Report of the ASHP Ad Hoc Committee on Ethnic Diversity and Cultural Competence

Am J Health-Syst Pharm. 2005; 62:1924-30

In June 2003, the Board of Directors of the American Society of Health-System Pharmacists (ASHP) established the Ad Hoc Committee on Ethnic Diversity and Cultural Competence as a result of a recommendation of the 2002 Council on Organizational Affairs. The Ad Hoc Committee comprises appointees representing individuals from diverse racial and ethnic backgrounds and with experience in issues of cultural competence. The specific charges of the Committee were to

1. Study the current and projected ethnic and racial composition of health-system pharmacy practitioners,
2. Develop a statement on ethnic and racial diversity for health-system pharmacy and ASHP,
3. Recommend mechanisms to foster ethnic and racial diversity within the ASHP membership,
4. Recommend mechanisms to foster ethnic and racial diversity within ASHP's Board of Directors, committees, councils, commissions, other component groups, and staff,
5. Discuss ways to raise awareness of the importance of cultural competence in the provision of patient care so that optimal therapeutic outcomes are achieved in diverse populations, and
6. Identify additional factors that contribute to disparities in health care so that optimal therapeutic outcomes are achieved in diverse populations.

The Committee held discussions via conference calls and e-mail between June 2003 and August 2004. Committee members also met in person at the ASHP Midyear Clinical Meeting in December 2003.

Building the case for diversity and fostering cultural competence

The growth of ethnic minorities, particularly Hispanics and Asians, in the United States over the past years has been phenomenal. Ethnic minorities comprise an estimated 27% of the U.S. population and are projected to constitute 37% in 2025.[1] Additional data indicate that between 1980 and 2000, the African-American population in the United States increased by 28%, the Native American population by 55%, the Hispanic population by 122%, and the Asian population by more than 190%.[2]

The U.S. Department of Commerce estimates that these ethnic minorities will account for 90% of the total growth in the nation's population between 1995 and 2050. In addition, ethnic minorities currently account for more than half of the nation's work force, which will become even more diverse in the future.[3]

Despite significant growth in the number of ethnic minorities in the United States, minorities are underrepresented in the health care work force.[3] In 2002, the American Hospital Association's Commission on Workforce for Hospitals and Health Systems released a report that described the challenges of overcoming work force shortages in hospitals.[4] The commission found that, despite the growing diversity of the national labor force, hospital employees are disproportionately female and Caucasian. The commission urged hospital leaders to aggressively develop a work force that represents the full spectrum of the community's population, including men and women, all racial and ethnic minorities, and immigrants.[4]

A 2004 Institute of Medicine (IOM) report cited a continuing shortage of minorities among health professionals.[5] IOM found that Lati-

HANNAH K. VANDERPOOL, PHARM.D., is Director, Member and Affiliate Relations and Forums, American Society of Health-System Pharmacists, 7272 Wisconsin Avenue, Bethesda, MD 20814.

The members of the ASHP Ad Hoc Committee on Ethnic Diversity and Cultural Competence are Magaly Rodriguez de Bittner, Pharm.D., BCPS, CDE, FAPhA (Chair), Lourdes Cuellar, B.S.Pharm., M.S., FASHP, Ernest Dole, B.S., Pharm.D., Amir Emamifar, B.S.Pharm., M.B.A., Rasheen Jackson, Pharm.D., Donald Kishi, Pharm.D., Manita Singh, Paul Tan, Pharm.D., FASHP, and Hannah K. Vanderpool, Pharm.D. (Secretary).

 1079-2082/05/0902-1924$06.00.
DOI 10.2146/ajhp050100

nos, who constitute 12% of the U.S. population, comprise only 2% of registered nurses, 3.4% of psychologists, and 3.5% of physicians. According to the report, 1 in 8 Americans is African American, but fewer than 1 in 20 physicians is African American. Though pharmacy was not specifically examined, the report cited pharmacists as critically important to ensuring that America's health care systems provide the highest quality of health care, health promotion, and disease prevention services.

