the relationships of the parts;
- opening the mindset of users;
- developing individuals and organizations;
- eliminating barriers to the desired outcome;
- leading the user in the direction of the preferred outcome; and
- self-examining by way of continually asking questions.

Models that have been established to address other health care concerns, as well as newly developed models, have been explored in the literature as potentially useful frameworks for following the principles of cultural competency at the practitioner level. For instance, the shifting perspective model, which has been exemplified as a useful tool for working with patients living with chronic illness, has also been identified as a cultural competence framework. In this model, "as the reality of the individual's experience and the personal and social context changes, the individual's perspectives shift in the degree to which difference is in the foreground or background," which is deemed neither right nor wrong (1). This model befits a cultural competency approach in that it recognizes that "the perception of reality, and not reality itself, is the essence of how people interpret and respond to their experiences" (1).

Because the recommendations for models in this context are relatively new, the efficacy and superiority of each is unknown at this time. However, commonalities do exist across the spectrum of models, most notably in the emphasis on communication, which has been established as a key variable in patient/client satisfaction (13).

MODELS OF CULTURAL COMPETENCY

The ETHNIC Model

The ETHNIC model* of culturally competent care represents explanation, treatment, healers, negotiation, intervention, and collaboration. This model is a practical paradigm for elucidating a patient's understanding of his or her illness and the treatment practices that are expected, and accepted, within that patient's culture, and determining treatment options as a collaborative, rather than imposed, process (14).

The ETHNIC model facilitates communication between provider and pa-

**The ETHNIC model was developed in 1997 by Steven J. Levin, MD; Robert C. Like, MD; and Jan E. Gottleib, MPH.*

tient by focusing on questions and conversations such as follows (14,15):

- *Explanation*
  - Why do you think you have these symptoms?
  - If you know other people with this condition, how are they addressing them?
  - What do your friends and family say about these symptoms?
  - Have you heard about these symptoms in the media, such as television or newspaper?
- *Treatment*
  - What kinds of medications or other remedies have you experimented with to treat your illness?
  - What sorts of foods and drinks do you consume or avoid to stay healthy or, specifically, to treat this illness?
  - What kind of treatment are you seeking from the practitioner?
- *Healers*
  - Have you sought advice about your illness from nontraditional (nonmedical) sources?
  - What did you like about this method of treatment?
- *Negotiation* (In this stage of the process, the practitioner should be collaborating with the patient to find treatment options that are mutually acceptable and incorporate the patient's beliefs.)
  - What changes do you expect to achieve with this treatment?
- *Intervention*
  - How do you feel about the treatment plan?
  - Which components of the treatment plan are you most concerned about?
- *Collaboration*
  - Here are the ways that other health care team members will help with the treatment plan.
  - Here are some community resources and some ways that your friends and family might help you with following the treatment plan.

The LEARN Model

The LEARN model[†] provides guidelines for circumventing communication barriers in the health care encounter. LEARN signifies the following (16):

- *Listen* with empathy and understanding of the patient's perception of the problem.
  - To discover the patient's illness and treatment perceptions and preferences during the patient interview, ask open-ended questions about what he or she thinks regarding the illness' cause, process, duration, and outcome, and the resources he or she has.
- *Explain* your perceptions of the problem.
  - For clients and patients who are unfamiliar with Western medicine, providing an explanation of the strategy for addressing a medical complaint could help to avoid misunderstandings.
- *Acknowledge* and discuss the differences and similarities.
  - In this step, conceptual reconciliation of the patient explanation and the clinician explanation regarding the causes, symptoms, and treatment for the illness is sought.
- *Recommend* treatment.
  - Recommendations for treatment should be rooted in the resolution achieved in the Acknowledge step of this process
- *Negotiate* agreement.
  - In partnership, the patient and practitioner should develop an agreed-upon treatment plan.

The BATHE Model

The BATHE model[‡] may be useful in providing a culturally competent environment to patients and clients because it focuses on extracting a psychosocial context for the patient's visit.