According to the IOM report, increasing racial and ethnic diversity among health care professionals is important because diversity is associated with improved access to care for racial and ethnic minorities, greater patient choice and satisfaction, better patient–clinician communication, and improved educational experiences for allied health students.[5]

Health care preferences of minorities. In a recent nationwide survey of households, minorities were over four times more likely to receive health care from nonwhite physicians.[5,6] Several studies have found that racial and ethnic minority health care professionals are significantly more likely than their white peers to serve minority and medically underserved areas.[5,7,8]

Several studies have shown that minorities are more likely to select clinicians who mirror their own racial or ethnic background.[5,9-11] The clinician's ability to speak the patient's language is a significant consideration in the patient's choice.[5,11] Racial and ethnic minorities are generally more satisfied with the care received from minority physicians.[5,12] For example, African-American patients who received care from African-American physicians were more likely to rate their physicians as excellent in providing health care, treating them with respect, explaining their medical issues, being accessible, and listening to their concerns.[5,12]

Knowledge of the health beliefs and health-seeking behaviors of diverse patient populations is vital to pharmacy practice and can strengthen and broaden the scope of health care delivery systems. Other cultures may provide a range of alternatives in services, conceptualizations of illness, and treatment modalities.

Cultural competence. The National Center for Cultural Competence (NCCC) defines culture as "an integrated pattern of human behavior which includes thoughts, communication, languages, beliefs, practices, customs, courtesies, rituals, manners of interacting, roles, relationships, and expected behaviors of a racial, ethnic, religious, social or political group."[13] According to NCCC, cultural competence requires that organizations

- Have a 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 value diversity, conduct self-assessment, manage the dynamics of difference, acquire and institutionalize cultural knowledge, and adapt to diversity and the cultural contexts of the communities they serve, and
- Incorporate the above in all aspects of policymaking, administration, practice, and service delivery and systematically involve consumers, key stakeholders, and communities in these endeavors.[13]

Cultural competence denotes the knowledge, skills, attitudes, and ability of practitioners to provide optimal health care services to patients from a wide range of cultural and ethnic backgrounds.[13] To provide culturally competent care, practitioners must be able to provide patient-centered care by adjusting their attitudes and behaviors to the needs of diverse patient groups. They must demonstrate an understanding of their patients' belief systems, cultural biases, ethnic origins, family structures, and other factors that influence the way in which people experience illness, adhere to medical advice, and respond to treatment. Health care providers who practice culturally competent care are more likely to satisfy their patients and provide their patients with effective care.[2,14] A list of additional key terms related to cultural competence can be found in Appendix A.

Cultural competence begins with being aware of one's own cultural beliefs and practices and recognizing that people from other cultures may not share them. Culturally competent care requires health care practitioners to be

- Knowledgeable about cultural differences and their effect on attitudes and behaviors,
- Sensitive, understanding, nonjudgmental, and respectful in dealings with patients whose culture differs from one's own, and
- Flexible and skillful in responding and adapting to different cultural contexts and circumstances.[16]

Cultural competence can significantly affect clinical outcomes. Research has shown that the overlooking of cultural beliefs may lead to negative health consequences.[16] Providers may miss opportunities for screening because they are not familiar with the prevalence of conditions among minority groups.[17-20] Diagnostic errors may occur because of miscommunication, and different responses to medication may not be considered. In addition, providers may lack knowledge about traditional remedies, which may lead to harmful interactions with prescribed medications. Culturally competent health care may result in better patient education, improved health-seeking behavior in patients, more appropriate testing and screening, fewer diagnostic errors, avoidance of drug complications, and greater adherence to medical advice.[14,17]

The U.S. Department of Health and Human Services' Office of Minority Health developed national standards to provide a consistent and comprehensive approach to cultural and linguistic competence in health care and published its final report on national standards for culturally and linguistically appropriate services (CLAS) in health care in 2001.[21] The 14 CLAS standards offer a framework for the implementation of services and organizational structures to assist health care organizations and providers in addressing the cultural and linguistic issues presented by diverse populations. A listing of all 14 CLAS standards for health care appears in Appendix B.

Ad Hoc Committee charges and recommendations

Charge 1: Study the current and projected ethnic and racial composition of health-system pharmacy practitioners. There are limited data regarding the ethnic and racial composition of health-system pharmacists. The report of the 2000–01 Ad Hoc Committee on Affirmative Action and Diversity of the American Association of Colleges of Pharmacy (AACP) compared race data for the total U.S. population in 2000 with data for those who received pharmacy degrees between 1998 and 2000 and the U.S. pharmacist population, regardless of setting, in 1990 (Table 1).[1]

The only survey to date to collect ethnic and racial information from health-system pharmacists is the 2000 National Pharmacist Workforce Survey.[22] Of the 4895 health-system pharmacists in the sample, 2250 (46%) completed the survey. Of these, 1845 surveys contained usable responses to the questions regarding ethnic or racial background. Of these, 465 were active pharmacists for nongovernment hospitals, government hospitals, managed care organizations, or pharmacy benefits management companies (Table 2).