The BATHE model incorporates the following tenets of patient concerns and patient-provider communication (15):

- *Background:* Educes the reason for patient visit.
  - What is going on in your life?
- *Affect:* Provides patient the opportunity to report on how he or she feels about the problem.
  - How have you been feeling about what is going on?
- *Trouble:* Provides focus to visit while extracting the significance of the problem to the patient.
  - What about the situation concerns you most?
- *Handling:* Facilitates discovery of what patient has been doing and can inform a course for intervention.
  - Before now, what have you been doing to address these problems?
- *Empathy:* Provides support by legitimizing patient's response to the problem.
  - This must be difficult for you.

The GREET Model

The GREET model,[§] which is specifically for non-native patients, and thus is appropriate for working with immigrant populations, helps practitioners "understand the context of the patient" and how that patient comprehends the information regarding his or her illness and its management (17):

- *Generation:* How acculturated is the patient?
- *Reason:* Why did the patient immigrate?
- *Extended family:* Has acculturation been affected by family?
- *Ethnic behavior:* Traditional language, clothing, and rituals may be indicative of the degree of adjustment to US culture.
- *Time living in the United States:* Amount of time living in the country may suggest lower acclimation.

Purnell Model for Cultural Competence

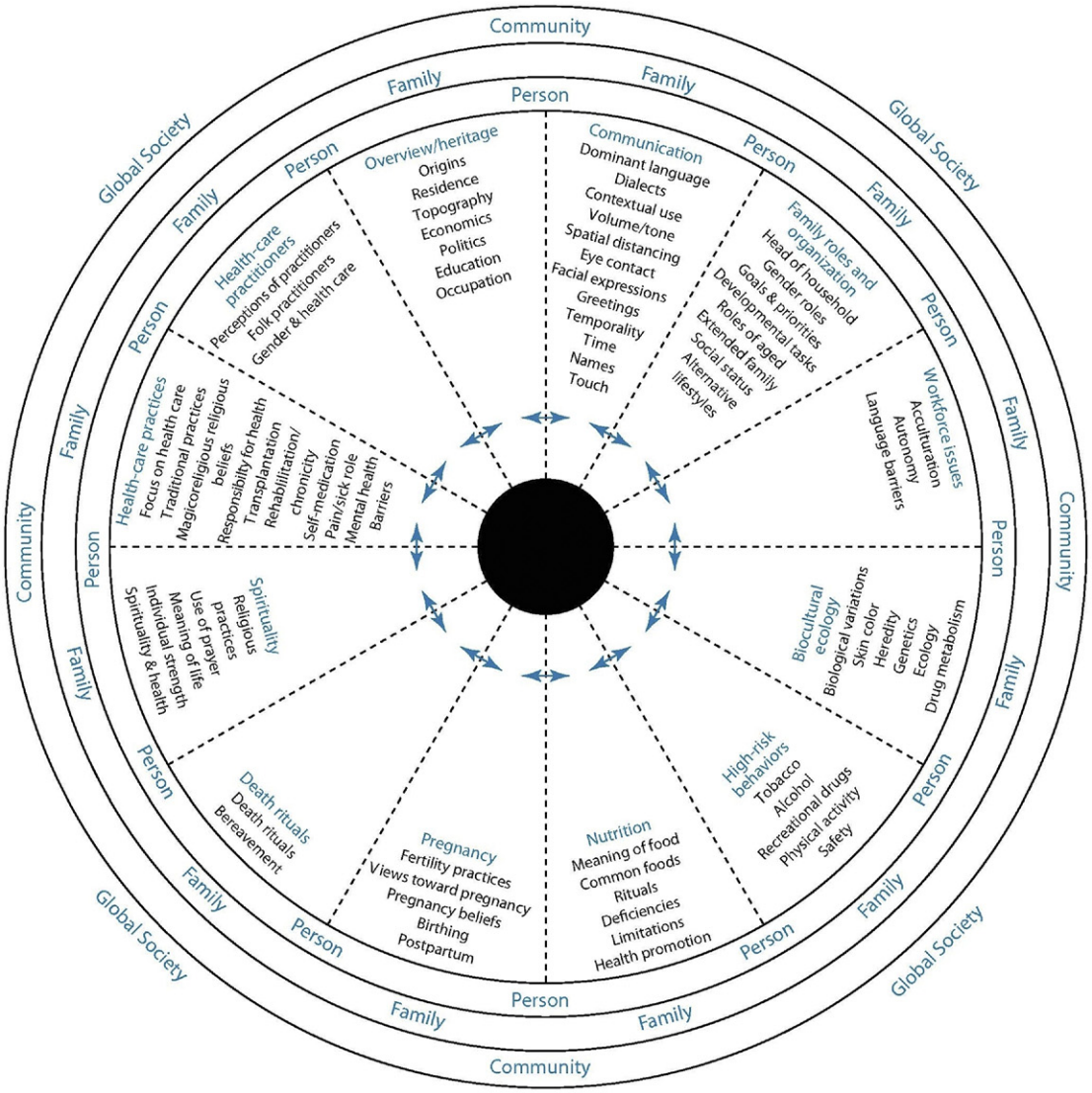
The Purnell model[‖] (Figure) is derived from multiple theories, including com-

†*The LEARN model was developed in 1983 by Elois Ann Berlin and William C. Fowlkes, Jr. See reference (16).*

‡*The BATHE model was developed by Marian Stuart, PhD, and Joseph A. Lieberman, III, MD, MPH, and published in* The Fifteen Minute Hour: Practical Therapeutic Interventions in Primary Care *(2002).*

§*The GREET model was presented by Nilda Chong, MD, PhD, MPH, director of Kaiser Permanente's Institute for Culturally Competent Care, in* The Latino Patient: A Cultural Guide for Health Care Providers *(2002).*

‖*The Purnell model was developed by Larry Purnell, PhD, RN, FAAN. See reference (6).*



Primary characteristics of culture: age, generation, nationality, race, color, gender, religion

Secondary characteristics of culture: educational status, socioeconomic status, occupation, military status, political beliefs, urban versus rural residence, enclave identity, marital status, parental status, physical characteristics, sexual orientation, gender issues, and reason for migration (sojourner, immigrant, undocumented status)

Unconsciously incompetent: not being aware that one is lacking knowledge about another culture
Consciously incompetent: being aware that one is lacking knowledge about another culture
Consciously competent: learning about the client's culture, verifying generalizations about the client's culture, and providing culturally specific interventions
Unconsciously competent: automatically providing culturally congruent care to clients of diverse cultures

Model created by Larry D. Purnell, PhD, RN, FAAN. Reprinted with permission.

Figure. Purnell Model for Cultural Competency. From Purnell L. The Purnell model for cultural competence. *J Transcult Nurs.* 2002;13(3):193-196. Reprinted with permission.

munication and organizational theories among others, as well as tenets of various disciplines, including anthropology, sociology, nutrition, political science, and linguistics (6). Purnell posits that "a culturally competent health care provider develops an awareness of his or her existence, sensations, thoughts, and environment without letting these factors have an undue effect on those for whom care is provided. Included among the 16 assumptions about culture in the Purnell model are that people belong to multiple cultural groups; all cultures share core similarities, but differences exist among, between, and within them; and health outcomes will be improved by considering patients as "coparticipants" and allowing them to have a choice in their health goals and interventions.

The Purnell model includes a schematic, a circle, depicting cultural domains. The outer rim represents global society; the next layer represents community, then family, then an inner rim that represents the individual with 12 cultural domains: overview/heritage, communication, family roles and organization, workforce issues, biocultural ecology, high-risk behaviors, nutrition (including access to an adequate diet, food choices and food aversions, and how food is used to treat illness or promote wellness), pregnancy and childbearing practices, death rituals, spirituality, and health care practice (including preventive care, beliefs about individual responsibility for health, and practices in self-medicating).