The ASHP Ad Hoc Committee on Ethnic Diversity and Cultural Competence believes that the health-system pharmacy work force should reflect the ethnic and racial composition of the U.S. pharmacist population. Further, the ethnic and racial makeup of the ASHP membership should mirror that of health-system pharmacists in the United States.

Recommendations. To meet these goals, the Committee has made the following recommendations:

1. Conduct a study to determine the ethnic and racial diversity of hospital and health-system pharmacists. This recommendation is based on the limited available data on the race and ethnicity of health-system pharmacists.
2. Survey the ASHP membership for race and ethnicity demographic data and track these data over time. As ASHP does not routinely collect ethnicity data about its members, the Committee recommended surveying the current ASHP membership to establish baseline race and ethnicity data. The annual membership census should include an optional demographic question about members' ethnicity and race.

Charge 2: Develop a statement about ethnic and racial diversity in health-system pharmacy and in ASHP. Ethnic and racial diversity and cultural competence are components of the broader issue of health disparities. Currently, several ASHP policies address health disparities, including policies on cultural diversity, health literacy, and nondiscriminatory pharmaceutical care. A thorough review of existing policies will be consolidated within an ASHP statement on health disparities. The final statement on health disparities, which will address cultural competence and ethnic and racial diversity, will be coordinated through the ASHP Council on Professional Affairs.

Charge 3: Recommend mechanisms to foster ethnic and racial diversity within the ASHP membership. The Committee believes that increasing diversity within ASHP and becoming more inclusive are central to achieving the Society's mission and vision. Committee members do not recommend isolat-

Table 1.
Race of Selected Comparative Groups[1]

Race	No. (%)			
	Total U.S. Population, 2000[a]	First Professional Pharmacy Degrees Conferred, 1998–99	Pharmacy Faculty Population, 1999–2000	U.S. Pharmacist Population, 1990
All races[b]	306,961,000	7,141	3,428	186,269
White	225,949,000 (73.6)	4,597 (64.4)	2,753 (80.3)	160,149 (86.0)
Black	35,231,000 (11.5)	401 (5.6)	176 (5.1)	7,836 (4.2)
American Indian or Alaskan Native	2,428,000 (0.8)	36 (0.5)	8 (0.2)	378 (0.2)
Asian or Pacific Islander	11,100,000 (3.6)	1,327 (18.6)	265 (7.7)	12,222 (6.6)
Hispanic origin of any race	32,253,000 (10.5)	266 (3.7)	73 (2.1)	5,684 (3.1)

[a]Projections of U.S. Census Bureau and based on 1990 census data; they do not reflect census 2000 counts.
[b]Indicates foreign nationals. Because multiple race designations may have applied to a single individual, the All races number may exceed the actual number of people surveyed.

Table 2.
Race of Health-System Pharmacists (n = 465)[22]

Race	No. (%) Health-System Pharmacists
White/Caucasian	386 (83.0)
Latino/Latina or Hispanic	8 (1.7)
American Indian	2 (0.4)
Black/African American	13 (2.8)
Asian American or Pacific Islander	51 (11.0)
Other	5 (1.1)

ing diversity as a distinct recruitment program in the organization but believe that an effort to increase diversity should guide ASHP's business practices and strategies.

One way of creating ethnic diversity among ASHP members is by focusing on students. Achieving ethnic diversity in the health professions is dependent on changing the precollege educational system. This concept is supported by the American Hospital Association's 2002 Commission on Workforce for Hospitals and Health Systems tactical recommendations to (1) actively recruit more ethnic and racial minorities into health careers, (2) reach out to schools and colleges that serve as primary points of entry to higher education, and (3) reach out to organizations that are recognized sources of ethnic and racial minorities who might consider health professions.[4]

Ethnic and racial diversity within its membership will allow ASHP to draw from a variety of perspectives and ideas and subsequently become a more effective organization. Diversity will add value to organizational effectiveness in terms of teamwork, productivity, customer relations, creativity, and job satisfaction and may allow ASHP to access new market segments for Society products and services.