Explanatory Models Approach

Ethnography, in the traditional sense, involves an individual who "visits a foreign country, learns the language, and, systematically, describes social patterns in a particular village, neighborhood, or network" and "appreciate[es] and humanly engage[es] with their foreignness and understanding their religion, moral values, and everyday practices" (6). However, in the context of an alternative to cultural competency, the basic idea behind ethnography is that culture is not viewed as static: it "eschews the 'trait list approach' that understands culture as a set of already-known factors." Instead, it "emphasizes engagement with others and with the practices that people undertake in their local worlds . . . [and] the ambivalence that many people feel as a result of being between worlds," that is, those who self-identify with multiple cultural groups (4).

The explanatory models approach[¶] is a six-step "mini-ethnography" that seeks to encourage practitioners to "set their expert knowledge alongside (not over and above) the patient's own explanation and viewpoint" (4).

Step 1: Ethnic identity

Inquire as to patient's ethnic identity and if it is an important construct in that individual's self-identity. This helps to avoid assumptions that lead to stereotyping and helps the clinician to better understand the patient/client.

Step 2: What Is at Stake?

Evaluate concerns related to relationships, resources, commitments, and life—the givens that might feel like risks in time of illness—in order to better understand patients and their families in the context of their "moral lives."

Step 3: The Illness Narrative

Ask a sequence of questions that aim to discover how the patient defines illness both pragmatically and personally. The queries that yield these responses include the following:

- What do you call this problem?
- What do you believe caused this problem?
- What do you believe is happening inside your body as a result of this problem?
- How is this problem affecting your body and mind?
- What is your biggest fear related to this problem?
- What is your biggest fear related to treatment?

Step 4: Psychosocial stresses

By noting the psychosocial problems the patient is experiencing with regard to illness and treatment—including anxiety, financial stresses, and troubles related to work and family—the health practitioner is able to better understand the challenges individual patients are confronting and provide recommendations and supports that can help to alleviate their burdens. This step can be crucial in assisting patients, as illness is frequently accompanied by depression and anxiety, which can worsen health outcomes (18).

Step 5: Influence of culture on clinical relationships

In this stage of self-reflection, practitioners should take a critical look at "the formative effect of biomedicine and institutions [on] the most routine clinical practices—including bias, inappropriate and excessive use of advanced technology interventions, and, of course, stereotyping" (4).

Step 6: Problems of cultural competency approach

This last step of the explanatory models approach acknowledges that "one size does not fit all," and a culturally competent intervention is not always going to be the best intervention—be it because "attention to cultural difference can be interpreted by patients and families as intrusive" or because lending excessive significance to these differences can lead to misguidance when seeking the root cause of the problem (4).

The Campinha-Bacote Model

Cultural competence originates in the individual, then progresses to the family and community levels in the Campinha-Bacote model.[#] This framework for incorporating cultural competence into the health care encounter is a five-step process that focuses on awareness, knowledge, skill, encounter, and desire (7).

In the cultural awareness construct of this model, for example, health care professionals are challenged to confront their assumptions about specific groups and determine how such conjectures might present difficulties in the clinical encounter, and are encouraged to ask the client questions about his or her health-related values, beliefs, and practices, including, "Is there anything you want me to know about your illness/condition that I have not asked?" In obtaining cultural knowledge, a provider familiarizes himself or herself with variations in the cultural impact on families, health beliefs, and sociodemographics; health care pursuit and practices and dietary habits; and physical,

¶The explanatory models approach was developed by Arthur Kleinman, MD, and Peter Benson, MD. See reference (4).

#Josepha Campinha-Bacote, PhD, developed this model in 1998.

biological, physiological, and psychological characteristics of individuals.

Expanding cultural skills requires collection of key information to effectively conduct an assessment and determine an intervention that accounts for how the individual is affected by the cultural categories with which he or she identifies. This data-mining process explores concerns related to languages spoken, preference for using an interpreter, foods consumed or avoided when feeling ill, foods consumed or avoided for cultural/religious reasons, and patient perspective regarding cause of illness and preferences regarding treatment (7).

In cultural encounters, practitioners must balance listening, observing, and asking nonjudgmental questions while interacting with clients both verbally and nonverbally. According to Goody and Drago (7), the best opportunity to discuss nutrition presents during the cultural encounter phase of this process, because questions related to the individual's experience regarding traditional foods, food behaviors related to health, new foods consumed, food acquisition, amount and quality of food, food preparation, and family interaction can assist the practitioner in better understanding the client or patient and in performing the nutrition assessment. Lastly, cultural desire refers to practitioners *wanting* to integrate cross-cultural care into their practices, rather than just going through the motions or responding to a directive.