Recommendations. To increase the ethnic and racial diversity within the ASHP membership, the Committee recommended that ASHP do the following:

1. Provide training and resources for members to use in discussing pharmacy as a career with young people from diverse racial and ethnic backgrounds.
2. Provide training and resources for members to use when discussing careers in health-system pharmacy and ASHP membership with pharmacy students from diverse racial and ethnic backgrounds.
3. Engage pharmacy groups that represent diverse ethnic groups in discussions on items of mutual interest.
4. Collaborate with AACP and other professional pharmacy organizations in the development of recruitment materials and other efforts (e.g., shadowing experiences in practice settings) for underrepresented populations.
5. Use ASHP communication vehicles to demonstrate commitment to diversity efforts. Publicize and distribute the ASHP statement on diversity among members and nonmembers to raise awareness and interest in ASHP.

Charge 4: Recommend mechanisms to foster ethnic and racial diversity within ASHP's Board of Directors, committees, councils, commissions, other component groups, and staff. ASHP should strive to foster inclusivity. A publication of the American Society of Association Executives Foundation explored emerging issues that will dramatically alter the future of associations, one of which was the issue of inclusivity.[23] Inclusivity emphasizes understanding and preserving the valuable differences in cultural and personal perspectives. It also uses these differences as a resource for creativity and problem solving.

A good example of an activity designed to promote inclusivity is the Institute for Diversity in Health Management, created by the American Hospital Association, the American College of Healthcare Executives, the National Association of Health Services Executives, and newer partners, the Association of Hispanic Healthcare Executives and the Catholic Health Association. The institute collaborates with educators and health services organizations to expand leadership opportunities to ethnic minorities.

Diversity may increase organizational effectiveness by bringing different and important knowledge and perspectives and can improve organizations by challenging assumptions about the organization's functions, strategies, operations, practices, and procedures.[24] The quality of ideas and content generated by organizations may improve with a diverse work force and membership base.

Recommendations. To foster ethnic and racial diversity within ASHP, the Committee has made the following recommendations:

1. Perform a self-assessment of diversity of current leadership groups and ASHP staff to build awareness.
2. Request recommendations for nominations and appointments from pharmacy groups representing different ethnic groups.
3. Provide diversity and cultural competency training as part of the annual ASHP Board of Directors and staff orientation process.
4. Collaborate with ASHP affiliates in the recruitment and development of a diversity of state leaders.

Charge 5: Discuss ways to raise awareness of the importance of cultural competence in the provision of patient care so that optimal therapeutic outcomes are achieved in diverse populations. In addition to the previous evidence presented on the significance and importance of cultural competence, the Institute for Safe Medication Practices has noted that an understanding of cultural beliefs about health, illness, and medications and of variations in physiological responses to medications among races and ethnicities is important for providing appropriate

care.[25] Cultural beliefs, including health-seeking behavior, can affect interaction between patient and provider. Acceptance and adherence to prescribed medication regimens vary among ethnic groups. Therefore, health care professionals must be able to understand these differences and communicate them to others on the health care team to ensure that each patient receives the best possible care.[25]

Several educational programs on cultural competence were presented at the 2004 Midyear Clinical Meeting. Specifically, one hour of programming introducing the concepts of cultural competence was targeted to students and new practitioners, and a three-hour session on more advanced concepts in cultural competence, targeted to practitioners, was also conducted. An additional program on cultural competence was presented at the 2005 Summer Meeting.

Recommendations. To raise awareness of the importance of cultural competence in the provision of optimal patient care, the Committee has made the following recommendations:

1. Develop a policy statement on cultural competence. ASHP has developed several policy positions on cultural competence; however, the Committee recommends the creation of a comprehensive policy statement. (A summary of related policies appears in Appendix C.)
2. Collaborate with the Joint Commission of Pharmacy Practitioners on broader professionwide efforts regarding cultural competence (e.g., development of a professionwide policy statement on cultural competence).
3. Conduct educational programs to increase member awareness and practice skills related to cultural competence. This education might include workshops, learning communities, pearls presentations, town hall meetings, and poster sessions. Education on cultural competency issues is encouraged in preceptor training sessions, residency standards, and leadership orientation at ASHP and affiliate levels.
4. Publish editorials and articles on the importance of cultural competence in *AJHP*. One editorial should be written to address the breadth of this issue and how it serves as the basis for an effective and successful pharmacy practice. Other future *AJHP* issues should include commentaries and relevant articles. The Committee is willing to assist in identifying potential topics and authors for these articles.
5. Utilize Action Line and ASHP e-mail NewsLinks to raise awareness of the issues of cultural competence. The use of these communications vehicles will help drive the importance of this initiative through all segments of the ASHP membership.
6. Create a Web resource center to compile news and activities, educational sessions, selected readings, and ASHP policy on cultural competence.
7. Engage affiliate leadership in discussions on the importance of cultural competence.