CONCEPTUAL, THEN CONCRETE

The process of change is one that comes with a learning curve, and because models of cultural competency are guidelines for sparking dialogue with patients and clients, it is erroneous to consider time spent on an approach that ultimately doesn't fit the dietetics practitioner's needs or produce expected results as "wasted." Dietetics practitioners might try various approaches to find the one that they deem superior, or there may be aspects of various methodologies from which to cherrypick to develop their own personal approach—or, because every patient is unique, they might determine that certain approaches work for particular patients. Of crucial importance, however, is that practitioners understand that culturally competent care it is meant as a means to *begin* a conversation, not end it (4).

Although many dietetics education programs focus on "assessing self-awareness of cultural prejudices, understanding cultural beliefs and practices, and addressing cultural or ethnic food preferences" in the first two semesters—and, for learning about clinical encounters, on theories of Stages of Change, motivational interviewing, health belief model, social learning theory, and other learning theories—"most of us were never taught these models of cultural competence as students and therefore don't know them or how to apply them effectively ourselves," says Lona Sandon, MEd, RD, assistant professor at the University of Texas Southwestern and chair of the Nutrition Educators of Health Professions Dietetic Practice Group.

Amy Knoblock-Hahn, MPH, MS, RD, dietetic internship director at the St Louis Department of Veterans Affairs Medical Center in Missouri, identifies the following reasons that a robust cultural competency program isn't included in dietetics education curricula:

- Perception of program directors that exposure to a diverse student body—for instance, by attending a diverse university or living in a diverse urban setting—translates into cultural competence.
- Program directors' feeling that they don't always have good field placement sites for development of cultural competence.
- Educators' sentiment that they already have too much to teach and believe there is no room for another course.
- Program directors' lack of knowledge of what constitutes cultural competency or diverse cultural groups.

Most dietitians are probably quite adept at knowing ethnic or religious food preferences. But when it comes to understanding how cultural groups make decisions about health care or their beliefs about how disease/sickness occurs and how it should be treated, and gathering this type of information from a client, "we probably fall short," Sandon says.

But, she notes, even though the ideas are not typically presented to students as frameworks, "Understanding these basic counseling and learning theories should easily translate into using something like the ETHNIC or LEARN frameworks."

Furthermore, notes Knoblock-Hahn, dietetics practitioners would benefit from learning the cultural competency models discussed herein, as "they are patient-centered models that allow the dietitian to gather other pertinent info that may not have otherwise come up in a counseling session."

For dietetics practitioners to determine an approach to incorporate into their practice, says Judith C. Rodriguez, PhD, RD, FADA—a professor in the Department of Nutrition and Dietetics, Brooks College of Health, University of North Florida, Jacksonville, a past member of the American Dietetic Association Diversity Committee, and current president-elect of ADA—they need to first familiarize themselves with the different models and "then think about their work setting and personal and institutional values and barriers and resources," which will inform how applicable each model is.

Rodriguez cautions that the models that apply well for individuals in private practice might not be the same as those that are ideal in institutional settings. However, she notes that, "Irrespective of the model one adopts or prefers, the approaches all should have some core elements: awareness, knowledge, skill development, and inductive reasoning. Cultural competence is a continuum or process of all of these."

Rodriguez herself tends to incorporate the tenets of the Campinha-Bacote model "because it involves reflection and action and is process-oriented" instead of emphasizing an end-result. Furthermore, she notes, it's easy to discuss this process and help individuals think of ways to apply it when she presents cultural competency seminars and lectures.

Although implementation of a culturally competent program to patient/client visits may seem burdensome to the busy practitioner—especially since time constraints of the health professional may affect the thoroughness of the clinical visit and lead to stereotyping and impetuous judgments born of biases (5)—cultural competence is expected to be added to the Joint Commission standards in 2010, which should be at least the minimal basis for performance motivation. Hopefully, dietetics practitioners won't need to be convinced of the worthiness of such programs. As Rodriguez notes, "If you see clients but do not work with them in a way that enables them to effec-

tively implement health goals, then no matter how much or how little time you spent with them, it was wasted, inadequate care and a disservice to the client. There are too many legal and ethical risks to doing it wrong—and much satisfaction to doing it right."

References

1. Alexander GR. Cultural competence models in nursing. *Crit Care Nurs Clin N Am*. 2008; 20:415-421.
2. Betancourt JR, Green AR, Carrillo JE, Park ER. From the Field: Cultural competence and health care disparities: Key perspectives and trends. *Health Aff*. 2005;24:499-505.
3. Romana H-W. Is evidence-based medicine patient-centered and is patient-centered care evidence-based? *Health Serv Res*. 2006;41:1-8.
4. Kleinman A, Benson P. Anthropology in the clinic: The problem of cultural competency and how to fix it. *PLoS Med*. 2006;3:e294. PLoS Medicine Web site. http://www.pubmedcentral.nih.gov/articlerender.fcgi?tool=pubmed&pubmedid=17076546. Accessed September 27, 2009.
5. Stein K. Cultural competency: Where it is and where it's headed. *J Am Diet Assoc*. 2009;109:388-394.
6. Purnell L. The Purnell Model for Cultural Competence. *J Transcult Nurs*. 2002;13:193-196.
7. Goody CM, Drago L. Using cultural competence constructs to understand food practices and provide diabetes care and education. *Diabetes Spectrum*. 2009;22:43-47. *Diabetes Spectrum* Web site. http://spectrum.diabetesjournals.org/content/22/1/43.full. Accessed October 5, 2009.
8. N.J. mandates cultural competency training. June 1, 2005. MeetingsNet Web site. http://meetingsnet.com/cmepharma/cme/meetings_nj_mandates_culturalcompetency/. Accessed May 5, 2009.
9. Satel S, Klick J. Don't despair over disparities. *Weekly Standard*. March 1, 2004. American Enterprise Institute Web site. http://www.aei.org/article/19981. Accessed September 27, 2009.
10. Wu E, Martinez M; California Pan-Ethnic Health Network. *Taking Cultural Competency from Theory to Action*. New York, NY: The Commonwealth Fund; 2006. The Commonwealth Fund Web site. http://www.commonwealthfund.org/usr_doc/Wu_takingcultcomptheoryaction_964.pdf. Accessed September 30, 2009.
11. Wilson-Stronks A, Galvez E. Hospitals, Language, and Culture: A Snapshot of the Nation: Exploring Cultural and Linguistic Services in the Nation's Hospitals: A Report of Findings. The Joint Commission Web site. http://www.jointcommission.org/NR/rdonlyres/E64E5E89-5734-4D1D-BB4D-C4ACD4BF8BD3/0/hlc_paper.pdf. Accessed April 11, 2009.
12. Stein K. Navigating cultural competency: In preparation for an expected standard in 2010. *J Am Diet Assoc*. 2009; 109:1676-1688.
13. Stein K. Communication is the heart of the patient-provider relationship. *J Am Diet Assoc*. 2006;106:508-512.
14. Drago L. Crossroads of nutrition and culture: Best culturally competent communication tools. *NewsFlash*. 2009;30:16-17.
15. University of Michigan, Program for Multicultural Health. Cultural competency: Cross-cultural communication. http://www.med.umich.edu/multicultural/ccp/commun.htm. Accessed October 5, 2009.
16. Berlin EA, Fowkes WC Jr. A teaching framework for cross-cultural competence: Application in family practice. *West J Med*. 1983; 139:934-938.
17. Campa D. Practical things that can be done in the 15-minute office visit. Paper presented at: California HealthCare Foundation's Chronic Disease Care: Better Ideas for Solving Real World Problems Conference; November 3, 2005; San Francisco, CA.
18. Telles-Correia D, Barbosa A. Anxiety and depression in medicine: Models and measurement [abstract]. *Acta Med Port*. 2009; 22:89-98.