Charge 6: Identify additional factors that contribute to disparities in health care so that optimal therapeutic outcomes are achieved in diverse populations. According to a recent IOM report, members of racial and ethnic minorities receive inferior health care.[26] The study defined disparities in health care as "racial or ethnic differences in the quality of health care that are not due to access-related factors or clinical needs, preferences, and appropriateness of intervention." Disparities in care were found in several disease states (i.e., cardiovascular care, cancer, HIV and AIDS, mental health, and respiratory disease) and were often associated with worse outcomes.

The authors of the report recommended the creation of a comprehensive strategy to eliminate these disparities.[26] Numerous sectors, including health care providers, patients, payors, health plan purchasers, and society-at-large, should be made aware of this health care gap. Patient and provider relationships may be strengthened by broadening the diversity in the health professions, which may result in higher patient satisfaction and greater patient adherence to treatment. The development and implementation of training programs in cultural competence for health care providers may be key to reducing health care disparities.[26]

Recommendations. The Committee has made the following recommendations for identifying additional factors that may contribute to health care disparities:

1. Provide educational programs on health disparities to increase the awareness of racial and ethnic disparities in health care among the general public, key stakeholders, and the ASHP membership.
2. Create a professional policy on health disparities for advocacy purposes.
3. Assume a leadership role in forming intraprofessional and interprofessional organizational collaborations to identify health disparities and develop an awareness of and solutions for correcting these disparities.

Additional Committee observations and comments

As the ASHP Board of Directors considers how to broaden the diversity of health-system pharmacy practitioners and their awareness and skills in cultural competence, the Committee encourages the Board to consider how these recommendations may also apply to pharmacy technicians working in health systems. As health-system pharmacists' roles broaden, the Committee believes that the roles of technicians will also expand. In doing so, their need for cultural awareness and sensitivity will increase. ASHP could collaborate with the Pharmacy Technician Certification Board to develop

parallel activities in diversity efforts and build cultural competency skills among health-system pharmacy technicians.

Summary

The ASHP Ad Hoc Committee on Ethnic Diversity and Cultural Competence believes there is a compelling need for ASHP to address the diversity of health-system pharmacists and the ASHP membership in an effort to improve patient care through proficiency in cultural competence and close the gaps in health care. Following the action of the ASHP Board of Directors, a staff committee was formed and has been meeting regularly to implement each of the recommendations of the Ad Hoc committee.

References

1. American Association of Colleges of Pharmacy. Report of the Ad Hoc Committee on Affirmative Action and Diversity. www.ajpe.org/legacy/pdfs/aj6404S15.pdf (accessed 2005 Jun 22).
2. Cohen JJ, Gabriel BA, Terrell C. The case for diversity in the health care workforce. *Health Aff.* 2002; 21:90-102.
3. American Hospital Association. Breaking down barriers . . . making the case for diversity. www.ahanews.com/ahanews/hospitalconnect/search/article.jsp?dcrpath+AHA/NewsStory_Article/dataAHA_News?021209_Breaking_barriers&domain=AHANews (accessed 2005 Jun 22).
4. American Hospital Association. In our hands. How hospital leaders can build a thriving workforce. www.aha.org/aha/key_issues/workforce/commission/InOurHands.html (accessed 2004 Jul 27).
5. Smedley BD, Butler AS, Bristow LR, eds. In the nation's compelling interest: ensuring diversity in the health-care workforce. Washington, DC: National Academies Press; 2004:1-22.
6. Moy E, Bartman BA. Physician race and care of minority and medically indigent patients. *JAMA.* 1995; 273:1515-20.
7. Solomon ES, Williams CR, Sinkford JC. Practice location characteristics of black dentists in Texas. *J Dent Educ.* 2001; 65:571-4.
8. Mertz EA, Grumbach K. Identifying communities with low dentist supply in California. *J Public Health Dent.* 2001; 61:172-7.
9. Bichsel RJ, Mallinckrodt B. Cultural commitment and the counseling preferences and counselor perceptions of Native American women. *Couns Psychol.* 29:858-81.
10. Lopez SR, Lopez AA, Fong KT. Mexican Americans' initial preferences for counselors: the role of ethnic factors. *J Couns Psychol.* 1991; 38:487-96.
11. Saha S, Taggart SH, Komaromy M et al. Do patients choose physicians of their own race? *Health Aff.* 2000; 19:76-83.
12. Saha S, Komaromy M, Koepsell TD et al. Patient-physician racial concordance and the perceived quality and use of health care. *Arch Intern Med.* 1999; 159:997-1004.
13. National Center for Cultural Competence. Conceptual frameworks/models, guiding values and principles. http://gucchd.georgetown.edu/nccc/framework.html (accessed 2004 Jul 27).
14. Brach C, Frasier I. Can cultural competency reduce racial and ethnic health disparities? A review and conceptual model. *Med Care Res Rev.* 2000; 57(suppl 1):181-217.
15. Cross TL, Bazron BJ, Dennis KW et al. Towards a culturally competent system of care. Vol. 1. Washington, DC: National Technical Assistance Center for Children's Mental Health/Georgetown University Child Development Center; 1989.
16. Administration on Aging. Achieving cultural competence. A guidebook for providers of services to older Americans and their families. www.aoa.gov/prof/adddiv/cultural/cc-guidebook.pdf (accessed 2005 Jun 22).
17. Management Sciences for Health. The providers guide to quality and culture main page. http://erc.msh.org/mainpage.cfm?file=1.0.htm&module=provider&language=English (accessed 2004 Aug 7).
18. Lavizzo-Mourley R, Mackenzie ER. Cultural competence: essential measurements of quality for managed care organizations. *Ann Intern Med.* 1996; 124:919-21.
19. Lawson WB. The art and science of the psychopharmacotherapy of African Americans. *Mt Sinai J Med.* 1996; 63:301-5.
20. Moffic HS, Kinzie JD. The history and future of cross-cultural psychiatric services. *Community Ment Health J.* 1996; 32:581-92.
21. Office of Minority Health. National standards for culturally and linguistically appropriate services in health care. Final report. www.omhrc.gov/omh/programs/2pgprograms/finalreport.pdf (accessed 2005 Jun 22).
22. American Association of Colleges of Pharmacy. Final report of the National Pharmacist Workforce Survey: 2000. www.aacp.org/site/page.asp?TRACKID=&VID=1&CID=503&DID=3897 (accessed 2004 Jul 27).
23. Olson R, Dighe A. Exploring the future: seven strategic conversations that could transform your association. Washington, DC: Foundation of the American Society of Association Executives; 2001:33-41.
24. Thomas D, Ely R. Making differences matter: a new paradigm for managing diversity. *Harv Bus Rev.* 1996; 74:79-90.
25. Institute for Safe Medication Practices. Cultural diversity and medication safety. www.ismp.org/msaarticles/diversityprint.htm (accessed 2004 Jul 27).
26. Smedley BD, Stith AY, Nelson AR, eds. Unequal treatment: confronting racial and ethnic disparities in health care. Washington, DC: National Academies Press; 2003:1-28.

Appendix A—Key terms related to cultural competence

Culture: Integrated patterns of human behavior that include the language, thoughts, communications, actions, customs, beliefs, values, and institutions of racial, ethnic, religious, or social groups.[15]

Competence: The capacity to function effectively as an individual and an organization within the context of the cultural beliefs, behaviors, and needs presented by consumers and their communities.[15]

Cultural competence: An integrated pattern of human behavior that includes thoughts, communication, languages, beliefs, practices, customs, courtesies, rituals, manners of interacting, roles, relationships, and expected behaviors of a racial, ethnic, religious, social, or political group.[13]

Cultural and linguistic competence: Cultural and linguistic competence is a set of congruent behaviors, attitudes, and policies that come together in a system, in an agency, or among professionals that enables effective work in cross-cultural situations.[15]

Culturally and linguistically appropriate services (CLAS): Health care services that are respectful of and responsive to cultural and linguistic needs.[13]

CLAS standards: The collective set of CLAS mandates, guidelines, and recommendations issued by the Office of Minority Health intended to inform, guide, and facilitate required and recommended practices related to culturally and linguistically appropriate health services.

Appendix B—National standards for culturally and linguistically appropriate services

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. Language access services (mandated).

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 group 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 notice in their communities about the availability of this information.

Appendix C—Current ASHP policies related to ethnic diversity and cultural competence

Policy 0314
Cultural competence
Source: Council on Educational Affairs

To foster cultural competence among pharmacy students, residents, and practitioners and within health systems for the purpose of achieving optimal therapeutic outcomes in diverse patient populations.

Policy 0409
Cultural diversity among health care providers
Source: Council on Educational Affairs

To foster awareness of the cultural diversity of health care providers; further,

To foster recognition of the impact that cultural diversity of health care providers may have on the medication-use process; further,

To develop the cultural competencies of pharmacy practitioners, technicians, students, and educators.